

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

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

GOOD SAMARITAN MEDICAL	)	
CENTER, INC., et al.,	)	
	)	
<i>Plaintiffs,</i>	)	
	)	
v.	)	
	)	
THE LEAPFROG GROUP,	)	
	)	
<i>Defendant.</i>	)	

**DECLARATION OF KIMBERLY E. BLAIR IN SUPPORT OF THE LEAPFROG
GROUP’S MOTION FOR SUMMARY JUDGMENT**

I, Kimberly E. Blair, declare and state as follows:

I am a partner at the law firm of Wilson Elser Moskowitz Edelman & Dicker LLP. I am an attorney and admitted to practice law in the State of Illinois. I have been granted permission by the Court to participate *pro hac vice* in this case. [ECF Dkt. No. 29]. I represent the Leapfrog Group in this matter, and I submit this Declaration in support of the Leapfrog Group’s Motion for Summary Judgment (the “Motion”) and Rule 56.1 Statement of Material Facts in Support of the Motion (the “Rule 56.1 Statement”) filed simultaneously herewith.

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

The various exhibits identified in the Motion and the Rule 56.1 Statement are organized by documents produced in the action by the Leapfrog Group (Bates stamp beginning with “LEAPFROG”), Plaintiff Hospitals (Bates stamp beginning with “PBHN”), Cura Strategies (Bates stamp beginning with “CURA”) (collectively “Produced Documents”); and publicly

available documents identified by web link and attached; and deposition transcripts, interrogatory responses, and deposition notices served in this case.

1. Attached as **Exhibit 1** is a true and correct copy Leapfrog’s “History,” page downloaded from the following website: <https://www.leapfroggroup.org/about/history>, and which was last accessed on November 12, 2025.

2. Attached as **Exhibit 2** is a true and correct copy of the transcript of the deposition of Leah Binder, CEO of the Leapfrog Group, taken in the above-captioned action on September 22, 2025.

3. Attached as **Exhibit 3** is a true and correct copy of the transcript of the deposition of Melissa Danforth, Leapfrog’s Senior Vice President of Healthcare Ratings, taken in the above-captioned action on September 18, 2025.

4. Attached as **Exhibit 4** is a true and correct copy Leapfrog’s “Mission and Vision,” page downloaded from the following website: <https://www.leapfroggroup.org/>, and which was last accessed on November 12, 2025.

5. Attached as **Exhibit 5** is a true and correct copy of the transcript of the deposition of Dr. Matt Austin, taken in the above-captioned action on September 25, 2025.

6. Attached as **Exhibit 6** is a true and correct copy of Johns Hopkins University’s “”Armstrong Institute to Aid the Leapfrog Group,” release downloaded from the following website: <https://www.hopkinsmedicine.org/-/media/armstrong-institute/documents/news/2012-12-12-ai-aids-leapfrog-group-in-grading.pdf>, and which was last accessed on November 12, 2025.

7. Attached as **Exhibit 7** is a true and correct copy Leapfrog’s “Hospital Survey”, background page downloaded from the following website: <https://www.leapfroggroup.org/data-users/leapfrog-hospital-survey> , and which was last accessed on November 11, 2025.

8. Attached as **Exhibit 8** is a true and correct copy Leapfrog’s “Innovators for Leapfrog,” page downloaded from the following website: <https://www.leapfroggroup.org/news-events/%E2%80%9CInnovators-leapfrog%E2%80%9D-launching-fuel-investment-patient-safety#:~:text=About%20The%20Leapfrog%20Group,sign%20up%20for%20our%20newsletter,> which was last accessed on November 12, 2025.

9. Attached as **Exhibit 9** is a true and correct copy Leapfrog’s “2025 Hospital Survey”, downloaded from the following website: https://www.leapfroggroup.org/sites/default/files/Files/2025%20HospitalSurvey_20250502_v9.1%20%28version%20%29.pdf, and which was last accessed on November 12, 2025.

10. Attached as **Exhibit 10** is a true and correct copy Leapfrog’s “Hospital FAQ”, page downloaded from the following website <https://www.hospitalsafetygrade.org/HospitalFAQ> which was last accessed November 12, 2025

11. Attached as **Exhibit 11** is a true and correct copy Leapfrog’s “Welcome to the 2025 Leapfrog Hospital Survey”, page downloaded from the following website: <https://www.leapfroggroup.org/survey-materials/survey-login-and-materials>, and which was last accessed on November 12, 2025.

12. Attached as **Exhibit 12** is a true and correct copy Leapfrog’s “Leapfrog Hospital Survey Login,” page downloaded from the following website: <https://survey.leapfroggroup.org/login>, and which was last accessed on November 12, 2025.

13. Attached as **Exhibit 13** is a true and correct copy Leapfrog’s “Hospital Survey Scoring and Results,” page downloaded from the following website: <https://www.leapfroggroup.org/survey-materials/scoring-and-results>, and which was last accessed on November 12, 2025.

14. Attached as **Exhibit 14** is a true and correct copy Leapfrog’s “Hospital Survey Scoring Algorithms,” page downloaded from the following website: https://www.leapfroggroup.org/sites/default/files/Files/2025%20HospitalSurveyScoringAlgorithm_20250401_v10.0_1.pdf, and which was last accessed on November 12, 2025.

15. Attached as **Exhibit 15** is a true and correct copy Leapfrog’s “Search Ratings,” page downloaded from the following website: <https://ratings.leapfroggroup.org/>, and which was last accessed on November 12, 2025.

16. Attached as **Exhibit 16** are June 2024 Leapfrog emails regarding public comment, which was Exhibit 19 to M. Danforth’s deposition.

17. Attached as **Exhibit 17** is a true and correct copy of an email chain between Tenet Healthcare employees about participation in Leapfrog’s Survey, marked as PBHN000005755.

18. Attached as **Exhibit 18** is a true and correct copy of a December 11, 2024 email from Heather Havericak to Jennifer Shoemaker and Nicole Jackson, marked as PBHN000004823.

19. Attached as **Exhibit 19** is a true and correct copy of a March 25, 2024 email from Regina West to Maureen Colandrea, Maritza Ortiz, and Taylor Pool (Tenet Employees), marked as PBHN000012727.

20. Attached as **Exhibit 20** is the a true and correct copy of Leapfrog’s “Methodology” accessed and downloaded from

<https://www.hospitalsafetygrade.org/media/file/Methodology-Spring-2025.pdf> , last accessed November 12, 2025.

21. Attached as **Exhibit 21** is a true and correct copy of the Leapfrog Hospital Safety Grade Scoring Methodology for Fall 2024, marked as LEAPFROG00065461.

22. Attached as **Exhibit 22** is a true and correct copy of the transcript of the deposition of Cynthia McCauley, Chief Executive Officer of St. Mary's Medical Center, Inc., taken in the above-captioned action on September 24, 2025.

23. Attached as **Exhibit 23** is a true and correct copy of the transcript of the deposition of Heather Havericak, Chief Executive Officer of Delray Medical Center, Inc., taken in the above-captioned action on September 19, 2025.

24. Attached as **Exhibit 24** is a true and correct copy of the transcript of the deposition of Jerad Hanlon, Chief Executive Officer of West Boca Medical Center, Inc., taken in the above-captioned action on September 23, 2025.

25. Attached as **Exhibit 25** is a true and correct copy of the transcript of the deposition of Sheri Montgomery, Chief Executive Officer of Good Samaritan Medical Center, Inc., taken in the above-captioned action on September 12, 2025.

26. Attached as **Exhibit 26** is a true and correct copy of the transcript of the deposition of Erik Cazares, Chief Executive Officer of Palm Beach Gardens Community Hospital, Inc., taken in the above-captioned action on September 24, 2025.

27. Attached as **Exhibit 27** are true and correct copies of historical (Spring 2023 – Spring 2025) Safety Grades for the Plaintiffs, accessible publicly upon clicking “see full score” on each Hospitals’ Safety Grade landing page, and then choosing the option to “Order 2 ½ years

of detailed scoring for this hospital for \$2.95” and then ordering, marked
LEAPFROG000005334-6359

28. Attached as **Exhibit 28** is a true and correct copy of Leapfrog’s “About the Grade,” page downloaded from the following website:
<https://www.hospitalsafetygrade.org/about-the-grade> , and which was last accessed on November 12, 2025.

29. Attached as **Exhibit 29** is a true and correct copy of the Leapfrog Hospital Safety Grade Scoring Methodology for Spring 2024, marked as LEAPFROG00039273.

30. Attached as **Exhibit 30** is a comparison of 2-step imputation method created for purposes of this Motion utilizing page 15 of the spring 2024 methodology document (LEAPFROG00039287) p. 15 of the fall 2024 methodology document (LEAPFROG00065475).

31. Attached as **Exhibit 31** is a true and correct copy of a May 21, 2024 email from The Leapfrog Group to Regina West, marked as PBHN000001589.

32. Attached as **Exhibit 32** are a true and correct copies Plaintiffs’ Interrogatory Answers.

33. Attached as **Exhibit 33** is a true and correct copy of August – November 2024 emails, marked PBHN0000005755-5760.

34. Attached as **Exhibit 34** is a true and correct copy of November 4, 2024 emails, marked PBHN000007230-7232.

35. Attached as **Exhibit 35** is a true and correct copy of Leapfrog’s “Safety Grade landing page,” downloaded from the following website: www.hospitalsafetygrade.org, and which was last accessed on November 12, 2025.

36. Attached as **Exhibit 36** is a true and correct copy of the “Initial Letter Grade landing page” for Safety Grade, accessed from https://www.hospitalsafetygrade.org/search?findBy=hospital&zip_code=&city=&state_prov=&hospital=west+boca and screenshotted, November 12, 2025.

37. Attached as **Exhibit 37** is a true and correct copy of the “Full Score Landing Page” for Safety Grade, with “practices to prevent errors” selected and downloaded from <https://www.hospitalsafetygrade.org/h/west-boca-medical-center?findBy=hospital&hospital=west+boca&rPos=0&rSort=grade> , last accessed November 12, 2025.

38. Attached as **Exhibit 38** is a true and correct copy of the “Detailed Table View” page for Safety Grade, accessed from <https://www.hospitalsafetygrade.org/table-details/west-boca-medical-center?findBy=hospital&hospital=west%20boca&rPos=0&rSort=grade> and screenshotted, November 12, 2025.

39. Attached as **Exhibit 39** is a true and correct copy of Leapfrog’s “Terms of Use” page, downloaded from <https://www.hospitalsafetygrade.org/terms-of-use> , last accessed November 12, 2025.

40. Attached as **Exhibit 40** is a true and correct copy of Leapfrog’s “Request for Public Comments: Planned Updates to the Leapfrog Hospital Safety Grade Methodology for Fall 2024,” marked as LEAPFROG00155015-00155018.

41. Attached as **Exhibit 41** is a true and correct copy of a draft of Leapfrog’s “Final Updates to the Leapfrog Hospital Safety Grade Methodology for Fall 2024” document, marked as LEAPFROG00178628.

42. Attached as **Exhibit 42** is a true and correct copy of an April 22, 2022 story from the Palm Beach Post downloaded from <https://www.palmbeachpost.com/story/news/healthcare/2022/04/22/5-tenet-healthcare-owned-florida-hospitals-rebrand-palm-beach-health-system/9478662002/>, last accessed November 6, 2022.

43. Attached as **Exhibit 43** is a true and correct copy of a press release from Palm Beach Health Network Physician Group downloaded from https://www.pbhnphysiciangroup.com/all-articles/news/2021/12/28/pbhnpg-is-rebranding-to-palm-beach-health-network-physician-group?utm_slc=SURG&c=pbnso, last accessed November 12, 2025.

44. Attached as **Exhibit 44** is a true and correct copy of a 4/24/24 email from Regina West (Tenet) with CMS data, marked PBHN000012595-12596.

45. Attached as **Exhibit 45** is a true, correct and combined copy Medicare.com's star ratings of Plaintiffs downloaded from the following website: <https://www.medicare.gov/care-compare/details/hospital/100287/view-all?city=Palm%20Beach%20Gardens&state=FL&zipcode=>, and which was last accessed on November 12, 2025.

46. Attached as **Exhibit 46** is a true, correct, and combined document containing the operative notices of deposition for: (i) Erik Cazares; (ii) Jerad Hanlon; (iii) Heather Haverciak; (iv) Cynthia McCauley; (v) Sheri Montgomery; and (vi) Regina West.

47. Attached as **Exhibit 47** is a true and correct copy of Plaintiffs' Witness List produced pursuant to Fed. R. Civ. Pro. 26(a)(2).

48. Attached as **Exhibit 48** is a true, correct, and combined document containing plaintiffs' publication of "Healthgrades" accolades, downloaded from www.palmbeachhealthnetwork.com , accessed November 7, 2025.

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

Signed:

Dated: November 12, 2025

A handwritten signature in black ink, appearing to read "Kimberly E. Blair", written in a cursive style.

Kimberly E. Blair

**IN THE UNITED STATES DISTRICT COURT
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CASE NO. 9:25-CV-80526-DMM

GOOD SAMARITAN MEDICAL	)	
CENTER, INC., et al.,	)	
	)	
<i>Plaintiffs,</i>	)	
	)	
v.	)	
	)	
THE LEAPFROG GROUP,	)	
	)	
<i>Defendant.</i>	)	

**DEFENDANT’S EXHIBIT LIST – MOTION FOR SUMMARY JUDGMENT AND
ACCOMPANYING STATEMENT OF FACTS**

Exhibit Number	Description
1.	Leapfrog History
2.	Binder Dep
3.	Danforth Dep
4.	Leapfrog Mission & Vision
5.	Dr. Austin Dep.
6.	Armstrong Initiative Press Release
7.	Hospital Survey Background Page “Hospital Survey”
8.	Innovators for Leapfrog Page
9.	2025 Hospital Survey
10.	Hospital FAQs Page
11.	Welcome Page 2025 Hospital Survey
12.	Hospital Survey Login Page
13.	Hospital Survey Scoring Results Page
14.	Hospital Survey Algorithms
15.	Search Ratings Page
16.	June 2024 Leapfrog emails regarding public comment and public comments
17.	Sep. 2024 St. Mary’s Email, PBHN000005755);
18.	Dec. 2024 Delray Email, PBHN000004823
19.	March 2024 Good Samaritan Emails, PBHN000012727.
20.	Spring 2025 (Current) Methodology
21.	Fall 2024 Methodology
22.	St. Mary’s CEO, McCauley Dep.

23.	Delray CEO, Haverciak Dep.
24.	West Boca CEO, Hanlon Dep.
25.	Good Samaritan CEO, Montgomery Dep.,
26.	Palm Beach CEO, Cazares Dep.
27.	Spring 2023 – Spring 2025 historical Safety Grades for Plaintiffs)
28.	About the Grade Page
29.	Spring 2024 methodology
30.	Comparison Spring '24/Fall '24 Methodologies
31.	May 21, 2024 email with planned fall 2024 Methodology updates to Regina West
32.	Plaintiffs' Combined Interrogatory Answers
33.	August – September Plaintiff/Home Office emails
34.	11/4/24 Plaintiff internal emails
35.	Safety Grade landing page
36.	Initial Letter Grade landing page
37.	Full Score Landing Page
38.	“Detailed Table View” page for Safety Grade
39.	Leapfrog’s “Terms of Use” page
40.	Leapfrog’s Request for Public Comments
41.	of Leapfrog’s Final Updates to Methodology
42.	4/22/22 Palm Beach Post Story
43.	PBHN Press Release
44.	4/24/24 Tenet Email
45.	Medicare.com’s star ratings of Plaintiffs
46.	Combined notices of deposition for Plaintiffs
47.	Plaintiffs’ witness list
48.	Plaintiffs’ publication of “Healthgrades” accolades

EXHIBIT 1

History

Mission and Vision

Our History

What's in a Name



[click to expand >](#)

Our Story

In 1998 a small group of business leaders gathered for dinner. By the time dessert was served, they had sketched out an idea to transform U.S. health care.

These employers recognized severe dysfunction in the health care marketplace. Throughout the country, employers were spending billions of dollars on health care—with no way of assessing its quality or enabling their employees to shop for care. And a 1999 report by the Institute of Medicine threw the magnitude of the problem into sharp relief. That report, "To Err is Human," revealed that up to 98,000 Americans die every year from preventable medical errors in hospitals.

Enough was enough. Our founders partnered with Business Roundtable, leading researchers and academics, and top quality and patient safety experts with a plan to reverse these troubling trends. Believing in the power of transparency to drive giant leaps forward in safety and quality of care, these pioneers created The Leapfrog Group.

Leapfrog started with a set of simple, focused principles that at the time of our founding were considered outrageous, but today are mainstream: people should have access to information to make informed decisions about their

health care, and purchasers should pay for the best outcomes at the best price. By shining the light on hospital performance, employers could use their purchasing power to reward the top achievers, and foster a marketplace for high-value care.

In 1999, "To Err is Human" revealed that

Leapfrog started with a set of simple, focused

98,000 people die every year due to medical errors.

principles that at the time of our founding were considered outrageous, but today are mainstream.

Leapfrog launched the Leapfrog Hospital Survey in 2001, asking hospitals to voluntarily and publicly report on their performance on a set of three "leaps":

1. Whether the hospital had Computerized Physician Order Entry (CPOE);
2. Whether their ICUs were staffed appropriately with intensivists; and,
3. Whether the hospital had enough surgical volume to safely perform certain high-risk procedures.

In that first year, 200 hospitals reported, and Leapfrog published the results on its website.

Fast Forward

In 2012, Leapfrog launched the highly successful Leapfrog Hospital Safety Grade, a letter grade assigned to all general hospitals rating how safe they are for patients. Issued twice per year, the Leapfrog Hospital Safety Grade empowers regular people to find a safer hospital in their community by using the easy-to-understand A, B, C, D, F grading system.

In 2019, Leapfrog launched the Leapfrog Ambulatory Surgery Center Survey and a corresponding new section of the Leapfrog Hospital Survey for Hospital Outpatient Departments.

This year, over 2,200 hospitals have reported to the Leapfrog Hospital Survey, which still contains the three original leaps, along with new measures critical to purchasers and consumers, including infection rates, Cesarean section rates, and health equity.

What's Next

While tools for consumers to compare among providers are more common today, Leapfrog is still the one and only national purchaser-driven initiative to collect information from hospitals for the purpose of public reporting. Leapfrog has a long way to go before the problem of patient safety is solved. But the vision that started our movement has changed the national conversation on safety and quality and we hope you'll join us as we leap into our next 25 years.

EXHIBIT 2

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

- - - - - X
GOOD SAMARITAN MEDICAL :
CENTER, INC., et al., :
Plaintiffs, : Case No.
v. : 9:25-CV-80526-DMM
THE LEAPFROG GROUP, :
Defendant. :

- - - - - X
Monday, September 22, 2025
Washington, D.C.

Videotaped Deposition of:

LEAH F. BINDER,
called for oral examination by counsel for the
Plaintiffs, pursuant to notice, at the law offices of
Gibson Dunn & Crutcher, LLP, 1700 M Street,
Northwest, Washington, D.C. 20036-4504, before
Christina S. Hotsko, RPR, CRR, CA CSR, of Veritext
Legal Solutions, a Notary Public in and for the
District of Columbia, beginning at 9:06 a.m., when
were present on behalf of the respective parties:

1 A P P E A R A N C E S 2 On behalf of Plaintiffs: 3 DANIEL P. CHUNG, ESQUIRE 4 Gibson Dunn & Crutcher, LLP 5 1700 M Street, Northwest 6 Washington, D.C. 20036 7 (202) 955-8500 8 9 MARC A. TAKAGAKI, ESQUIRE 10 Gibson Dunn & Crutcher, LLP 11 200 Park Avenue 12 New York, New York 10166-0193 13 (212) 351-4000 14 15 On behalf of Defendant: 16 KIMBERLY E. BLAIR, ESQUIRE 17 COURTNEY L. WOOD, ESQUIRE 18 Wilson Elser Moskowitz Edelman & Dicker, LLP 19 161 N Clark, Suite 4500 20 Chicago, Illinois 60601 21 (312) 704-0550 22 Also Present: Orson Braithwaite, Video Technician 15 16 17 18 19 20 21 22 Page 2	1 BINDER DEPOSITION EXHIBITS: * PAGE 2 Exhibit 14 Board Minutes, March 2024 166 3 Exhibit 15 Slide Deck, Technical Overview of the Hospital Safety Score 172 4 Fall of 2012 5 Exhibit 16 E-mail Chain 188 6 Exhibit 17 E-mail Chain 200 7 Exhibit 18 PowerPoint, How the Survey Compares to Other Measurement Programs 200 8 9 Exhibit 19 E-mail Chain 215 10 Exhibit 20 Attachment to Exhibit 19 215 11 Exhibit 21 Cover Letter for Exhibit 22 226 12 Exhibit 22 Letter 226 13 Exhibit 23 Slack Messages 230 14 Exhibit 24 leapfroggroup.org, Delray Medical Center with Pop-Up Box 246 15 Exhibit 25 leapfroggroup.org, Delray Medical Center without Pop-Up Box 246 16 17 Exhibit 26 hospitalsafetygrade.org website 249 18 Exhibit 27 E-mail Chain 259 19 Exhibit 28 E-mail Chain 273 20 Exhibit 29 E-mail Attachment, Tables 273 21 Exhibit 30 Leapfrog Long-Range Strategic Intent for Fiscal Year 2026 to '32 287 22 Page 4
1 C O N T E N T S 2 EXAMINATION BY: PAGE 3 Counsel for Plaintiffs 07 4 5 6 BINDER DEPOSITION EXHIBITS: * PAGE 7 Exhibit 1 E-mail Chain 71 8 Exhibit 2 In-Person Meeting Agenda 96 9 Exhibit 3 E-mail Chain 102 10 Exhibit 4 E-mail Attachment, Expert Panel's Guiding Principles on the Development of Leapfrog's Composite Patient Safety Score for U.S. Hospitals 102 11 12 13 Exhibit 5 E-mail Chain 110 14 Exhibit 6 E-mail Chain 114 15 Exhibit 7 E-mail Attachment, Final Updates to the Leapfrog Hospital Safety Grade Methodology, Fall 2022 114 16 17 Exhibit 8 E-mail Chain 130 18 Exhibit 9 Expert Panel Meeting Notes 130 19 Exhibit 10 E-mail Chain 143 20 Exhibit 11 Attachment to Exhibit 10 143 21 Exhibit 12 E-mail Chain 156 22 Exhibit 13 CEO Report, June 2024 164 Page 3	1 BINDER DEPOSITION EXHIBITS: * PAGE 2 Exhibit 31 Memorandum to Board of Directors' Executive Committee, 25 Feb 2024 298 3 Exhibit 32 Key Elements of Requested Changes to the CEO Employment Contract 316 4 5 Exhibit 33 E-mail Chain 353 6 Exhibit 34 E-mail Chain 359 7 Exhibit 35 E-mail Chain 363 8 Exhibit 36 Leapfrog's Answer to Plaintiffs' Amended Complaint 373 9 Exhibit 37 Final Updates to the Leapfrog Hospital Safety Grade Methodology 378 10 11 Exhibit 38 E-mail Chain 393 12 Exhibit 39 Slack Conversation 396 13 Exhibit 40 Article 397 14 Exhibit 41 E-mail Chain 403 15 Exhibit 42 hospitalsafetygrade.org Hilo Benioff Medical Center 422 16 Exhibit 43 hospitalsafetygrade.org Hilo Benioff Medical Center Survey Measures 426 17 18 19 20 21 * (Exhibits attached to transcript.) 22 Page 5

1 PROCEEDINGS 2 VIDEO TECHNICIAN: Good morning. We are 3 going on the record at 9:06 a.m. on 4 September 22nd, 2025. 5 Please note that the microphones are 6 sensitive and may pick up whispering and private 7 conversations. 8 Please mute your phones at this time. 9 Audio and video recording will continue 10 to take place unless all parties agree to go off 11 the record. 12 This is media unit 1 of the 13 video-recorded deposition of Ms. Leah Binder in 14 the matter of Good Samaritan Medical Center, 15 Inc., et al., versus The Leapfrog Group, filed in 16 the United States District Court for the Southern 17 District of Florida, West Palm Beach Division, 18 case number 9:25-CV-80526-DMM. 19 My name is Orson Braithwaite representing 20 Veritext Legal Solutions, and I am the 21 videographer. 22 The Court Reporter is Christina Hotsko Page 6	1 your name -- full name for the record, please. 2 A. Leah Frieda Binder. 3 Q. Have you gone by any other names? 4 A. No. 5 Q. And you understand that the court 6 reporter is taking down everything that's being 7 said during this proceeding. 8 Do you understand that? 9 A. Yes. 10 Q. So before we get into the substance, I 11 just want to go over some basic ground rules that 12 are applicable to all depositions. 13 The first is that we should try our best 14 not to talk over each other. So if you could 15 wait for me to finish my question before you 16 answer, and I'll wait for you to finish your 17 answer before I move on to the next question. 18 It's important that you -- that any response you 19 give is with words. So an uh-huh or an huh-uh is 20 very tough for the court reporter to take down. 21 So that's very important. 22 You also understand that you're Page 8
1 from the firm Veritext Legal Solutions. 2 Counsel will now state their appearances 3 and affiliations for the record, beginning with 4 the noticing attorney. 5 MR. CHUNG: Daniel Chung, Gibson, Dunn & 6 Crutcher, for plaintiffs. 7 MR. TAKAGAKI: Mark Aaron Takagaki, 8 Gibson, Dunn & Crutcher, for plaintiffs. 9 MS. BLAIR: Kim Blair, Wilson Elser, for 10 Leapfrog Group. 11 MS. WOOD: Courtney Wood, Wilson Elser, 12 on behalf of defendant Leapfrog Group. 13 VIDEO TECHNICIAN: Thank you. Will the 14 court reporter please swear in the witness. 15 Whereupon, 16 LEAH F. BINDER, 17 being first duly sworn or affirmed to testify to 18 the truth, the whole truth, and nothing but the 19 truth, was examined and testified as follows: 20 EXAMINATION BY COUNSEL FOR PLAINTIFFS 21 BY MR. CHUNG: 22 Q. Good morning. Could you please state Page 7	1 testifying under oath and you understand that, by 2 taking that oath, you're promising to answer my 3 questions truthfully and accurately as possible. 4 Do you understand that? 5 A. Yes. 6 Q. All right. Are you taking any 7 medications or under the influence of any 8 substances or is there any reason today that 9 might prevent you or hinder you from 10 understanding my questions or what's happening 11 here today? 12 A. No. 13 Q. All right. If you don't understand one 14 of my questions, just ask me to clarify it and 15 I'll do my best to do that. 16 From time to time, your attorney may 17 object to certain of my questions. Unless 18 Ms. Blair instructs you not to answer the 19 question, though, you have to answer the 20 question. 21 Do you understand that? 22 A. Yes. Page 9

1 Q. All right. If you need a break at any 2 time, just let us know. The only ground rule 3 with respect to breaks is that I ask you to 4 answer any pending questions before we take a 5 break. 6 Do you understand that? 7 A. Yes. 8 Q. All right. So let's get started. 9 Have you ever had your deposition taken 10 prior to today? 11 A. Once, 30 years ago. 12 Q. Okay. And what kind of case was that? 13 A. It was a car accident I witnessed. 14 Q. All right. So you were not a party. You 15 were a witness to the car accident? 16 A. Yes. 17 Q. All right. And where was that -- where 18 was the case filed or where did it take place? 19 A. In New York. 20 Q. All right. And for today's purposes, do 21 you understand that you're testifying not only on 22 behalf of yourself in your personal capacity but Page 10	1 looked at our materials, looked at our public 2 relations and our finances. 3 Q. Okay. When did you -- when did you -- 4 when was the first preparation session with your 5 counsel? 6 A. About four weeks ago. It was a joint 7 session with all of the Leapfrog employees who 8 were deposed in this matter. 9 Q. Deposed or to be deposed? 10 A. To be deposed. 11 Q. To be -- 12 A. I mean, nobody had been deposed yet. 13 Q. Okay. So that first session about four 14 weeks ago was with all of the Leapfrog employees 15 who had been noticed for deposition; is that 16 right? 17 A. Right. To sort of give us kind of the 18 deposition 101, what -- what it's going to be 19 like and et cetera. So... 20 Q. Okay. And who -- approximately how long 21 did that meeting take? 22 A. I can't remember. Two hours, something Page 12
1 also with respect to certain topics on behalf of 2 The Leapfrog Group? 3 Do you understand that? 4 A. Yes. 5 Q. All right. And are you aware of what the 6 topics are generally based on discussions with 7 your counsel? 8 A. Yes. 9 Q. Okay. So at various points throughout 10 the deposition, I'll kind of identify for you 11 whether there's a topic tied to the questions I'm 12 going to ask you so you know when you'll be 13 testifying in your corporate representative 14 capacity and when you're testifying in your 15 personal capacity. Okay? 16 A. Yes. 17 Q. Did you prepare for your deposition 18 today? 19 A. Yes. 20 Q. And how did you prepare? 21 A. I met with counsel four times. And I 22 studied up, you know, read over our website, Page 11	1 like that. 2 Q. All right. And who led that meeting? 3 A. Counsel, Kim Blair. 4 Q. All right. Was there, like, an agenda 5 for that meeting or talking points for that 6 meeting? 7 MS. BLAIR: Objection to form. 8 To the extent you're asking her about 9 specific communications from counsel, I'm going 10 to instruct you not to answer that. You can 11 answer yes or no as to whether there was an 12 agenda, but the content of the agenda you cannot 13 disclose. 14 THE WITNESS: Okay. Yes, there was an 15 agenda. 16 BY MR. CHUNG: 17 Q. Okay. And thereafter -- so that initial 18 meeting was just a joint meeting with all the 19 other folks who had been noticed; is that right? 20 A. Yes. 21 Q. Okay. And then there were subsequently 22 three additional preparation sessions; is that Page 13

1 right? 2 A. Yeah, there was one short one and then 3 there was -- there were two longer ones. 4 Q. Okay. And were those subsequent -- the 5 other three -- just with yourself or were there 6 other Leapfrog employees present at those 7 sessions? 8 A. Just myself. 9 Q. All right. Did you review any documents 10 in preparation for this deposition. You 11 mentioned that you reviewed some materials, but 12 if you could go over what you reviewed. 13 A. I reviewed our board minutes and packets, 14 all of the materials that were given to our board 15 over the past couple of years. And I reviewed 16 some of the materials that had been given out in 17 prior depositions of employees. I reviewed our 18 website and I reviewed some of the information on 19 our methodology just to refresh myself, make sure 20 I had a memory for all the details -- or as many 21 of them as I'm aware of -- for the methodology. 22 Q. All right. And so -- you mentioned that Page 14	1 Q. Kush Banerjee? 2 A. Yes. 3 Q. Alexandra Campione? 4 A. Yes. 5 Q. All right. Any others? 6 A. I don't think so. Those are all the 7 employees -- 8 Q. Those are all the folks who have been 9 deposed so far. 10 A. Right. Okay. Yeah. Yes. 11 Q. All right. Did you watch any videos in 12 preparation for today's deposition? 13 A. No. 14 Q. Did you listen to any audio recordings of 15 meetings or calls? 16 A. No. 17 Q. Did you -- what about transcripts of any 18 meetings? 19 A. I didn't -- for this deposition, I did 20 not review the -- any transcripts. 21 Q. Okay. But you mentioned I think you 22 reviewed board materials, like, minutes for board Page 16
1 you reviewed the materials for other depositions 2 that have taken place -- 3 A. Uh-huh. 4 Q. -- in this case. 5 And were those depositions of other 6 Leapfrog employees? 7 A. Yes. 8 Q. All right. Did you review the 9 deposition -- deposition transcripts of -- 10 A. Yes. 11 Q. -- any -- anyone other than Leapfrog 12 employees? 13 A. No. 14 Q. All right. And so in terms of the other 15 depositions -- the transcripts of the other 16 depositions, did you review the one for Melissa 17 Danforth? 18 A. Yes. 19 Q. All right. How about Lauren Bailey? 20 A. Yes. 21 Q. Karen Jupiter? 22 A. Yes. Page 15	1 meetings. 2 A. Right. 3 Q. Okay. But those are not transcripts, 4 correct? 5 A. Right. No, those are minutes. 6 Q. Did you speak with any of the other 7 Leapfrog deponents before their deposition? And 8 I'm not talking about that initial joint prep 9 session. 10 A. Uh-huh. 11 Q. But other than that. 12 MS. BLAIR: I'll object to form to the 13 extent counsel may have been involved. 14 But if counsel was not involved, please 15 answer the question. 16 BY MR. CHUNG: 17 Q. I'm not interested in any communications 18 you had with any of your colleagues that was 19 involved in the presence of counsel or involved 20 counsel. 21 A. I -- when counsel was not present, I 22 spoke to employees to give -- offer encouragement Page 17

1 and thanks for doing this. 2 Q. Okay. And who in particular? 3 A. All of them. 4 Q. All right. Did you -- in addition to 5 offering them thanks for doing this, did you 6 discuss anything else about the case with any of 7 the deponents? 8 A. I just said, speak from your heart, tell 9 the truth. That's it. That's all I said to my 10 employees outside of counsel, but even with 11 counsel. 12 Q. Okay. How about after their depositions? 13 You mentioned that you reviewed their deposition 14 transcripts, but did you have any conversations 15 with any of the other deponents after they had 16 finished their depositions? 17 A. Yes, with counsel present. 18 Q. Okay. And so were there -- so were there 19 discussions with other deponents after their 20 depositions but with counsel present? Is that 21 right? 22 A. Yes. Page 18	1 A. Yes. 2 Q. Okay. Let's go into your background. If 3 we can just start with your educational 4 background, your schooling from college on 5 forward. 6 A. I went to Brandeis University, and I 7 graduated officially in 1985, but I was actually 8 the class of '84. My father died at the end 9 of '84, so I had delayed my graduation. But I am 10 very much a proud '84 graduate. 11 I then worked -- I worked in publishing 12 for a little while. And -- I liked books, so I 13 decided at the age of 22 -- that's kind of how 14 you make decisions about your career -- is, I 15 like books, I think I'll get into publishing. So 16 I got a job at a publisher in Cambridge, 17 Massachusetts, worked there for about a year, two 18 years. Then ended up moving to New York for -- I 19 was recruited for another job, another publisher, 20 worked there for a while. 21 And then real -- well, I worked for a 22 family-owned publisher that had a fascinating Page 20
1 Q. All right. And were those meetings or 2 calls? 3 A. Yes. 4 Q. Okay. And were those with just -- again, 5 joint discussions with multiple deponents or with 6 just single deponents who had just finished their 7 depositions? 8 A. With counsel and with single deponents 9 and sometimes -- I don't think anybody else was 10 there -- and myself and maybe one other person 11 sometimes depending on who it was. 12 Q. Okay. And this was after each 13 deposition; is that right? 14 A. Uh-huh. 15 Q. And is it with -- was it for each -- for 16 all the folks who had been deposed: Ms. Jupiter, 17 Ms. Bailey, Ms. Campione, Mr. Banerjee, and then 18 Ms. Danforth? 19 A. Yes. 20 Q. Okay. So after each deposition there was 21 a meeting or a discussion with counsel present 22 and you? Page 19	1 background. They were called Schocken Books, and 2 they were founded by -- they were founded by a 3 Jewish family in -- I think, in Europe that had 4 fled Nazi Germany and burned their warehouse down 5 with all the books because they didn't want the 6 Nazis to take down the manuscripts. And they 7 just took one copy of each book, fled to New York 8 and Israel -- anyway, it was an incredible story. 9 And they had classic books, like Kafka, things 10 like that. It was a fascinating place to work. 11 And so -- and I worked for Miriam 12 Schocken, who was the granddaughter of the family 13 that fled. It was just an incredible experience. 14 However, that was a time period in the '80s when 15 a lot of businesses were -- especially in 16 publishing, medium-sized publishers, like this 17 one, were really not doing well. So they were 18 bought by Pantheon Books, which was part of 19 Random House. They retained two employees. One 20 was the editor, who was the acquisitions editor, 21 and one was me. I was the publicist. 22 And -- so I went over to Random House, Page 21

1 and it was very different. It wasn't this 2 family-owned business anymore. And it -- I -- 3 Q. Ms. Binder, I'm going to stop you there. 4 Your educational history. 5 A. Oh, okay. After working there for a 6 while, I went to University of Pennsylvania and I 7 got two master's degrees, one from the Fels 8 Institute of Government and one from Annenberg 9 School for Communication. 10 Q. Okay. And those -- I think those degrees 11 you received in 1994; is that right? 12 A. Yes. 13 Q. Okay. Let's -- so post the advanced 14 degree, the master's degree, can you talk about 15 your employment history? 16 A. So after I was working in publishing in 17 New York, I wanted to go into nonprofit and I saw 18 this position for a special assistant to the CEO 19 of an organization called the National League for 20 Nursing. And I had not been particularly 21 interested in healthcare as a career, but I 22 decided to interview because it sounded Page 22	1 recruited to go to New York City to work in the 2 Giuliani administration for Maria Mitchell, who 3 was the deputy -- I forgot her title; it wasn't 4 deputy mayor, but it was equivalent -- for 5 healthcare. 6 And then I worked there for four years 7 and then moved to Maine, where I was CEO of a 8 nonprofit called Healthy Community Coalition, 9 which was an affiliate of a health system called 10 the Franklin Community Health Network. 11 And I worked for the CEO of the network 12 and, over time, we grew it. We raised a lot of 13 money through grants and things like that, so it 14 grew. 15 And so I had more people. And he -- my 16 boss, Rick Batt, asked me to take on a few other 17 things within the hospital. So I started working 18 on, like, education in the hospital, public 19 relations in the hospital. I did a lot of stuff 20 in the hospital. 21 Q. And you mentioned that this network was a 22 not-for-profit organization -- Page 24
1 interesting. And -- the job sounded interesting. 2 So I interviewed with Pam Maraldo, who 3 was the CEO. And I really just wanted to work 4 for her. She was amazing. 5 Q. And when was that? 6 A. '86, something like that. 7 Q. I'm talking about after you got your 8 master's degree. Your employment history. That 9 was my question. What was -- 10 A. Oh, I missed the part that -- you wanted 11 after my master's? 12 Q. Yes. 13 A. Okay. After my master's -- well, I was 14 working during my master's. I worked while I was 15 in school. 16 Q. Okay. 17 A. But -- I was working for the National 18 League for Nursing while I was in school. And 19 then I -- then what did I do? I went to Planned 20 Parenthood for one year. I was there -- I ended 21 up being their Senate lobbyist. 22 And then I went to -- then I was Page 23	1 A. Yes. 2 Q. -- is that right? Okay. 3 And am I right that you were there for 4 about nine years? 5 A. Eight. 6 Q. Eight years? Okay. 7 A. Uh-huh. 8 Q. 1999 to about 2000- -- 9 A. 2008. 10 Q. '8, okay. 11 A. So -- yeah, but I was -- so 12 eight-and-a-half, maybe, something like that. 13 Q. Okay. So -- and then you moved on to 14 The Leapfrog Group, am I right, after that? 15 A. Yes. 16 Q. Okay. And how did that opportunity come 17 about? 18 A. Well, my boss, Rick, had announced he was 19 retiring in a year, and so I started to think 20 about what's my next step. And this was a rural 21 community with not that many opportunities unless 22 I wanted to compete for his position, which -- Page 25

1 they certainly wanted me to, but I didn't want 2 that particular position. 3 So I started looking online and I saw 4 that there was a national search for the CEO of 5 The Leapfrog Group, and so I thought, wow, well, 6 I'll put my hat in the ring. The reason I was 7 interested in particular was because I had seen 8 the impact of the Leapfrog survey and the process 9 of Leapfrog, I had seen an impact at our system 10 that was extremely powerful. It was even more 11 impactful than, say, Joint Commission 12 accreditation in those visits. It had a huge 13 impact on really transforming our patient safety. 14 So I had seen that, and so I was very 15 supportive and very excited about the 16 opportunity, but really didn't think that they 17 would find me out of nowhere. You know, I was in 18 the middle of nowhere, literally. 19 And they -- obviously they did. I mean, 20 I went through several interviews with the search 21 committee and -- et cetera, and then they offered 22 me the position. So... Page 26	1 grant writing. 2 Q. Right. Raising money to fund the 3 operations of the organization; is that right? 4 A. Partly the operations, but also 5 particular projects that we wanted to do, such as 6 we had a mobile health unit that went around 7 giving flu shots and screenings throughout this 8 very poor community. And we had an adolescent 9 anti-tobacco campaign we got funding for. We had 10 a breast cancer screening program. Things like 11 that. Things that would be related to preventive 12 care. 13 Q. Okay. So you joined The Leapfrog Group 14 in 2008 as the CEO and president; is that right? 15 A. No. I joined as CEO. 16 Q. And then -- was the president title added 17 later on? 18 A. Yes. 19 Q. All right. And who are your direct 20 reports currently? 21 A. Missy Danforth, Ralph Johnson, Karen 22 Jupiter, Daran Gaus. Page 28
1 Q. Okay. Just backtracking a little bit. 2 In your several years at the Franklin 3 Community Health Network in the middle of 4 nowhere -- don't tell that to Maine folks -- in 5 your role there, am I right that kind of the 6 ultimate position that you reached was 7 vice-president -- 8 A. Yes. 9 Q. -- of that organization? 10 A. I was, like, vice-president and CEO of 11 the Healthy Community Coalition. 12 Q. Understood. Okay. 13 And as part of and as vice-president and 14 CEO of that organization -- and again, it was a 15 501(c)(3), correct? 16 A. Yeah. 17 Q. Right. It sounds like, based on kind of 18 what you were talking about in terms of the 19 growth of the organization while you were there, 20 that one of the your responsibilities as CEO was 21 basically fundraising; is that right? 22 A. Yeah. Raising money primarily through Page 27	1 I think that's it. 2 Q. Okay. And Leapfrog, safe to assume, was 3 founded before you joined, correct? 4 A. Yes. 5 Q. In about 2000 or so? 6 A. 2000. 7 Q. All right. Now, I want to allude to 8 the -- Leapfrog's mission statement as it's set 9 forth on the website. I'm sure you're familiar 10 with it. Let me know if you're not. 11 But it says that the mission is to 12 trigger giant leaps forward in the safety, 13 quality, and affordability of U.S. healthcare by 14 using transparency to support informed healthcare 15 decisions and promote high-value care. 16 Are you familiar with that language from 17 the website? 18 A. Yes. 19 Q. Okay. Was that the mission or the 20 mission statement when you first joined as CEO in 21 2008? 22 A. "Trigger giant leaps forward" was always Page 29

1 the tagline. There was variations on the full 2 mission statement -- 3 Q. Okay. 4 A. -- over time. 5 Q. But at least kind of in its current 6 version, whenever -- 7 A. Uh-huh. 8 Q. -- it came into being, Leapfrog's mission 9 is -- the foundation of it is in transparency, 10 correct? 11 A. And patient safety in particular. 12 Q. Right. And the goal of using 13 transparency is to equip healthcare consumers 14 with information that really helps them make 15 informed healthcare decisions, right? 16 A. Yes. And also to inform purchasers who 17 are employers of companies that offer health 18 benefits -- to give them information as well to 19 ensure that their employees can get the very best 20 care. 21 Q. Okay. Has Leapfrog always been a 22 not-profit [sic]? Page 30	1 I'm not sure. 2 Q. Okay. You mentioned that there was a 3 little bit of revenue from the data licensure 4 programs. 5 A. Yeah, yeah, but there was also lots of 6 revenue from -- not lots. There was not that 7 much revenue at all, but there was some revenue 8 from some programs. And they had a grant -- I 9 say "they" because I wasn't here when they got 10 it, but they got a grant from ARC. They had a 11 conference -- some conference sponsorships. They 12 had probably about 200,000 -- well, I'm trying to 13 remember. They had some money from the 14 partnerships. I just can't remember which was 15 the largest source. 16 Q. Okay. Now, what are the most significant 17 sources of revenue for the organization? 18 A. The number one source of revenue for us 19 right now is accolade sales. These are sales of 20 the logo for an A to hospitals that earn an A 21 from the hospital safety grade. 22 The second highest source of income is Page 32
1 A. Yes. 2 Q. All right. When you started out in 2008, 3 how did Leapfrog fund its operations? Where did 4 it get its revenue? 5 A. They had a couple of grants that were 6 finishing. And Leapfrog also had a little bit of 7 revenue from licensing its data. 8 And -- I'm trying to remember. I think 9 those were the two main sources, the grants 10 and -- for different projects. And -- oh, and 11 they had -- I'm sorry. They had partners. They 12 had a partners program. These were industry 13 partners who paid dues to be part of Leapfrog. 14 Not in a governance way. They were never part of 15 governance. 16 And then they also had sponsorships and 17 things like that for annual meeting. 18 Q. Okay. So at the time when you joined, 19 what was the most significant source of revenue 20 among the ones that you enumerated? 21 A. I think it -- I'm not sure. It might 22 have been licensure, the licensure programs, but Page 31	1 licensure of our data. 2 Q. All right. And that's what you mentioned 3 earlier? This is the -- 4 A. Uh-huh. 5 Q. -- licensure of data that the -- 6 A. Yeah. 7 Q. -- organization collects or the hospital 8 survey; is that right? 9 A. From a variety of -- primarily the 10 survey, but also the safety grade itself. 11 Q. Okay. Now, you were the CEO when 12 Leapfrog launched the hospital safety grade 13 program in 2012, correct? 14 A. Yes. 15 Q. Was that the first year of the hospital 16 safety grade? 17 A. 2012. Yes. 18 Q. 2012. Okay. 19 How did that come to be, the safety grade 20 program? 21 A. There was a conversation at our board in 22 the year 2010. In 2010, we were reflecting as an Page 33

1 organization on progress of the United States 2 since To Err is Human. 3 To Err is Human was a report that was 4 issued by the Institute of Medicine, which -- now 5 called the National Academy of Medicine. That 6 report suggested that upwards of 100,000 people 7 were dying every year from preventable errors in 8 hospitals. 9 And the employers who formed Leapfrog 10 were outraged by that and wanted to form Leapfrog 11 as a way of getting more transparency so they 12 could identify where the issues were and they 13 could inform their employees about where the 14 hazards are. 15 So that was what -- and also, primarily, 16 they wanted to see a reduction in these problems 17 in hospitals and save some lives. 18 So in 2010, there was a reflection ten 19 years out, ten years after To Err is Human, how 20 are we doing as a country? How are we doing at 21 Leapfrog? 22 And there were a number of studies that Page 34	1 completely agree -- that the problem with what 2 the Leapfrog model is is not that it's a bad idea 3 to have transparency in the marketplace. That 4 works in every market. It will work in 5 healthcare. 6 The problem we had was that hospitals 7 that chose not to be transparent and declined to 8 report to the survey just got a pass. So that 9 wasn't going to be a functional market if 10 hospitals were declining to report to the survey. 11 So -- and you don't have data from every 12 competitor in a market. So -- and there was no 13 other data source. 14 So we decided that what we had to do was 15 figure out how we can get enough data to be able 16 to have a functional market in healthcare so that 17 hospitals can compete to deliver top quality care 18 to the employees of these businesses that were 19 part of Leapfrog. 20 So that was what we set out to do. Then 21 the following year, one of our board members 22 said, you know, in L.A. -- I think he was talking Page 36
1 came out that year asking that question. And the 2 answer was, we're not doing well at all. It's 3 gotten -- the only evidence we have is it's 4 gotten worse. And -- in part because we can 5 measure it better. 6 So we can -- we're not -- To Err is 7 Human, they had to really estimate a lot because 8 there was just no measurement; there was no data. 9 They had to really bring some experts in and try 10 to figure it out from pulling records from 11 hospitals. And it was -- so it was an estimate. 12 And now they think -- they thought in 13 2010 it's more like twice that at least. 14 So the only evidence we had in 2010 was 15 that things got worse, that we made no progress; 16 things probably got worse. 17 And so that was a really big issue for 18 the board at Leapfrog. What does that mean for 19 us as an organization? Are we headed in the 20 right direction? 21 And we talked a lot about what's the 22 problem, and we -- I think the board felt -- I Page 35	1 about L.A. -- they have this thing with 2 restaurants where restaurants -- they used to 3 have -- we've always had reporting publicly in 4 the newspaper of hygiene problems at restaurants. 5 Q. Yup. I'm familiar with it? 6 A. Yeah. So most people don't like reading 7 those because they're, like, gross. It's, like, 8 you've got to read about rats and stuff like 9 that. Right? So -- but -- most people ignored 10 them until they started grading the restaurants 11 and requiring the restaurants to post the grade 12 in their front window. 13 And once they started doing that, all of 14 a sudden -- the way our board member put it is 15 there's no more C-restaurants because no one 16 wants to go to a C-restaurants. And -- or it 17 just -- people don't -- they're scared of that. 18 So it had a real impact. People paid attention 19 to that. 20 So he said, why can't we just do that 21 with healthcare? Why can't we do that with 22 hospitals? And we put our heads together. Page 37

1 At that time, thanks to the Affordable 2 Care Act, there was suddenly data available from 3 CMS. That had not been available before, but we 4 now had it. We had some very good data on 5 patient safety by hospital, and we could use it. 6 So we suddenly realized that we could 7 grade hospitals and we could get all of them and 8 not wait for just the ones that are willing to be 9 transparent. We could do that. 10 Now, the data we had was not -- it was 11 good, but it wasn't enough. We wanted more. And 12 we wanted more comprehensive data, especially on 13 some of the areas that are the most dangerous for 14 patients, such as medication safety, which is the 15 number one error that hospitals make. 16 So we wanted more data. And so we 17 thought, well, let's get some experts together 18 and figure out how we could do it with CMS data. 19 AHA had some data. And Leapfrog had some data. 20 Let's see if we could put it all together into a 21 grade. 22 So I worked with Arnie Milstein, who is Page 38	1 Ashish Jha who is now pretty well-known. He's 2 now the dean at Brown and he was the COVID 3 coordinator for a while -- 4 Q. So Ms. Binder, I'm going to stop you 5 there because we are going to get to the expert 6 panel topic -- 7 A. Okay. 8 Q. -- so why don't we -- you're kind of 9 skipping ahead to an area that I wanted to get 10 to -- 11 A. Sure -- 12 Q. -- later, but -- 13 A. Well, anyway, I personally recruited the 14 expert -- you asked me how this -- founded, so 15 I'm going to tell you -- 16 Q. Yeah. 17 A. So I personally recruited that expert 18 panel, along with Arnie and Lucian Leape. And 19 then they met, and we worked with -- we worked 20 with the scientific team that we had at the time 21 and we developed a whole -- a protocol for 22 figuring out how we take all this data and how we Page 40
1 still on our board. He came back to our board. 2 Actually, he was on the original board of 3 Leapfrog, and a founder of Leapfrog and very much 4 involved. He's now at Stanford. At the time, he 5 was at Pacific Business Group on Health. And 6 he -- and also, he worked as a consultant to 7 Boeing as part of -- he was part of Mercer. 8 Anyway, so Arnie and I worked together to 9 identify people for the expert panel. And the 10 first person I called beside Arnie was Lucian 11 Leape, who's, like -- he's sort of considered 12 like the father of the patient safety movement. 13 He sadly passed just about a month ago. 14 But, anyway, Lucian Leape gave me a 15 couple of people that he thought would be great. 16 He himself really was enthusiastic and joined the 17 expert panel. 18 And we -- the different -- he said, I've 19 got this young guy, he's brilliant, he's 20 written -- he's got tons of published research 21 already, he's at Harvard with me. I think he's 22 going places. And he wanted him. His name was Page 39	1 weight it so that it will turn into, ultimately, 2 composite scores. 3 And there was a process to that that was 4 built on -- it was built on a platform, a 5 research platform, from ARC that Patrick Romano 6 had been instrumental in developing, which was we 7 weighed each measure by impact, opportunity, and 8 evidence based. 9 Q. And these are the 30 measures; is that 10 right? 11 A. At the time, it wasn't -- at the time, 12 actually, we had 40 or 45 that -- 13 Q. So the number of -- 14 A. -- we were looking at. 15 Q. -- total measures or metrics has changed 16 over time, correct? 17 A. Yeah. As the methodology has evolved 18 with the science and the evidence. But at the 19 time, we were looking at about 45 measures, some 20 of which were not very good that were available. 21 So they had to weight it, and some of 22 them they cut out because they didn't think they Page 41

1 were good. 2 Q. You testified just a little while ago 3 that a purpose -- or one of the purposes of the 4 health safety grade was to -- hospital safety 5 grade was to basically create a marketplace. 6 Right? Do you remember your testimony -- 7 MS. BLAIR: Objection to form. 8 BY MR. CHUNG: 9 Q. -- on that? 10 A. I didn't say the safety grade was to 11 develop a marketplace. That was The Leapfrog 12 Group -- that Leapfrog wanted a marketplace -- 13 Q. Okay. 14 A. -- that was functional. 15 Q. A -- 16 A. That was before, they wanted -- 17 THE REPORTER: I just can't get you both. 18 BY MR. CHUNG: 19 Q. Go ahead. 20 A. I was saying Leapfrog in 2010, which was 21 before the safety grade, wanted a functional 22 marketplace. They needed to have all hospitals Page 42	1 A. No. That wasn't a goal, per se. We just 2 wanted to have a letter grade available. 3 Q. Well, how would they -- how would the 4 hospital -- you said that one of the goals, at 5 least with respect to hospitals, was to encourage 6 them or -- encourage them to aim for an A, 7 correct? 8 A. Yes. 9 Q. Right? But in order to aim for an A, is 10 it correct that they would have to participate in 11 the hospital survey? 12 MS. BLAIR: Objection to form. 13 THE WITNESS: In order to aim for an A, 14 they would have to do well on most of the 15 measures in the grade, and most of the measures 16 come from CMS. So they would need to do very 17 well on patient safety. And CMS, if they 18 participated in the survey, they would have to do 19 well on that, too. 20 BY MR. CHUNG: 21 Q. Okay. Some questions about Leapfrog's 22 organizational structure. And this is topic 1 Page 44
1 in. 2 Q. Okay. And am I correct that at least one 3 purpose of the hospital safety grade or -- that 4 came into being was to build or promote that 5 marketplace? Is that right? 6 A. Yes. 7 Q. And in this marketplace, hospitals would 8 be essentially competing against one another 9 based on the hospital safety grades that had been 10 assigned to them; is that right? 11 MS. BLAIR: Objection to form. 12 THE WITNESS: I don't think our goal was 13 to do anything with hospitals. Our goal was to 14 help patients and families and communities and 15 the employees of the purchasers to select the 16 right place to go. So I don't -- we weren't 17 focused on what impact specifically that would 18 have on hospitals except for the fact we hoped 19 that it would cause them to aim for an A. 20 BY MR. CHUNG: 21 Q. Right. And participate in the survey, 22 correct? Page 43	1 from the list of topics in the 30(b)(6) notice. 2 How many employees does Leapfrog have 3 currently? 4 A. 20. 5 Q. Any part-time employees? 6 A. No. 7 Q. All right. Does Leapfrog hire any 8 independent contractors or consultants? 9 A. Oh, yes. On occasion. 10 Q. Okay. And who are they currently? 11 A. We have a -- we have -- let's see. We 12 have a lot of contractors. 13 So John Hopkins Medicine. Matt Austin is 14 a contractor for the science behind the survey. 15 We have Raven -- we have -- which handles 16 some of the programming on our websites. 17 We have a company called Square that does 18 other kinds of programming for the data analysis 19 and the data collection through the survey and 20 safety grade. 21 Mathematica helps us with double-checking 22 calculations now and also helped us -- helps us Page 45

1 with some statistical analysis, things like that, 2 on occasion. 3 We have -- we have a number of -- let's 4 see. We have CURA, which is our public relations 5 firm. 6 We have a number of different consultants 7 who help us with, like -- we do radio -- we do, 8 like, some radio announcements around some of our 9 PR. 10 We have a photographer who works with us. 11 A videographer who works with us on the annual 12 meeting. 13 Q. Okay. Well, we'll discuss I think in 14 more detail some of the consultants. 15 But it sounds like a lot of contractors 16 and consultants -- 17 A. Yes. 18 Q. -- is that right? All right. 19 And the organization has a board of 20 directors, right? 21 A. Yes. 22 Q. And what's the process for selecting Page 46	1 that is offering us insights into the hospital 2 industry and concerns and priorities around 3 quality. They look at long-terms issues only. 4 We make it very clear in every communication with 5 them that they have no influence on current 6 programs, like the current survey or the current 7 safety grade. But we will ask them things like, 8 we know there's a nursing shortage; how is that 9 impacting hospitals and what are the kinds of 10 things you look to to improve nursing? For 11 instance, something that we would talk to the 12 hospital advisory committee about. 13 That -- so that's one committee. Do you 14 want to know more about their composition or any 15 of that? Or you just want me to tell you what -- 16 Q. Just kind of high level, yeah. 17 A. Yeah. And then we have a partners 18 advisory committee that's industry partners, 19 meaning representatives of companies that do 20 business in the healthcare industry. 21 Leapfrog's board deliberately does not 22 have anyone on it who is in the healthcare Page 48
1 members of the board? 2 A. We have a nominations committee that 3 reviews a matrix of -- it's a matrix of the 4 skills and experiences, diversity, geographic 5 diversity and other kinds of diversity, of board 6 members, and then sets goals for what we are 7 going to need in the coming year, or coming two 8 years, and helps to identify candidates. 9 Then the nominations committee screens 10 those candidates by interviewing them and 11 ultimately decides on -- if they wish, they 12 decide on candidates they want to bring forward 13 to the board for election to the board. 14 Q. Okay. 15 A. And the board elects them. 16 Q. And do you attend board meetings? 17 A. Yes. 18 Q. All right. Does Leapfrog have any 19 advisory committees? 20 A. Yes. 21 Q. And what do they do? 22 A. We have a hospital advisory committee Page 47	1 industry. If a board member gets a job within 2 the healthcare industry, they resign. They're -- 3 and that's happened a few times. 4 Q. Okay. 5 A. So the partners advisory committee is an 6 opportunity for us to get some insight from 7 people who are clearly committed to the Leapfrog 8 mission because they pay dues to the organization 9 and we are able to get some insights from them. 10 We also have an ASC advisory committee, 11 because we now have an ASC survey. 12 I'm sure I'm -- let me think. 13 Q. Okay. We may come back to other advisory 14 committees, but -- 15 A. Sure. 16 Q. All right. Let's -- I want to ask you a 17 few questions -- looping back to the expert panel 18 that you mentioned earlier, what's your role with 19 respect to the expert panel? 20 A. I watch it from a distance. So -- 21 Q. What do you mean by that? 22 A. I rarely go to any of their meetings. Page 49

1 When they've had in-person one-day meetings, 2 which is, like, twice, I want to say, we've had, 3 I will go to those. But otherwise -- and those 4 are more like long-term planning kinds of 5 meetings. 6 But in terms of their deliberations, 7 which are sometimes in group meetings and 8 sometimes just one-on-one with Matt or Missy or 9 others, I do not -- I try to stay away from 10 those. I don't want the expert panelists to have 11 the impression that they're being watched by the 12 CEO. I want them to be independent and feel 13 comfortable being as absolutely candid as 14 possible. 15 So I have -- I learn about what their 16 views are by reading minutes or looking at, you 17 know, transcripts or -- and talking to, 18 particularly, Missy Danforth or Matt Austin. I 19 speak to those two very frequently to really 20 understand where the expert panel is on various 21 issues. 22 Q. So you may not attend many of the expert Page 50	1 key scientific advisor. So he will -- so when 2 there's frequently follow-up from an expert -- 3 any expert panel meeting, whether it's a 4 one-on-one with one member or the whole group, 5 they will often say, well, can you run some 6 analysis of something, or this or that, or can 7 you do a statistical -- blah, blah, blah. 8 There's often follow-up. He will do that. 9 And he will also -- or they'll say 10 there's been a couple of studies we just heard 11 about that came out; we need to look at those. 12 He'll get those studies, he'll do analyses for 13 them. 14 So the follow-up that has to do with the 15 scientific analysis and evidence base of our -- 16 both our survey and our safety grade he works on. 17 And so for the process for the hospital 18 safety grade, he does that kind of analysis. 19 Q. Okay. Does Leapfrog itself present 20 proposed changes to the expert panel? 21 A. Uh-huh. Yeah. 22 Q. All right. And does the panel -- and is Page 52
1 panel meetings, but Ms. Danforth does; is that 2 right? 3 A. Yes. 4 Q. All right. And in addition to members of 5 her -- the ratings team; am I right about that? 6 A. Usually one member of -- I don't think 7 she wants to populate the whole meeting with -- 8 Q. Right. But at -- 9 A. -- just Leapfrog people. 10 Q. -- least Ms. Danforth and a member of 11 her -- 12 A. Yeah. 13 Q. -- team. 14 A. Yes. 15 Q. Okay. 16 A. And Matt Austin also facilitates the 17 expert panel process. 18 Q. Is Matt Austin a member of the expert 19 panel? 20 A. No. 21 Q. All right. What is his role, then? 22 A. He's a facilitator. And he's also our Page 51	1 the panel then expected to make a decision on 2 whether to adopt that change? 3 MS. BLAIR: Objection to form. 4 THE WITNESS: The panel is not -- they 5 don't make a group decision. It's a -- they -- 6 they have a process for evaluating anything we 7 bring forward or anything that they bring 8 forward. Sometimes they bring it, or an 9 individual will bring it. 10 But they have a process that is sometimes 11 in a group meeting and sometimes separately for 12 ultimately reaching consensus on a particular 13 issue. But it is not a -- it's not a one 14 decision. 15 BY MR. CHUNG: 16 Q. What do you mean -- 17 A. They don't vote. They don't vote. 18 Q. Oh. So there's no process -- 19 A. It's a traditional -- it's a traditional 20 expert panel. 21 Q. So there's no process by which they vote 22 on a proposed change? Page 53

1 A. No. But they reach consensus and they 2 are -- and I make sure that there's consensus 3 whenever I agree to any change. 4 Q. How do you make sure that there's 5 consensus among all members of that panel? 6 A. Well, I will ask, first of all, Matt and 7 Missy exactly where each member of the expert 8 panel is on this issue or that issue. And 9 there's often lots of follow-up with individual 10 members of the expert panel to find that out. 11 If I actually really want to know, I'll 12 call one of the members myself. That has 13 happened occasionally. 14 But I would never go forward -- we're not 15 going to go forward with anything on the survey 16 or the safety grade where the expert panel 17 disagrees -- or any member of the expert panel 18 disagrees. We're very careful about making sure 19 that there's agreement. 20 And these are not -- these are not shy 21 people, so I know they'll tell me if there's a 22 problem. And -- or they'll tell Missy or Matt. Page 54	1 Q. You said unanimous consen- -- is it 2 unanimous consensus? 3 A. Yeah, I want unanimous consensus. 4 They're advisors to us so, in theory, if it 5 wasn't unanimous, we could still go forward with 6 it. But I like it unanimous. 7 Q. So how is that unanimity in the consensus 8 among the expert panel members memorialized? 9 A. It isn't. 10 Q. Okay. 11 A. It just -- we have the -- 12 Q. Why not? 13 A. It's memorialized by the fact that -- we 14 don't have anything that says we voted on this or 15 this is the final thing. We don't -- because we 16 don't vote. 17 It's memorialized by the fact that the 18 expert panelists are okay when we put out for 19 public comment. They get a copy of what we're 20 putting out for public comment in advance, and 21 they will tell us in about two seconds if they 22 don't agree with something on there. But they've Page 56
1 And so that -- so the process is not 2 Congress. This is a process that's, like, very 3 traditional expert panel -- scientific expert 4 panel process where they meet, they confer, they 5 ask for further follow-up, they look at other 6 studies, they look over time, we call someone; 7 they say -- you know, there's a process to and 8 it, and then ultimately they reach a consensus. 9 Q. And how is that -- is that consensus 10 memorialized? 11 A. It's memorialized because we put out for 12 public comment what we ultimately want to make 13 for a change, and -- 14 Q. But my question is, is the -- you said 15 that the -- with respect to any proposed 16 change -- 17 A. Yeah. 18 Q. -- the consensus has to be unanimous 19 among the members of the expert panel, correct? 20 A. There has to be -- 21 Q. Right. But is -- 22 A. -- there has to be consensus, yeah. Page 55	1 agreed to it already. 2 So it's memorialized by the fact that 3 it's out for public comment, and they support it. 4 Q. But there isn't a separate documentation 5 or minutes or any sort of document where it's 6 memorialized that each member of the expert panel 7 has agreed to the proposed change; is that right? 8 A. Right. 9 MS. BLAIR: Objection to form. Asked and 10 answered. 11 BY MR. CHUNG: 12 Q. Does the expert panel make 13 recommendations? 14 A. Yes. 15 Q. All right. And is Leapfrog bound to 16 follow those recommendations? 17 A. Individuals within the expert panel make 18 recommendations all the time. Does the whole 19 expert panel end up agreeing that that's where it 20 should all go? Not always. 21 Q. I'm actually asking, does the whole 22 expert panel -- right? -- as a group, make Page 57

1 recommendations to Leapfrog? 2 A. No. Well, I mean -- I'm sorry. I'm not 3 sure I can even understand that. How does a 4 whole group make one recommendation? 5 Q. That's exactly my question. 6 Does the -- are there recommendations 7 that the expert panel makes to Leapfrog? 8 A. Recommendations that go out for public 9 comment are the consensus of the expert panel. 10 Q. But those recommendations -- but those 11 recommendations are coming from Leapfrog, 12 correct? 13 MS. BLAIR: Objection to form. 14 THE WITNESS: They're coming from the 15 expert panel. These are not -- these are not 16 rubber stamp people. These are, like, in some 17 cases, world experts. They don't rubber stamp 18 what we bring them, and they didn't in this -- 19 BY MR. CHUNG: 20 Q. I'm not asking about -- 21 A. -- case either. 22 Q. -- rubber stamping, Ms. Binder. Page 58	1 THE WITNESS: The Z-score methodology is 2 what is behind the A, B, C, D, or F. So for 3 instance, a hospital that scores three 4 standard -- on the Z-score scores three standard 5 deviations below the mean would be like an F. 6 BY MR. CHUNG: 7 Q. Okay. Well, is one of the purposes -- at 8 least one of the purposes of using the A, B, C, 9 D, F scale of grades is that it's easy for 10 consumers to understand? 11 A. Yes. 12 Q. All right. Are you familiar with 13 Leapfrog's scoring methodology behind the 14 hospital safety grades? 15 A. Yes. 16 Q. All right. Do you have any role in 17 designing that scoring methodology? 18 A. Well, I'm the decisionmaker. So if 19 there's any fundamental change, yes, I would -- I 20 better be familiar with what's going on. 21 Q. Okay. 22 A. But I'm not a -- I'm not a, you know, Page 60
1 You testified earlier that, with respect 2 to -- actually, why don't we illustrate it with a 3 specific example later on. We'll get to that 4 later. 5 All right. Let's talk about the scoring 6 methodology behind the hospital safety grade. 7 How did Leapfrog -- or actually, in terms 8 of the hospital safety grade itself, I understand 9 that Leapfrog uses, like, a report card scale -- 10 right? -- A, B, C, D, F, for purposes of the 11 hospital safety grade. 12 Why not assign a numerical score, like 60 13 out of 100 or 80 out of 100 or 100 out of 100? 14 A. We chose to use a Z-score methodology. 15 Q. What does that mean? 16 A. A Z-score methodology is kind of like 17 grading on a curve. It allows you to score based 18 on how a hospital performs relative to others in 19 the cohort. 20 Q. Okay. So why use the A, B, C, D, F 21 scale? 22 MS. BLAIR: Objection to form. Page 59	1 expert on -- I'm not an expert on statistics or 2 on healthcare measurement. I'm not Patrick 3 Romano. But I am -- obviously I do have to have 4 a strong familiarity with the methodology 5 because, ultimately, the buck stops with me; I 6 have to make the decisions. 7 Q. Okay. Who within Leapfrog is responsible 8 for designing the methodology? 9 A. There's a number of people who design 10 various aspects of the methodology. 11 Q. Okay. Can you just briefly go over them? 12 A. Well, Missy Danforth designs some 13 methodology for some of it. 14 Matt Austin has a lot to do with some 15 methodology for the survey, some aspects of -- 16 for instance, when there's a new measure on the 17 survey, like, we'll need to come up with a 18 scoring methodology for it, and he will help us 19 and work with sometimes -- sometimes we'll hire a 20 statistician, even within Johns Hopkins, to help 21 us with that, to figure out how we're going to 22 score things, so -- Page 61

1 Q. Do you have any role in designing the 2 survey, the hospital survey? 3 A. Do I have any role in -- 4 Q. Yes. 5 A. -- the hospital survey? 6 Q. Yes. 7 A. I'm not sure what you mean by designing. 8 Q. Do you have any role in coming up with 9 the content or the questions or the requests in 10 the hospital survey? 11 A. I often will have a role in looking at a 12 particular issue that we know is coming to the 13 fore that is of great importance, and I will then 14 ask the team to start researching to see if this 15 is an area we should add to the survey that -- 16 for instance, we have added to the survey 17 something on ER boarding, which is clearly 18 becoming an increasing major problem, and there's 19 been some studies recently that I was seeing. 20 And some physicians, actually, from Yale New 21 Haven Hospital had come to me personally and 22 said, we really want you to look at this issue; Page 62	1 Q. -- referring to then? 2 A. -- I meant -- what I meant was the public 3 comments. So we have -- 4 Q. Oh. 5 A. -- public comments that come in for the 6 safety grade, for the survey, frequently during 7 the year, and I read those. 8 Q. Okay. But not the actual survey -- the 9 data that's submitted in response to the survey, 10 you don't review that? 11 A. Sometimes, but rarely. 12 Q. Okay. How does Leapfrog verify the 13 accuracy of the information, the data -- 14 right? -- submitted by hospitals in response to 15 the survey? 16 Let me kind of break that down. 17 A. Okay. 18 Q. Does Leapfrog conduct onsite audits of 19 hospitals pursuant to their survey responses? 20 A. For four or five hospitals, yes, we do. 21 Q. Four or five hospitals out of every 22 cycle; is that right? Page 64
1 it's a big problem in patient safety; it's 2 emerging nationally. 3 And so I asked the team to start 4 researching it. They did find a significant 5 amount of peer-reviewed research, which is very 6 important to us -- 7 Q. Right. 8 A. And -- 9 Q. And did that feedback make its way into 10 the survey eventually? 11 A. Yes. 12 Q. All right. Do you have any role in 13 reviewing responses from hospitals to the 14 hospital survey? 15 A. Yes. I read every one of them. 16 Q. Okay. 17 A. Or -- I'm sorry, wait a minute. Let me 18 be clear about that. Wait a minute. 19 The responses to the actual surveys that 20 are submitted? No, I don't read all those. 21 Q. What are you -- 22 A. I'm sorry. What -- Page 63	1 A. Are you talking about the safety grade or 2 the survey? 3 Q. The survey. 4 A. The survey? 5 Q. Yeah. 6 A. For each year, we do the onsite -- the 7 onsite verification is about five hospitals. 8 Q. Okay. And that's out of the entire 9 population of hospitals -- 10 A. For onsite only. 11 Q. If you can let me finish the question. 12 A. Sorry. 13 Q. And that's out of the entire population 14 of hospitals that have responded to the survey -- 15 A. Yes. 16 Q. -- is that right? 17 A. Yes. 18 Q. All right. And how are those four or 19 five chosen? 20 A. They are fairly randomly selected. 21 Q. Okay. 22 A. I wouldn't say it's perfect random, but Page 65

1 they -- but fairly randomly. 2 Q. All right. And does -- am I right that 3 Leapfrog does not require sworn attestations from 4 responding hospitals? 5 A. They require attestations in order to 6 submit the survey. 7 Q. Are they sworn, though? 8 MS. BLAIR: Objection to form. 9 THE WITNESS: What's sworn mean? 10 BY MR. CHUNG: 11 Q. Are they -- sworn means -- 12 A. By who? Who would swear them other than 13 the CEO at- -- attesting to when they submit the 14 survey. 15 Q. Are they notarized? 16 A. No, they're not notarized. 17 Q. All right. Does Leapfrog have mechanisms 18 to verify the truthfulness of survey responses? 19 A. Yes. Significantly. 20 Q. All right. How does it do that? 21 A. It has several layers of it, actually. 22 It has -- it has a verification at the Page 66	1 selection of hospitals every month to send us 2 their never-events policy and show us the board 3 minutes where it was approved. 4 Things like that. So it is extensively 5 verified every single month. So those -- so it's 6 a very intensive process. 7 And most hospitals that complete the 8 survey say this drives them crazy because we are 9 so picky and our team is so on top of things. 10 Q. Does every section of the survey have a 11 verification process? 12 A. Uh-huh. 13 Q. Okay. And when you mentioned earlier 14 that first step -- right? -- is it -- the first 15 step of the verification, is that an algorithm or 16 some sort of automated process? 17 A. It's an automated process. 18 Q. All right. Does a hospital face any 19 consequences for submitting inaccurate 20 information? 21 A. We'll decertify their survey and remove 22 it. Page 68
1 submission, which looks at patterns that don't 2 make sense or issues that don't make sense that 3 are quite complex. 4 So for instance, if a hospital says that 5 they're reporting on maternity care and they 6 said, we had 300 births this year, the electronic 7 programming within the survey will spit it back 8 and say, wait, you said 400 last year. 9 So there's very -- there's some pretty 10 significant built-in safeguards to assure the -- 11 or not assure always, but to look at the 12 accuracy. 13 Then, once the survey arrives at us, once 14 it gets through that, then that's when our team 15 gets started. And our team has -- spends 16 enormous amounts of time requiring documentation 17 from a selection of hospitals. Every month they 18 demand documentation. 19 So for instance, there's a section on the 20 survey on a never-events policy. We ask 21 hospitals, do you have a never-events policy that 22 follows Leapfrog's guidelines? They require a Page 67	1 Q. What do you mean by remove it? 2 A. Remove it from public reporting. Or 3 sometimes we'll decertify the section where the 4 inaccuracy occurred. 5 Q. Okay. Does that mean it's basically as 6 if they never submitted it? 7 A. Yes. And then sometimes we will then ask 8 them to resubmit, which we'll then verify again. 9 Q. All right. Do they -- so can hospitals 10 update or correct their survey responses after 11 that initial submission? 12 A. Yes. 13 Q. All right. And what's the process for 14 correcting responses? 15 A. We send -- first we send notification to 16 them that they have 30 days to verify and/or 17 correct a particular issue that we've observed. 18 If they don't come back, we decertify that 19 section and then we come back to them again. And 20 we report it as either -- yeah, we -- we take 21 down that section of the survey or we take down 22 their entire hospital's results and we don't use Page 69

1 them in other programs such as the top hospital 2 qualification or the safety grade. 3 Q. Have hospitals -- has a hospital ever 4 been asked to revise their submission? 5 A. Yes. Well, they're asked to correct it. 6 Q. Okay. Has Leapfrog ever changed a 7 hospital's safety grade after it's been issued? 8 A. No. 9 Q. No? Okay. So once it's issued, that's 10 it? 11 A. One thing we will do, if we find that 12 there's something wrong with data underlying 13 it -- and that happened a lot with the AHA 14 data -- is we will remove their grade from 15 reporting. We have, I believe, done that in a 16 small handful of times. 17 Q. Okay. 18 A. But we have never changed a grade. 19 Q. All right. 20 MR. CHUNG: Why don't we turn to our 21 first document, which is tab 8. 22 So this will be Exhibit 1. Page 70	1 Do you see that at the bottom of Bates 2 number 3130? 3 A. Yes. 4 Q. All right. And then he continues on to 5 the next page, The Leapfrog survey is lengthy, 6 with over 500 questions and data gathering 7 required for many of the questions. It is one of 8 the more resource-intensive surveys in many 9 hospitals, and health systems are still 10 struggling with significant workforce shortages. 11 Is it right that Mr. -- I think it's 12 Dr. Sharma -- is expressing that the survey is 13 burdensome for hospitals to complete? Is that 14 right? 15 A. That -- 16 MS. BLAIR: Objection to form. 17 THE WITNESS: As I'm reading this, he 18 says that it's resource-intensive and many 19 hospitals are still struggling with workforce 20 shortages. 21 He also says that -- so is the Magnet 22 status survey. Page 72
1 (Binder Deposition Exhibit 1 marked for 2 identification and attached to the 3 transcript.) 4 BY MR. CHUNG: 5 Q. So Ms. Binder, Exhibit 1 is an e-mail 6 chain from July through August of 2023 between 7 you and an Adhi Sharma from -- the CEO, Mount 8 Sinai South Nassau Hospital. 9 And I want to direct your attention first 10 to -- if you look at the lower right-hand -- on 11 these documents, I'll be identifying page numbers 12 by what's called the Bates number on the lower 13 right-hand corner. 14 A. Uh-huh. 15 Q. You'll see that. So this will be -- 16 let's focus on Bates ending in 3130. 17 A. I'm probably going to need to read 18 through this because I don't recall this. 19 Q. Okay. Well, I'm going to direct your 20 attention to -- Mr. Sharma says he wanted to 21 bring to items to your attention for your 22 consideration. Page 71	1 BY MR. CHUNG: 2 Q. Yeah. I mean, do you agree with 3 Dr. Sharma's characterization of Leapfrog's 4 survey? 5 A. I don't agree that it's burdensome, 6 but -- no, I don't agree with his 7 characterization. 8 Q. Okay. So you don't agree that it's a 9 resource-intensive survey while hospitals are 10 facing staffing shortages? 11 A. Resource-intensive is relative. It's 12 nowhere near as resource-intensive as most of the 13 other kinds of work that a quality department 14 will do, such as prepare for accreditation, 15 handle registry reporting and things like that. 16 So those are extremely 17 resource-intensive. Those require the hiring of 18 full-time people all year to work on them. 19 This -- 20 Q. But the -- 21 A. -- ours is -- 22 Q. -- survey is a voluntary survey -- Page 73

1 A. -- a -- 2 Q. -- correct? But the survey is a 3 voluntary survey, correct? 4 A. Yes. 5 Q. Okay. And the other items that you 6 mentioned that you called resource-intensive, are 7 those voluntary as well? 8 A. Registries are voluntary. They're 9 just -- the difference between registries and 10 Leapfrog is that registries almost never make the 11 data public. So there's no transparency 12 whatsoever. 13 Same with accreditation, which they -- I 14 mean, I guess they could choose not to be 15 accredited, but they will be accredited. 16 But that's still very resource-intensive. 17 Most of what a quality department is doing is 18 extensive -- extensive and requires -- some 19 registries require hiring at least one full-time 20 equivalent for the entire year. 21 Q. Okay. 22 A. Leapfrog requires about 80 hours of staff Page 74	1 hospital with strong quality measures from 2 performing well on the survey? 3 MS. BLAIR: Objection to form. 4 THE WITNESS: Yeah, I'm going to need to 5 read this because now, as you're saying this, I'm 6 realizing this is a gentleman who had the very 7 common problem of confusing the safety grade and 8 the survey. 9 So what I was just referring to was the 10 survey. 11 BY MR. CHUNG: 12 Q. Okay. 13 A. He's not actually talking about that. 14 He's talking -- even though he says it's the 15 survey, it's not the survey. He's talking about 16 the safety grade, because patient satisfaction, 17 which isn't patient -- it's patient experience 18 scores that are on the safety grade have been 19 correlated with good evidence, are the ones that 20 are correlated with outcomes in patient safety, 21 and that's where we use them. 22 But -- yeah, so that's what he's talking Page 76
1 time. 2 Q. Okay. And what is that based on? 3 A. That's based on conversations over time 4 that both Missy Danforth and myself have had. 5 We've asked repeatedly how long does it take, and 6 we get answers anywhere from 20 to 100 hours, and 7 most of them are around 80. 8 Q. So on the same page Dr. Sharma continues 9 that, The weight given to the patient experience 10 survey is disproportionate, and that one of the 11 reasons we -- or his hospital -- did not submit 12 in the past was simply because we knew that, 13 despite very strong quality measures, our patient 14 satisfaction scores would prevent us from -- 15 A. Oh, I -- 16 Q. -- performing as well -- 17 A. -- am seeing this now. 18 Q. Do you see that? 19 A. Sorry. 20 Q. And so the question is, do you agree with 21 Dr. Sharma's statement here, position here, that 22 patient satisfaction scores can prevent a Page 75	1 about, as I read this. 2 Q. Okay. Now, in response to Dr. Sharma -- 3 and I'm looking at Bates ending in 3129. So it's 4 basically -- it's your response, your first 5 response, to his e-mail. 6 You write, Hi, Rob. 7 And then in third paragraph you write, 8 There are -- but there are 30 measures considered 9 overall, so outstanding performance on some 10 measures can tip the scales in a hospital's favor 11 even when some other measures are mediocre. 12 Do you see that? 13 A. Yeah. I'm just going to take a minute to 14 read this -- 15 Q. Sure. 16 A. -- because I don't recall it. 17 Okay. So -- 18 Q. So just reading that sentence, does this 19 mean that a hospital can perform poorly in one 20 category but highly in another and receive a high 21 hospital safety grade? 22 A. Yes. Page 77

1 Q. Okay. 2 A. In fact, I'm -- probably most hospitals 3 will have some measures where they perform 4 poorly. 5 Q. Okay. Are -- just on a separate topic, 6 are pediatric or children's hospitals, included 7 in the hospital survey? 8 A. They're invited and -- they're invited to 9 participate and they can, and some do. 10 Q. All right. What do you consider to be 11 the definitions of a children's hospital? 12 A. A hospital that serves pediatric 13 patients. 14 Q. Okay. You're familiar with the 15 plaintiff -- the five plaintiff hospitals that 16 are involved in this case? 17 A. Yes. 18 Q. Okay. Are you aware that the St. Mary's 19 Hospital is a combined adult and children's 20 hospital? Do you understand -- do you know that? 21 A. I'm not sure -- 22 Q. Not sure? Page 78	1 for the fact that it serves both adults and 2 children? 3 MS. BLAIR: Objection to form. 4 THE WITNESS: The safety grade uses CMS 5 data, and CMS data is tied to adult patients. So 6 it's only going to be looking at the adult -- 7 measures of how adult patients are treated. 8 BY MR. CHUNG: 9 Q. Okay. So it focuses on the adult 10 treatment, the adult population -- 11 A. The safety -- 12 Q. -- being treated at -- at that hospital, 13 correct? 14 A. The safety grade does. The survey is an 15 opportunity if they -- if it's a separate 16 hospital, the pediatric hospital is a separate 17 hospital, they would be able to also report on 18 their pediatric patients to the survey. 19 Q. Okay. 20 A. But it has nothing to do with the safety 21 grade. 22 Q. Understood. Thank you for making that Page 80
1 A. I'm not sure. 2 Q. Okay. 3 A. Most hospitals -- most general hospitals 4 also have pediatric patients. They have 5 patients -- so -- are you saying they serve 6 pediatric patients and -- or you're saying 7 they're two hospitals? 8 Q. They are -- it's a combined adult and 9 children's hospital. 10 Are you aware of that? 11 A. Now I am. 12 Q. Okay. 13 A. But you're saying that -- most general 14 hospitals -- 15 Q. Let me just -- 16 A. -- do serve -- 17 Q. Let me -- 18 A. -- pediatric patients, so I'm not 19 understanding how that makes them different from 20 other general hospitals. 21 Q. Do you know whether the Leapfrog safety 22 grade that's been assigned to St. Mary's accounts Page 79	1 clear. 2 So with respect -- if a hospital that has 3 both an adult hospital and a children's hospital 4 is assigned, let's say, a D grade or an F grade, 5 that hospital safety grade is -- that grade is 6 solely for the adult -- the treatment or the 7 patient safety around adult -- the adult 8 population, right? 9 MS. BLAIR: Objection to form. 10 THE WITNESS: The safety grade measures 11 are primarily from CMS, and those measures apply 12 to -- those measures apply to adult populations. 13 However, some of the measures, 14 particularly the Leapfrog measures, would be 15 applicable to the pediatric patients as well. So 16 for instance, CPOE would be applicable. If they 17 are using a CPOE system, that would be applicable 18 to the -- that would affect the care of the 19 pediatric patients. 20 BY MR. CHUNG: 21 Q. Okay. But the CMS data that is -- that 22 the hospital safety grade is based on is focused Page 81

1 on the adult population; is that right? 2 A. I believe so, but I guess I would need 3 to -- I would need to check on that. 4 Q. Okay. I mean, if that's correct -- 5 assuming that's correct, then a -- isn't the -- I 6 mean, for a consumer, let's say the parent of a 7 child -- right? -- that's looking for a hospital 8 in their area to send their child to for 9 pediatric care, if they see a D grade or an 10 F grade for a hospital that serves both adult and 11 children population and for want -- and for a 12 hospital that didn't report -- respond to the 13 survey, how does Leapfrog communicate to the 14 consumer, to that parent, that the hospital 15 safety grade is based on just CMS data that's 16 focused on the adult population? 17 MS. BLAIR: Objection to form. 18 THE WITNESS: We communicate the letter 19 grades. A hospital that has high rates of 20 problems that are in the CMS data is not going to 21 be safe for any of the patients. General. So 22 for instance, if they have a high rate of leaving Page 82	1 MS. BLAIR: Can you let her answer, 2 Daniel? 3 BY MR. CHUNG: 4 Q. Isn't that what you just did, though? 5 MS. BLAIR: No. Let her answer the 6 question. 7 BY MR. CHUNG: 8 Q. You testified, Ms. Binder, that if there 9 are certain issues relating to patient safety for 10 the adult population, that you're sure or that -- 11 that will generally apply to the rest of the 12 hospital; isn't that what you testified to? 13 MS. BLAIR: Objection to form. 14 Mischaracterizes her testimony. 15 THE WITNESS: We provide the information 16 that people need to understand -- 17 BY MR. CHUNG: 18 Q. If you can just answer the question, 19 Ms. Binder. 20 MS. BLAIR: Can you just let her give an 21 answer? 22 MR. CHUNG: I'm trying -- Page 84
1 objects in after surgery or they have a high rate 2 of infection or central line infections, that's 3 not a safe environment. That's a problem. 4 So it is -- even though it's -- I'm not 5 sure, and I would have to check -- I'm not sure, 6 but I don't believe the CMS data is accounting 7 for pediatric patients, per se. It is still -- 8 safety problems that are happening within a 9 hospital's four walls are going to affect all the 10 patients that are there. 11 BY MR. CHUNG: 12 Q. But assuming that the CMS data is just 13 focused on the adult population, I think what 14 you're saying is you would just extrapolate that 15 data to the children's population; is that right? 16 MS. BLAIR: Objection to form. 17 THE WITNESS: I don't extrapolate. I 18 would -- we provide -- 19 BY MR. CHUNG: 20 Q. Isn't that what -- 21 A. -- the information -- 22 Q. -- you just did, though? Page 83	1 MS. BLAIR: You're asking very long -- 2 MR. CHUNG: I'm trying -- actually, that 3 one was quite short. 4 BY MR. CHUNG: 5 Q. So if you could answer that question. 6 A. I would expect consumers to look at the 7 data that we provide and make their own 8 decisions. 9 Q. Okay. 10 A. That's why we provide them with as much 11 data as we do. 12 Q. Which data are you referring to? 13 A. How hospitals perform on each of the 14 measures that we use in the safety grade. 15 Q. On the hospital -- so you're referring to 16 the hospitalsafetygrade.org website. 17 A. Yes. 18 Q. Okay. The -- I wanted to ask you a few 19 questions about the certificate coach program. 20 Are you familiar with that? 21 A. No. 22 Q. All right. Is there -- Page 85

1 A. We have a coach program, but it's not 2 certificate. 3 Q. Which coach program are you referring to? 4 A. Certified coach -- I don't think we call 5 it certified. It's a coach -- coach program. 6 Q. Okay. And what is that? 7 A. That is an opportunity for healthcare 8 industry leaders who are interested in 9 understanding the survey process and the hospital 10 safety grade, the measurement of it and the data 11 that's used, they want to understand that better, 12 it's an opportunity for them to have -- to be 13 educated on it and then take a test to see that 14 they know and understand the elements of the 15 survey and the elements of the safety grade. 16 It's only about the measures. 17 It's because a lot of industry leaders 18 had approached us and said, well, some of my 19 hospital clients are asking me if, you know -- if 20 this is going to help us with the intensivist 21 coverage in the ICU standard or something, and 22 they don't really understand the Leapfrog survey. Page 86	1 BY MR. CHUNG: 2 Q. Quality leaders at the hospitals; is that 3 right? 4 A. Yeah. But we don't go to the hospitals, 5 but we do offer additional -- we offer a variety 6 of different supports for hospitals in completing 7 the survey and understanding the measures, 8 understanding the questions, understanding the 9 evidence behind them and what they should 10 prepare. We help them to prepare for our 11 verification process because pretty much every 12 hospital encounters that. So what kinds of 13 documents they should have -- they should have 14 prepared in advance. 15 We also educate them on some of the 16 topics that come up and why they matter. But 17 we -- that's all about -- 18 Q. Is there a cost -- 19 A. -- the survey -- 20 Q. -- associated with this -- the 21 counseling, everything you described in the 22 program? Page 88
1 It's not really aimed at hospitals. They 2 haven't been interested in it because the 3 hospitals that report to the survey, and those 4 hospitals that get safety grades, do already know 5 a lot about their own measurement because they're 6 immersed in it, and that's their business. But 7 for somebody who's selling a product or involved 8 in the industry in some way, they often do not 9 have that level of familiarity with Leapfrog's 10 measurement. 11 Q. So is there any program, whether it's 12 coach, a consultant, whatever the verbiage may 13 be, is there any program that Leapfrog has 14 that -- where hospitals can take on -- you know, 15 pay for a consultant or a coach to help them with 16 the survey? 17 MS. BLAIR: Objection to form. 18 THE WITNESS: To help them with the 19 survey or to help -- well, first of all, we don't 20 offer consulting, but we do offer support for 21 quality leaders completing the survey. 22 Page 87	1 MS. BLAIR: Objection to form 2 regarding "counseling." 3 THE WITNESS: Again, we don't offer 4 consulting. 5 BY MR. CHUNG: 6 Q. Right. 7 A. We do offer -- there is -- most of it is 8 at no cost. We do a lot of one-on-one 9 conversations. There is one webinar series that 10 hospitals that want a really deep dive and want 11 extra can sign up for. Those typically are 12 signed up for by hospitals that have been in the 13 survey a long time and want even more nuanced 14 understanding of it. But 99 percent of what 15 we're offering is all free to all hospitals. 16 Help desk, lots of webinars, town hall calls we 17 call them. Also one-on-one -- numerous 18 one-on-one meetings and conversations between our 19 team and teams at hospitals. 20 Q. Okay. Just going back to the survey, 21 Leapfrog requires survey participants to affirm 22 that they may use the survey information in a Page 89

1 commercial manner for profit. 2 Do you -- does that language sound 3 familiar to you from the survey? 4 A. Yes. 5 Q. Okay. Can a hospital opt out of that 6 affirmation and still complete the survey? 7 A. They can complete the survey, but to 8 submit the survey, they do need to attest to it. 9 Q. Okay. Has any hospital ever complained 10 about not being able to opt out of that 11 attestation or affirmation regarding the 12 commercial use? 13 A. The attestation is longer than that and 14 it does require them to attest to the 15 truthfulness of what's on the survey -- 16 Q. Right. 17 A. -- so that's why it's very important to 18 us. And we are as candid as possible about the 19 fact that we license the data. 20 Q. Okay. 21 A. Now, we license the ratings and our 22 assessment of their data, not what they submit to Page 90	1 A. -- and we, in turn, are truthful about 2 the fact that we license it -- that data, what 3 they submit to us, we score and we determine to 4 what extent that hospital meets our very high 5 standards for each one of the measures. 6 That is what we license, is their scores 7 on the variety of measures. We do not license 8 the raw content of their survey. 9 Q. Okay. But without the data that the 10 hospital is submitting in response to the survey, 11 you would not have the scores that you're 12 licensing; is that right? 13 A. That we're licensing for the survey. 14 Right. 15 Q. Okay. And then -- so in terms of the 16 licensing program, the data licensing program, 17 Leapfrog licenses that data to researchers; is 18 that right? 19 A. Yes. 20 Q. Okay. And they also license the data to 21 businesses; is that right? 22 A. Yes. Page 92
1 us, per se. 2 Q. So in terms of -- and, in practice, 3 Leapfrog does use the survey information in a 4 commercial manner for profit; is that right? 5 MS. BLAIR: Objection to form. 6 THE WITNESS: We use the ratings that we 7 derive from the surveys that are submitted. We 8 use that for licensure. 9 BY MR. CHUNG: 10 Q. That's the hospital safety grade, the 11 accolade licensing program, or is that different? 12 A. No. That's different. 13 Q. Okay. 14 A. So you're asking me about the survey. 15 Q. Right. 16 A. You just asked me -- attestation that's 17 only on the survey; it's not on the safety grade. 18 Q. Right. 19 A. Okay. That data that's provided to us on 20 the survey that we ask hospitals to attest to its 21 truthfulness -- that's what that attestation is. 22 Q. Right. Page 91	1 Q. Okay. What kinds of businesses? 2 A. Well, health plans are probably the 3 primary -- primary ones. 4 Also businesses that are themselves in -- 5 publishers of data. 6 And also -- so for instance, companies -- 7 well, companies that also publish data and they 8 incorporate Leapfrog data into their reporting. 9 One of the companies provides employers with 10 information that they can use to tell their 11 employees about various -- the quality of various 12 providers. They incorporate Leapfrog data. They 13 license the data to do that. 14 Q. So researchers, health plans, other 15 businesses. 16 Any persons or entities that also license 17 the survey data from Leapfrog? 18 A. Other than businesses and health plans, 19 not that I can think of. 20 Q. Do other hospitals -- do hospitals 21 license data from Leapfrog? 22 A. We provide some hospital systems, upon Page 93

1 request, with reports about their own systems. 2 Q. How about reports or data about other 3 hospitals? 4 A. Only insofar as their system will give 5 them benchmarks on how they compare nationally. 6 So the national part of the data, the national 7 numbers, are coming from our broader database, 8 but we'll give them their own performance 9 compared nationally. 10 Q. So -- 11 A. So no, we -- to my knowledge, we have not 12 licensed the full data set to any hospitals. I 13 don't think they want that. 14 Q. Have any hospitals asked for license -- 15 licensure to data for hospitals within their 16 regional market? 17 A. No. 18 Q. Okay. Your -- 19 A. By the way, if they want to know their 20 regional market, we are public, so we're 21 transparent. I'm sorry to interrupt you, but I 22 just thought of something to add to the answer. Page 94	1 the hospital safety grades. 2 Fair to say that that methodology has 3 changed over time at least during your time as 4 CEO at Leapfrog? 5 A. It has changed a bit. Yes. 6 Q. Okay. And I want to put in front of you 7 the second exhibit, Exhibit 2. 8 (Binder Deposition Exhibit 2 marked for 9 identification and attached to the 10 transcript.) 11 BY MR. CHUNG: 12 Q. So Exhibit 2 is -- 13 MS. BLAIR: Do you have copies of that? 14 MR. CHUNG: Yeah. 15 MS. BLAIR: Sorry. Thank you. 16 BY MR. CHUNG: 17 Q. -- is an in-person meeting agenda, 18 including expert panelists, and it says that 19 you're an attendee in terms of the board and 20 staff of Leapfrog. 21 Do you see that? 22 A. Yes, I do. Page 96
1 Q. Okay. 2 A. So if you're in the regional market, you 3 can look up on Leapfrog for free to see how your 4 other hospitals are doing or to go and find other 5 hospitals somewhere else in the country that 6 might be doing better than you on a particular 7 measure and so that you can ask them for advice. 8 We see that happen quite frequently, and I think 9 it's a positive trend. 10 Q. Okay. 11 MR. CHUNG: We've been going for about an 12 hour and a half or so. We're going to move on to 13 the next topic, so why don't we take a break. 14 MS. BLAIR: Sure. 15 VIDEO TECHNICIAN: The time is 10:28 a.m. 16 This ends unit 1. We're off the record. 17 (A recess was taken.) 18 VIDEO TECHNICIAN: The time is 10:55 a.m. 19 This begins unit number 2. We're on the record. 20 BY MR. CHUNG: 21 Q. So Ms. Binder, I wanted to ask you 22 questions about the scoring methodology behind Page 95	1 Q. And it's from June 14, 2017. 2 And these are -- these are meeting notes 3 from a meeting of the expert panel from that 4 date; is that right? 5 A. I'm not familiar with this document, so 6 I -- I don't know. 7 Q. Okay. 8 A. Looks like it. 9 Q. So there is -- towards the bottom of the 10 page, so Bates ending 3576 -- the first page, I 11 mean -- there is a heading, Unintentional 12 consequences of how we currently treat missing 13 data. 14 Do you see that? 15 A. Yes. 16 Q. And do you see that, towards the bottom, 17 that there are three possible solutions proposed? 18 A. Yes. 19 Q. All right. And then, on the second 20 page -- so Bates 3577 -- under number 2 it says, 21 Imputation of the score when we have missing 22 data. Page 97

1 Do you see that? 2 A. Yes. 3 Q. And then the first bullet point says, 4 Matt -- and fair to say that's referring to Matt 5 Austin, who you testified about earlier? 6 A. Yes. 7 Q. Okay. Matt mentioned that expert panel 8 discussed this in the past and did not feel it 9 supported the goal of the safety grade but that 10 imputation would incentivize hospitals to report. 11 Do you see that? I'm looking at the 12 second page, Ms. Binder. 13 A. Uh-huh. 14 Q. Do you see that language? 15 A. Yeah, I'm just going to need to read this 16 through -- 17 Q. Okay. 18 A. -- to be sure that I understand the 19 context -- 20 Q. Okay. 21 A. -- of what you just said. 22 Yeah, so I'm remembering this meeting Page 98	1 A. So to the extent it's about safe 2 practices, they had discussed not applying 3 imputation to certain of the safe practices. 4 Q. Right. And that's -- 5 A. That's probably what he's talking about, 6 but I don't know for certain. 7 Q. And is that because imputed scores on 8 safe practices would not actually reflect the 9 safety conditions or the safe practices at the 10 hospitals, correct? 11 MS. BLAIR: Object to form. 12 THE WITNESS: It's not described here 13 what the reasoning was in the past. But as I 14 recall, Sara Singer, one of the expert panelists 15 who is an expert on quality improvement, had 16 specifically cited three safe practices that she 17 felt that we did not have adequate evidence and 18 experience to impute in an accurate way. But she 19 was specifically referring to three safe 20 practices -- 21 BY MR. CHUNG: 22 Q. Okay. Page 100
1 was -- 2 Q. So I'm going to ask a question. 3 So is it -- so based on the language that 4 we just read across the top here, Matt mentioned 5 that expert panel discussed this in the past and 6 did not feel it supported the goal of the safety 7 grade but that imputing scores for individual 8 measures like safe practices would incentive them 9 to report on the survey -- so does this reflect 10 that members of the expert panel believe that 11 using the imputation method did not support the 12 goal of the safety grade? Is that right? 13 MS. BLAIR: Objection to form. 14 THE WITNESS: It says that Matt mentioned 15 that the expert panel discussed this. 16 BY MR. CHUNG: 17 Q. Uh-huh. 18 A. So it's not altogether clear to me 19 what "this" is, because they seem to be talking 20 about safe practices, which they had discussed in 21 the past, should not be imputed. 22 Q. Okay. Page 99	1 A. -- in the past. 2 Q. And at this point, in June 2017, our 3 understanding is that Leapfrog decided not to use 4 an imputation model for -- in the circumstances 5 where there was missing data for hospitals; is 6 that correct? 7 MS. BLAIR: Objection to form. 8 THE WITNESS: For the safe practices, the 9 specific safe practices, yes. We decided early 10 on, earlier in the course of it, not to apply an 11 imputation model for certain safe practices. 12 BY MR. CHUNG: 13 Q. Was there an imputation model or 14 imputation method for any of the metrics at this 15 time? I get your point regarding the safe 16 practice -- 17 A. Uh-huh. 18 Q. -- but any, any metrics? 19 A. Yeah, I don't believe so. We had 20 secondary data from AHA, and we used that. 21 Q. Right. And fair to say that AHA was one 22 of your -- one of Leapfrog's principal sources Page 101

1 for secondary data on a number of metrics? Is 2 that right? 3 MS. BLAIR: Objection to form. 4 THE WITNESS: Well, CMS was also 5 secondary for the infection measures. 6 BY MR. CHUNG: 7 Q. Okay. 8 A. So we had two sources of secondary data. 9 Q. And AHA, as a source of secondary data, 10 that's data that is submitted or reported by the 11 hospitals to AHA, correct? 12 A. Yes. 13 Q. All right. 14 MR. CHUNG: Let's move on to 82 and 82a. 15 And this document -- we'll say Exhibits 3 16 and 4. 17 (Binder Deposition Exhibits 3 and 4 18 marked for identification and attached to 19 the transcript.) 20 BY MR. CHUNG: 21 Q. So Ms. Binder, what you have in front of 22 you, Exhibit 3 is an e-mail that Mr. Austin, Matt Page 102	1 MS. BLAIR: Objection to form. 2 THE WITNESS: This is a draft. 3 BY MR. CHUNG: 4 Q. Right. A draft of that type of document, 5 correct? A draft of the guiding principles, 6 correct? 7 A. A draft of guiding principles that I'm 8 unclear have actually gone to the expert panel. 9 So it would be a draft they have not necessarily 10 seen. I don't know for sure. 11 Q. Okay. And we're looking at the second 12 page of this attachment, Bates ending in 4494. 13 And the first paragraph says, under 14 imputing missing data toward the bottom -- do you 15 see that? 16 A. Yes. 17 Q. -- When a hospital is missing data for a 18 particular performance measure, we recommend 19 ignoring the measure and recalibrating the weight 20 within the domain so that hospitals are scored 21 only on the measures for which their performance 22 data are available. Page 104
1 Austin, sent to himself, and he's attached a file 2 that's named, Expert panel guiding principles. 3 Do you see that? 4 A. Yes. 5 Q. And it looks like Matt forwards an e-mail 6 from himself from July 3 of 2017. 7 Do you see that? 8 A. I see -- 9 Q. Okay. 10 A. -- October 27th. 11 Q. That's right. 12 And then Exhibit 4, which is the 13 attachment to that e-mail, it's titled, Expert 14 Panel's Guiding Principles on the Development of 15 Leapfrog's Composite Patient Safety Score for 16 U.S. Hospitals. 17 Do you see that? 18 A. Yes. 19 Q. All right. Is this a document that 20 describes guiding principles that the expert 21 panel uses for any recommendations it makes in 22 calculating the hospital safety grade? Page 103	1 Did the expert panel recommend ignoring 2 measures when hospitals had missing data with 3 respect to those measures at any point during 4 this time? 5 A. As I mentioned, the safe practices, that 6 is the methodology that we've used for the three 7 safe practices that Sara Singer first brought up. 8 That is how we do it for those three safe 9 practices. 10 Q. Okay. Well, how about generally at this 11 time? 12 MS. BLAIR: Object to form. 13 BY MR. CHUNG: 14 Q. This is not -- 15 A. I don't know generally. 16 Q. -- you will see that he doesn't qualify 17 this -- that he doesn't limit this to the safe 18 practices, right? 19 A. Okay. So there's no "he." I don't know 20 who drafted this. Maybe Matt did, but this is a 21 draft. So I don't know who's -- made these 22 comments. Page 105

1 Q. Understood. 2 So the question is, you recalled that 3 this -- this statement is applicable to the safe 4 practices that we were -- that we were discussing 5 earlier, correct? 6 MS. BLAIR: Objection to form. 7 BY MR. CHUNG: 8 Q. At least at this time? 9 A. I mean, that's a -- one wording of what 10 we do with three safe practices currently. 11 Q. Okay. 12 A. I don't know if it's perfectly accurate 13 wording. So -- this is a draft. We often have 14 drafts go back and forth quite a bit. 15 Q. Okay. Well, there's a comment bubble 16 next to it with an MA, and it states, May need to 17 update based on panel's final recommendation. 18 Did the panel, expert panel, make a final 19 recommendation along these lines to ignore -- 20 when a hospital is missing data for a particular 21 performance measure, to ignore that measure and 22 recalibrate the weights within the domain so that Page 106	1 panel made at this time? 2 A. This is a draft. 3 Q. I understand. But I'm asking -- I'm 4 not -- I'm asking -- I read this sentence from 5 the draft. But -- 6 A. Yeah, this -- 7 Q. -- did they make that recommendation? 8 A. Yes. That is a fundamental part of the 9 methodology from day one. 10 Q. So they did make that recommendation. 11 A. Uh-huh. 12 Q. Okay. 13 A. If they're missing a large number of 14 measures, yes. They have defined that over time, 15 but yes, they have -- if they're missing too much 16 data, they don't get a grade. 17 Q. Okay. Now, going back to the AHA data, 18 which was one of the secondary sources, along 19 with CMS -- CMS data, at some point, am I right 20 that Leapfrog stopped using AHA data as a 21 secondary source of data? 22 A. We were forced to. Page 108
1 the hospital is scored only on the measures for 2 which their performance data is available? 3 A. You're asking me if the expert panel 4 followed up from this draft? 5 Q. Right. 6 A. I don't know. I don't know what they did 7 with this draft. I don't even know if they saw 8 it. 9 Q. Okay. If you turn to the next page, 10 Ms. Binder. Same section under this imputing 11 missing data, but the next page. 12 The last paragraph, it reads, If a 13 hospital is missing data for a large number of 14 performance measures, then a score cannot be 15 reliably calculated. In this situation, no score 16 should be issued for the hospital. 17 Is this a recommendation that the expert 18 panel made at this time? 19 MS. BLAIR: Objection to form. 20 THE WITNESS: Well, it -- 21 BY MR. CHUNG: 22 Q. Is this a recommendation that the expert Page 107	1 Q. Yeah. And is it because the license ran 2 out? What was the issue there? 3 A. AHA told us they would no longer sell us 4 the data. They gave us one-year notice on that 5 and told us they wouldn't sell it to us. 6 Q. And that was -- when was that? About 7 2021? 8 A. Something like that. 9 Q. Okay. So did that -- that development 10 kind of spur Leapfrog to try to figure out a new 11 way to score hospitals when they were missing 12 data from the hospital? 13 MS. BLAIR: Objection to form. 14 THE WITNESS: It spurred us to identify 15 an alternative secondary source, which we spent 16 considerable amount of time looking for. So we 17 looked at other organizations that collect data, 18 such as HIMSS, et cetera. We looked at surveys 19 that are out there. There's a number of them, 20 but none were either not [sic] available publicly 21 by a hospital or -- in fact, that's 90 percent of 22 them are not publicly available by hospitals. Page 109

1 Almost nothing publicly available by hospital, 2 hence the need for Leapfrog. 3 BY MR. CHUNG: 4 Q. Okay. 5 A. But there was no source that we could 6 identify as a secondary source that would be 7 adequate, meet our needs, and be publicly 8 available. So we -- that is -- so we looked at 9 imputation strategies and brought that to the 10 expert panel for sure. 11 Q. Okay. 12 MR. CHUNG: 71. This will be Exhibit 5. 13 (Binder Deposition Exhibit 5 marked for 14 identification and attached to the 15 transcript.) 16 BY MR. CHUNG: 17 Q. So Ms. Binder, Exhibit 5, it's an e-mail 18 chain from March 2021. 19 And is it correct that the participants 20 in this e-mail chain are members of the expert 21 panel and Leapfrog personnel? 22 A. Yes. I wasn't on this chain, that I can Page 110	1 Q. And he writes that Leapfrog would no 2 longer use the step 2, using the mode of scores 3 assigned to hospitals in the same health system, 4 and instead the methodology would use step 1, use 5 a hospital's most recent score on the measure. 6 And then, as a step 3, use the mean of 7 the scores assigned to other like hospitals in 8 the U.S. 9 Do you see that? 10 A. Yes. 11 Q. All right. And is this the imputation 12 methodology that went into effect following this 13 update? 14 A. I believe so. I'd have to check with 15 Missy Danforth and Matt Austin about that, but I 16 believe that is -- 17 Q. Okay. 18 A. -- the methodology that went into effect. 19 Q. So why don't we go to -- 20 MR. CHUNG: 89 and 89a. 21 BY MR. CHUNG: 22 Q. Actually, one more question on that Page 112
1 see anyway -- 2 Q. Yes. 3 A. -- so I'm going to need to read it. 4 Q. Okay. And just to kind of focus the 5 discussion -- please read it, but I will be 6 focusing first on -- it's really the Bates ending 7 in 1532. 8 A. Okay. 9 Q. So Ms. Binder -- 10 A. Okay. 11 Q. -- I have, like, basically, two or three 12 questions -- 13 A. Okay. 14 Q. -- for this document. 15 A. I'm now finished reading it. 16 Q. So on that page that I directed you to, 17 Bates 1532, Matt Austin writes to the group here 18 with a quick update on -- with respect to the 19 imputation approach, correct? Is that right? 20 A. On 32? 21 Q. Yes. 1532. 22 A. Oh, yes. Page 111	1 e-mail. He writes on the next page, Bates ending 2 1533, after he goes through the steps, To offer 3 you some perspective on the implementation of the 4 imputation model, of the 101 hospitals that will 5 have one or more scores imputed and receive a 6 grade in the last round, 78 of the 101 will 7 receive the same grade as fall 2020. 8 And then he says, We were pleased to see 9 that the imputation of the scores didn't cause a 10 drastic shift in scoring. 11 Do you see that? 12 A. Yes. 13 Q. All right. Do you have an understanding 14 as to why he -- why the expert panel was pleased 15 to see that this imputation method didn't cause a 16 drastic shift in scoring? 17 MS. BLAIR: Object to form. 18 THE WITNESS: My assumption is because it 19 suggests that the imputation was clearly accurate 20 and was consistent with earlier data. 21 MR. CHUNG: All right. Okay. 22 THE WITNESS: I'd also say that this Page 113

1 exhibit is an excellent example of our expert 2 panel process. It really does show how it works. 3 MR. CHUNG: So next exhibits will be 6 4 and 7. 5 (Binder Deposition Exhibits 6 and 7 6 marked for identification and attached to 7 the transcript.) 8 BY MR. CHUNG: 9 Q. So Ms. Binder, kind of similar to other 10 exhibits, Exhibits 6 and 7 is an e-mail and then 11 you have an attachment which is titled, Final 12 Updates to the Leapfrog Hospital Safety Grade 13 Methodology for fall 2022. 14 You'll see that you're on the e-mail 15 chain. 16 A. Yes. 17 Q. Am I right that, for Exhibit 7 -- so with 18 the attachment -- that you edited this document 19 and tracked changes? 20 A. Yes. 21 Q. All right. And is this document -- this 22 document, am I right, responds to comments, or Page 114	1 A. Yes. 2 Q. All right. And then you left a comment 3 here -- looking off to the right, and I apologize 4 for the size of the font here -- that We need to 5 emphasize survey participation is important. 6 Please clarify that available data is superior to 7 imputed data and up-to-date data is superior to 8 older data, but in testing for accuracy on this 9 measure, we have found reliability is maximized 10 for missing data when -- blah, blah, blah. Just 11 be honest, it's a tradeoff. 12 So is it correct that the imputation 13 method you are using in 2022 maximized 14 reliability in your view? 15 MS. BLAIR: Objection to form. 16 THE WITNESS: I'm sorry, I don't even 17 understand that question. 18 Are you asking me what I was talking 19 about in this document or are you asking me 20 something else? 21 BY MR. CHUNG: 22 Q. I'm asking you based on what you wrote as Page 116
1 public comments, about Leapfrog's 2022 hospital 2 safety grade methodology? Is that right? 3 A. This is a draft of the responses to 4 public comments. 5 Q. Right. Correct. 6 And then, by this time, 2022, Leapfrog 7 was using an imputation method for -- with 8 respect to hospitals for which it was missing 9 data, correct? 10 A. In fall of '22? 11 Q. Yeah. 12 A. We were using an imputation method. 13 Q. Okay. 14 A. Not the same one that we use now. 15 Q. Right. 16 So under responses to public comments the 17 document reads, Several commenters shared 18 concerns about allowing hospitals that did not 19 submit a 2022 Leapfrog hospital survey to receive 20 points for the hand hygiene score through the 21 safety grade imputation model. 22 Do you see that? Page 115	1 a comment here -- 2 A. Yes. 3 Q. -- in this document: Did you believe 4 that the imputation method that Leapfrog was 5 using in 2022 maximized reliability? 6 MS. BLAIR: Objection to form. Misstates 7 the comment. 8 BY MR. CHUNG: 9 Q. I should say, let me be more -- 10 A. I -- 11 Q. Let me be more precise. 12 A. Okay. 13 Q. Is it correct that, in 2022, you believed 14 that the imputation method that Leapfrog was 15 using maximized reliability with respect to 16 scoring hospitals in metrics for which you were 17 missing data? 18 A. That the prior -- so you're asking me, 19 did the prior method for imputation maximize 20 reliability? 21 Q. Yes. At the time. The imputation at the 22 time. Which you're right, it's different from Page 117

1 what it is now. Right. 2 A. Right. 3 MS. BLAIR: I'm going to object to form. 4 THE WITNESS: Okay. The maximum 5 reliability that we can get is when we have the 6 actual survey data, period. 7 BY MR. CHUNG: 8 Q. Okay. 9 A. And the survey -- what I was -- what 10 we're getting at in this comment is that the 11 survey is actually an extremely high standard, 12 that hospitals that complete the survey and do 13 well on it -- that's an "and" -- deserve the 14 credit for that within the methodology, and that 15 imputed -- 16 Q. So -- 17 A. -- data cannot -- 18 Q. I'm just going to stop you there. 19 MS. BLAIR: Let her finish -- 20 BY MR. CHUNG: 21 Q. You're not answering the question, 22 Ms. Binder. Page 118	1 that. 2 Q. Okay. Let's hear that -- 3 A. Can I answer? 4 Q. Yes. 5 A. Yes, thank you. 6 So at the time that we were using that 7 imputation methodology, it was appropriate. But 8 times change. Data changes. It evolves, and so 9 does the performance and so do the -- so as the 10 expert panel talked about in your earlier 11 exhibit, there are -- there's lots of evidence to 12 show that performance changes over time and that 13 we no longer can consider this imputation 14 strategy the most reliable. 15 Q. Okay. I was just asking at this time. 16 So -- all right. You also wrote in this 17 comment at the top, I prefer Alex's comment 18 below. 19 Do you see that? 20 A. I don't think so. I don't see it. 21 Q. Well, in the same comment bubble that we 22 were just going over, it's actually at the top of Page 120
1 My question was, based on your comment 2 here, was the imputation method that Leapfrog was 3 using at this time -- right? -- not now, but at 4 this time -- in your view, did that imputation 5 method maximize the reliability with respect to 6 metrics for which you didn't have data for a 7 particular hospital? 8 MS. BLAIR: Objection to form. 9 BY MR. CHUNG: 10 Q. Not reliability overall, but for these 11 hospitals on metrics for which you had missing 12 data. 13 A. At the time period that we were using 14 that older imputation method, it was the maximum 15 reliability that we could determine. However -- 16 Q. Okay. Now -- 17 A. -- times -- 18 Q. -- I'm going to go on to -- 19 A. No, I would like to finish my -- 20 Q. I'm going to go on to -- 21 A. You said we were going to -- I was able 22 to answer, and we were interrupting each other on Page 119	1 that comment bubble. 2 A. Oh, okay. 3 Q. I prefer Alex's comment below. 4 Do you see that? 5 A. Uh-huh. 6 Q. All right. And is Alex referring to Alex 7 Campione -- 8 A. Yes. 9 Q. -- Alexandra Campione? 10 A. Yes. 11 Q. Okay. And is she a member of the ratings 12 team? 13 A. Yes. 14 Q. Okay. And that is referring to 15 Ms. Campione's comment I think immediately below 16 yours; is that right? 17 A. I'm not sure. Probably. 18 Q. Okay. She writes in that comment bubble, 19 We could include language from spring 2022 public 20 comments: When hospitals decline to provide key 21 data, Leapfrog imputes scores using a methodology 22 designed to estimate their performance as Page 121

1 accurately as possible. 2 Do you see that? 3 A. I think so. 4 Q. Okay. She also wrote, Several different 5 options for imputation were tested for both 6 validity and reliability. Using the mean 7 performance rather than the bottom quartile or 8 decile produced the strongest agreement between 9 predicted and actual scores, meaning the use of 10 the mean most accurately resembled the actual 11 performance we could expect if hospitals were to 12 report to the Leapfrog hospital survey. 13 Do you see that in -- 14 A. I don't. Where is that? 15 MS. BLAIR: It's in this bubble, the 16 second bubble. 17 THE WITNESS: The second bubble? 18 BY MR. CHUNG: 19 Q. Yes. 20 A. Okay. I just -- 21 Q. If you could just read it. 22 A. I need to read it. Page 122	1 performance on -- 2 A. Yes. 3 Q. -- such a metric? All right. 4 But do they also -- do the metrics, where 5 you used the imputation method, do they also -- 6 do they also reflect a lack of data with respect 7 to that metric? 8 MS. BLAIR: Objection to form. 9 THE WITNESS: I'm not sure I understand. 10 BY MR. CHUNG: 11 Q. Well, if you're estimating -- if the 12 imputation method here is to get an estimate of a 13 hospital's performance on a particular metric 14 where you didn't have the data, isn't it true 15 also that imputation assumes a lack of data for 16 that metric? 17 MS. BLAIR: Objection to form. 18 BY MR. CHUNG: 19 Q. Otherwise, you wouldn't need imputation, 20 correct? 21 MS. BLAIR: Same objection. 22 THE WITNESS: Not always. Not always. Page 124
1 Q. If you could just read that comment 2 bubble that I just read from. 3 So Ms. Binder, my question is, was 4 Leapfrog's goal to estimate non-participating 5 hospitals' performance as accurately as possible? 6 Is that right? 7 A. Our goal is to estimate in -- as 8 accurately as possible in a way that will be most 9 useful for consumers. 10 Q. Right. So do the imputed scores -- and 11 we're just looking at the imputation method that 12 was used at this time, Ms. Binder. 13 The imputed scores, do they reflect a 14 hospital's actual performance on the metrics for 15 which you're missing data? 16 A. It's an imputed score. So... 17 Q. Not an actual performance, correct? 18 A. Well, what's actual? Like, is -- 19 sometimes data is not even actual, so... 20 It is an imputation. 21 Q. Okay. And that imputation, was it 22 designed to get an estimate of the hospital's Page 123	1 For instance, as I think Patrick Romano talked 2 about in your earlier exhibit, you can use data 3 from last year's survey. And we have, you know, 4 25 years of experience with hospitals and 5 hospital surveys and ratings and some very good 6 information about how we could anticipate 7 hospital performance based on certain factors, 8 which are, I think, really nicely discussed and 9 debated by the expert panel in that last exhibit. 10 So, yeah, imputation is not just a wild 11 guess. Imputation is a very well-thought-through 12 estimate that's based on real evidence. 13 BY MR. CHUNG: 14 Q. All right. Leapfrog -- is it correct 15 that Leapfrog changed its scoring methodology 16 again in 2024? 17 A. Yes. 18 Q. All right. And that change was where it 19 started using the limited achievement score for 20 imputed metrics for hospitals that did not 21 participate in the survey; is that right? 22 A. Yes. Page 125

1 Q. All right. 2 A. For certain measures, yes. 3 Q. Yes, for certain measures. Exactly. 4 What was your role with respect to that 5 particular change in the imputation methodology? 6 We're looking at fall 2024. 7 A. I reviewed -- I reviewed information 8 about how the expert panel had discussed and 9 debated the issues around imputation. 10 I talked extensively with Matt Austin and 11 Missy Danforth and -- repeatedly. So this was a 12 series of discussions. 13 And I looked at some of the background 14 information that they had put together around 15 this and then made the decision that we would go 16 forward. 17 Q. What materials? You just testified that 18 there were materials -- 19 A. Well, like this public comments. Things 20 like that. 21 Q. Okay. I think you mentioned materials 22 where the expert panelists were discussing the Page 126	1 meeting? 2 A. No. 3 Q. Okay. Why not? 4 A. As I said earlier, I don't attend most 5 expert panel meetings because I want the expert 6 panel to feel free to be as independent as 7 possible. I don't want them to get the 8 impression that there's some kind of executive 9 oversight on their deliberations. There isn't. 10 They're expected to be totally independent 11 volunteers. 12 Q. Okay. But Ms. Danforth and I think 13 Ms. Campione were there, right? 14 A. Yes. 15 Q. Okay. What did you understand occurred 16 at that April 12, 2024, meeting as it relates to 17 the imputation methodology? 18 A. There was some discussion about what 19 would be the best method. There were some that 20 felt that hospitals should get zero points for 21 the -- for the four measures that they were -- 22 that was under discussion about imputation. Page 128
1 methodology change. 2 Can you describe? What were those 3 materials exactly? 4 A. Well, they had a meeting, and I reviewed 5 the transcription of that meeting. And in 6 addition, there were some one-on-one 7 conversations that were recounted to me. 8 Q. Okay. 9 A. I needed to be reassured that every 10 member of the expert panel was solidly behind 11 this and really wanted this to go forward. 12 Q. Okay. And the meeting that you're 13 referring to, is that an April 12, 2024, meeting? 14 A. I don't recall the exact date but 15 something like that. 16 Q. Okay. Did you review any slides or other 17 materials that came out of that meeting? 18 A. Yes. 19 Q. Okay. Do you remember reviewing the 20 meeting agenda? 21 A. No. 22 Q. Okay. Did you actually attend that Page 127	1 There was a lot of discussion about the 2 fact that, for those four measures, we've seen 3 what we call topping out. We've seen those 4 scores in hospitals that report to the survey 5 have gone way up. And so when we impute the 6 mean, we are giving hospitals a very, very high 7 score on these four very difficult standards in 8 the Leapfrog survey. 9 So it's like saying someone has gotten, 10 you know, a gold medal in the Olympics when they 11 are just playing JV soccer. 12 Q. And is this based on your review of, I 13 think you mentioned, a transcript of that 14 meeting; is that right? 15 A. I looked at the transcript. Yes. 16 Q. Okay. Was the -- based on your review of 17 the transcript of that meeting, was there any 18 discussion of the limited achievement proposal 19 that eventually became the methodology for 20 imputation? 21 A. There was a discussion about scoring 22 hospitals that don't complete the survey at Page 129

1 the -- either at the lowest quartile or the 2 lowest score of any hospital in the survey. Or 3 there was one very credible member of the expert 4 panel, just a superstar -- 5 Q. Who was that? 6 A. Arjun Srinivasan. He's a superstar at 7 the CDC. He wanted zero points, which we didn't 8 go forward with that. But he was strongly 9 advocating for that. 10 Q. Okay. 11 A. We ended up giving, depending on the 12 measure, about 15 -- 5 to 15 points. 13 Q. Okay. 14 MR. CHUNG: Let's go to 73 and 73a. 15 So these are Exhibits 8 and 9. 16 (Binder Deposition Exhibits 8 and 9 17 marked for identification and attached to 18 the transcript.) 19 BY MR. CHUNG: 20 Q. So you'll see here, Ms. Binder, this is 21 an e-mail chain from May 15, 2024, where Preeti 22 Joshi is sending -- circulating expert panel Page 130	1 expert panel with a quick overview of the current 2 imputation model/approaches Leapfrog has been 3 using and some of the challenges those approaches 4 have created for issuing accurate grades. 5 And then the notes continue, The current 6 imputation model has two steps when data are 7 missing -- and you'll see here it just describes 8 the imputation method at the time -- right? -- 9 the two-step method -- 10 A. Yes. 11 Q. -- and then the -- step 2 has been to 12 assign such a hospital the mean score of their 13 assigned cohort. 14 Do you see that? 15 A. Yes. 16 Q. Okay. And then the proposed change from 17 Leapfrog, the very next bullet point, is -- was 18 to retire step 1 of the model, which was to use a 19 hospital's historical data up to four rounds old, 20 and use only step 2, which was assigning 21 hospitals the mean score for their cohort. 22 Do you see that? Page 132
1 meeting notes. 2 Do you see that? 3 A. Yes. 4 Q. And who is Preeti Joshi? 5 A. She's a research analyst at Johns Hopkins 6 Medicine. 7 Q. Okay. Is she on the expert panel? 8 A. No. 9 Q. Okay. And then let's take a look at 10 Exhibit 9, which is what she circulated. 11 And then if you look at page 1, there's a 12 section under number 2, Proposed changes to the 13 imputation model. 14 Do you see that? 15 A. Yes. Again, I'm going to need to read 16 this now -- 17 Q. Okay. 18 A. -- because I wasn't on this chain. 19 Q. All right. 20 A. Okay. 21 Q. Okay. So the notes -- under that 22 section, you'll see that Matt Austin provided the Page 131	1 A. Yes. 2 Q. All right. Do you have an understanding 3 as to how Leapfrog reached the decision in this 4 proposal to remove step 1 from the imputation 5 process? 6 A. It's proposed changes. It's not a 7 decision. 8 Q. Okay. So -- 9 A. And it didn't go forward that way. 10 Q. And this is from -- and these are notes 11 from the April 12, 2024, meeting that we've been 12 discussing, correct? 13 A. Right. And that was the discussion at 14 the April 12th meeting. Yes. 15 Q. Okay. So Leapfrog discussed with the 16 expert panel during the April 12, 2024, meeting 17 the possibility of removing a hospital's 18 historical data from that imputation process, 19 correct? 20 A. They did discuss that, and I think the 21 group was in favor of it. However, Patrick 22 Romano was not at the meeting, so they did follow Page 133

1 up with him, and he had, I think, a very 2 important and insightful perspective on that, 3 which we then shared, and that ended up being 4 what informed the final decision. 5 So this is not a decision; this was a 6 proposed -- 7 Q. Right. 8 A. -- change. That's how the expert panel 9 process works. 10 Q. But there's no discussion in the -- in 11 the meeting notes here, there's no discussion of 12 assigning a limited achievement score, right? 13 A. Limited -- 14 Q. On this -- in this document, the notes of 15 the April 12, 2024, meeting. Is that right? 16 A. They discussed assigning very low scores 17 or zero in the expert panel meeting. 18 Q. Where is that reflected here? 19 A. It's not here, but I read the transcripts 20 and they did discuss that. 21 Q. Okay. So a transcript would reveal that 22 they discussed -- Page 134	1 score for missing data only and not to use a 2 hospital's historical data; is that right? 3 MS. BLAIR: Object to form. 4 BY MR. CHUNG: 5 Q. This is based on what we just read, that 6 Leapfrog's proposal was to retire step 1 of the 7 model and use only step 2. 8 Do you see that? 9 Again, I'm just focusing on April 12, 10 2024, what came out of that meeting, Ms. Binder. 11 A. Okay. Yeah. That's the -- yeah, that's 12 the prior imputation model he's describing in 13 this. Current as of April 2024. 14 Q. Right. And then Leapfrog's proposal 15 during this April 12, 2024, meeting, Leapfrog's 16 proposal in this discussion with the expert 17 panel, was from the model at that time, let's 18 retire step 1 of that model -- 19 A. Right. 20 Q. -- and just use step 2, i.e., let's just 21 assign non-reporting hospitals the mean score for 22 their cohort; is that right? Page 136
1 A. I -- 2 Q. -- assigning a zero score -- 3 A. Yeah. 4 Q. -- or a limited achievement score; is 5 that right? 6 A. Yeah. And this is a summary. So the 7 summary of the meeting, he's showing what they -- 8 sort of the consensus the group reached at the 9 end, proposed changes, and that's why -- 10 Q. But limited achievement scores are not 11 mentioned anywhere in these notes, correct? 12 A. Well, limited achievement is 15 on CPOE 13 and 5 points on IPS. It already has a score 14 assigned. 15 Q. Okay. 16 A. If you complete the survey and you get 17 limited achievement on IPS, you get 5 points on 18 the safety grade. That's -- it's not -- it's 19 assumed. 20 Q. So after this expert panel meeting -- 21 again, we're just focusing on this April 12, 22 2024, meeting -- the plan was to impute the mean Page 135	1 A. Right. And then Arjun -- that was 2 apparently what was presented to them, but then 3 they disagreed with that, and Arjun and Peter 4 Pronovost said, no, let's -- let's give them 5 lower scores than that. 6 Q. Where does it say that any of the expert 7 panelists disagreed with that proposal? 8 A. Peter asked whether Leapfrog has a way to 9 keep low-performing hospitals in the lowest 10 quartile. That's not the mean. 11 And then Arjun mentioned one of his 12 concerns with the current step 2 imputation 13 method is if a hospital is performing very 14 poorly, they would choose to not a submit a 15 survey and they'd get a better score than their 16 actual performance. 17 So that's disagreement. I mean, that's 18 how the expert panel debates and deliberates. 19 Q. You take that to mean disagreement with 20 the proposal. 21 A. No, I just take it to me deliberation 22 that the expert panel does. They were pushing Page 137

1 back on the original proposal from, apparently, 2 Matt, just -- what Matt would be presenting as 3 something from our team in general. And they 4 were saying, I think they should probably impute 5 a lower score, be more -- it would be more 6 accurate. 7 Q. Okay. Now -- so after this, the March -- 8 or the April 2024 meeting, it's fair to say that 9 Leapfrog ultimately did not approach -- adopt the 10 approach of the proposal laid out in the bullet 11 point that we just -- 12 A. Correct. 13 Q. -- read, right? 14 It settled on a different approach, 15 correct? 16 A. With the full consensus of the expert 17 panel, it settled -- it came up with a new 18 approach. 19 Q. All right. And it ultimately adopted a 20 different approach, correct? 21 A. Yes. 22 Q. All right. And instead of assigning Page 138	1 grade. 2 So it's a well-established scoring 3 methodology that is related to their performance 4 on the Leapfrog hospital survey. 5 BY MR. CHUNG: 6 Q. What do you mean by well-established? 7 A. It's been in place since the beginning of 8 the hospital safety grade. 9 Q. Okay. 10 MR. CHUNG: Let's go to 75 and 75a. 11 THE WITNESS: Oh, it says here, 12 actually -- no, they did discuss that. The 13 expert panel got a -- So like the idea of 14 imputing the equivalent of willing-to-report to 15 hospitals that do not submit a survey. 16 So actually, they do discuss that. 17 BY MR. CHUNG: 18 Q. What are you referring to? 19 A. On 8532 -- 20 Q. Which exhibit -- 21 A. -- Exhibit 9. 22 Q. -- are you referring to? Page 140
1 hospitals a mean score pursuant to step 2, as 2 it's described here, the new plan was to assign 3 non-participating hospitals the limited 4 achievement score; is that right? On the 5 selected metrics; is that right? 6 A. On the selected metrics, on the advice of 7 several expert panelists who proposed it -- 8 Q. Okay. We'll get to that. 9 A. Uh-huh. 10 Q. And the limited achievement score was the 11 lowest score possible, is that right, on those 12 metrics? 13 MS. BLAIR: Objection to form. 14 THE WITNESS: Limited achievement is on 15 the survey. And the hospital safety grade 16 interprets a limited achievement for each of the 17 four measures with a certain number of points 18 already, and that was retained. So example being 19 IPS is 5 points. A hospital that completes the 20 Leapfrog hospital survey and it gets limited 21 achievement on IPS would get automatically 5 22 points for IPS on the -- in their hospital safety Page 139	1 A. Exhibit 9, under the section 2, proposed 2 changes to the imputation model, the last dash, 3 The expert panel were in support of having 4 hospitals share their current performance, so 5 like the idea of imputing the equivalent of 6 willing-to-report to hospitals that do not submit 7 a survey. 8 So that -- so, yeah, they were aware that 9 willing-to-report equals the lowest score. 10 Q. Okay. Willing-to-report. What does that 11 mean? 12 A. Actually, that's how we used to refer to 13 one out of four bars. 14 So the hospital survey, which is, as you 15 know, different from the hospital safety grade, 16 for each measure, we score hospitals on the 17 extent to which they achieve the standard. And 18 they get one -- it's like cell phone bars -- one, 19 two, three, or four bars. Four bars mean you've 20 met the standard. Leapfrog's standards are very 21 high, so it's an excellent performance. One bar 22 means -- we used to call it willing-to-report. Page 141

1 So it's referred to here as willing-to-report. 2 Q. Okay. 3 A. Just means they're willing to be public 4 and transparent, which we give them one bar for. 5 But they didn't meet the standard otherwise. 6 Q. But these are -- but this 7 willing-to-report designation is for hospitals 8 that actually did respond to the survey, correct? 9 A. Yes. 10 Q. Okay. So this is different from the 11 scenario that we've been discussing of hospitals 12 that don't respond to the survey, correct? 13 MS. BLAIR: Objection to form. 14 THE WITNESS: I don't think so. Can you 15 restate the question? I'm not -- I don't think 16 that's right. 17 BY MR. CHUNG: 18 Q. What -- so in terms of -- how do you take 19 this to mean that the limited achievement 20 imputation methodology that was eventually -- 21 that was adopted, right? -- 22 A. Uh-huh. Page 142	1 Ms. Binder, is an e-mail chain involving Patrick 2 Romano, Matt Austin, Missy Danforth, and 3 Alexandra Campione. It's from May 14, 2024. 4 A. Yes. 5 Q. And you'll see here Matt Austin e-mails 6 Mr. -- or Patrick Romano attaching what he 7 describes as language to share with hospitals 8 about the proposed changes; is that right? 9 A. Yes. 10 Q. Okay. And then at the bottom of page 1, 11 Dr. Austin follows up and writes, Peter offered 12 some suggested edits to clarify the concept of 13 imputation. 14 And -- 15 A. I'm sorry, where is that? Am I 16 missing -- is that -- 17 MS. BLAIR: It's at the bottom -- 18 MR. CHUNG: Toward the bottom. 19 MS. BLAIR: -- very bottom. Other side. 20 THE WITNESS: Oh, okay. 21 MS. BLAIR: No, other side. He's 22 referring you to the bottom of 8275. Page 144
1 Q. -- was discussed during this April 12, 2 2024, meeting? 3 A. Right. So they -- they basically said 4 that they want to -- they liked the idea of 5 imputing the equivalent of willing-to-report, 6 which is one out of four bars, for each of those 7 four measures. And the equivalent of 8 willing-to-report is a scored amount on the 9 hospital safety grade. 10 Q. Okay. And you take that to mean what was 11 eventually adopted? 12 A. Well, that's part of what was adopted. 13 Yes. 14 Q. Okay. 15 A. Part of it. It's not the whole thing. 16 MR. CHUNG: Let's go on to our next 17 exhibits. These will be 10 and 11. 18 (Binder Deposition Exhibits 10 and 11 19 marked for identification and attached to 20 the transcript.) 21 BY MR. CHUNG: 22 Q. All right. So exhibits 10 and 11, Page 143	1 MR. CHUNG: Yes. Thank you. 2 THE WITNESS: Oh, I see. Yes. 3 BY MR. CHUNG: 4 Q. And is the Peter here likely referring to 5 Peter Pronovost? Is that right? 6 A. Yes. 7 Q. And he's a member of the expert panel, 8 correct? 9 A. Yes. 10 Q. Okay. And then Dr. Romano responds on 11 May 14 up above. 12 Do you see that? 13 A. Yes. 14 Q. All right. And he writes, I like the 15 simpler and more direct approach here. If the 16 goal is to penalize non-participants, you might 17 as well do so in a clear and unmistakable manner 18 while allowing for hospitals to manage their 19 burden and jump back on the wagon after a year. 20 Do you see that? 21 A. Yes. 22 Q. Okay. Is it correct that the new Page 145

1 imputation model will penalize non-participants? 2 MS. BLAIR: Objection to form. 3 THE WITNESS: That's not the intention. 4 We don't penalize -- we don't penalize hospitals. 5 That's not our goal. Our goal is to inform 6 consumers. So we don't do penalizing. We 7 don't -- that's not what we're about. 8 BY MR. CHUNG: 9 Q. So do you disagree with Dr. Romano's view 10 here? 11 A. I agreed with his -- I agreed in the end 12 with his recommendation in here. I don't agree 13 with the idea of penalize- -- that we are trying 14 to penalize hospitals. We aren't. 15 Q. But do you agree that the limited 16 achievement imputation model -- right? -- is -- 17 it's punitive to non-participating hospitals? 18 Do you agree with that? 19 MS. BLAIR: Objection to form. 20 THE WITNESS: It's meant to be helpful to 21 consumers so that we are not overestimating the 22 performance of a hospital when we don't have -- Page 146	1 which was accepting the results from one year's 2 worth of survey results. And I think he makes a 3 good case for that, and that's what we ended up 4 doing. 5 So -- and we then brought that back to 6 the others on the expert panel who were the ones 7 recommending the original proposal that was sent 8 out to Patrick, as you can see from this chain, 9 actually, that they were supportive of. 10 And I think I think this is just another 11 great example of a very strong expert panel. 12 Q. So he writes, The underlying hypothesis 13 behind your proposed step 2 approach was that 14 hospitals stop reporting because their true 15 performance deteriorated relative to their 16 cohort. 17 Do you see that? 18 A. Yes. 19 Q. All right. And then he writes, My 20 hypothesis, by comparison, was that most 21 hospitals stop reporting because it is too 22 burdensome and because they only find market Page 148
1 when they've declined to report their data. 2 BY MR. CHUNG: 3 Q. I'm asking with respect to hospitals, not 4 consumers. Okay? 5 With respect to the non-participating 6 hospitals -- right? -- hospitals that have not 7 filled out the survey, responded to the hospital 8 survey, by automatically assigning those 9 hospitals on four of the most critical metrics a 10 limited achievement score, is that not punitive 11 to those non-participating hospitals for not 12 participating? 13 MS. BLAIR: Objection to form. 14 THE WITNESS: It's not meant to be 15 punitive. It's meant to be informative to 16 consumers. That's what we're about. 17 BY MR. CHUNG: 18 Q. Okay. 19 A. Now, he has a different approach, which 20 he's laid out here, but I also thought his 21 recommendation was excellent -- it was a really 22 good compromise and a really good way to do it -- Page 147	1 value in an A grade, which proves impossible to 2 attain or maintain. 3 Do you see that? 4 A. Yes. 5 Q. Okay. And so he's articulating his view 6 that hospitals that don't -- do not participate 7 in this survey do so because they find it, in his 8 words, too burdensome, right? 9 MS. BLAIR: Objection to form. 10 THE WITNESS: If -- 11 BY MR. CHUNG: 12 Q. I'm just asking you whether that's his 13 view, as it's articulated in this e-mail? 14 A. In this e-mail -- 15 Q. Can you please answer the question? I'm 16 asking you -- 17 MS. BLAIR: She's trying to answer the 18 question, Daniel. 19 MR. CHUNG: I don't think she is. 20 BY MR. CHUNG: 21 Q. The question is -- 22 MS. BLAIR: She hasn't even started her Page 149

1 answer. I don't know how you know -- 2 BY MR. CHUNG: 3 Q. The question is, is that his view as 4 articulated in this e-mail? 5 MS. BLAIR: Objection to form. 6 THE WITNESS: Say that -- what view, 7 again? 8 BY MR. CHUNG: 9 Q. That hospitals that do not participate in 10 the survey, they don't do it because they find it 11 too burdensome. 12 MS. BLAIR: Same objection. 13 THE WITNESS: In this e-mail, that 14 appears to be his view. 15 BY MR. CHUNG: 16 Q. All right. And -- 17 A. But in the earlier exhibits -- 18 Q. -- do you agree -- 19 A. -- just so -- 20 Q. -- with that hypothesis? 21 A. In the earlier exhibits -- 22 Q. Do you agree with that hypothesis? Page 150	1 BY MR. CHUNG: 2 Q. This is your deposition, Ms. Binder. 3 What do you understand him to be saying 4 here? What do you understand him to be saying? 5 A. That -- 6 MS. BLAIR: Objection to form. 7 THE WITNESS: He seems to have a 8 perception of the intention of his colleagues on 9 the expert panel, as well as Leapfrog people, 10 Matt and Missy in particular. He seems to have a 11 perception of their intention, which is not, in 12 fact, their intention. 13 BY MR. CHUNG: 14 Q. Would you call his e-mail supportive of 15 the proposed methodology? 16 A. Yes. He comes up with a very good 17 recommendation. 18 Q. Okay. So even though he views the 19 methodology as penalizing non-participating 20 hospitals, you believe that he's supportive of 21 the proposed methodology? 22 MS. BLAIR: Objection to form. Page 152
1 A. In the earlier exhibits -- 2 Q. Do you agree with that hypothesis? 3 A. No, absolutely not. I -- 4 Q. All right. 5 A. -- disagree with that -- 6 Q. Now, at the end -- 7 A. -- hypothesis. 8 THE REPORTER: I'm sorry. I can't take 9 both of you talking at the same time. 10 BY MR. CHUNG: 11 Q. Now, at the end of the e-mail, Dr. Romano 12 writes, If you want to penalize non-participants, 13 then don't pretend that you are imputing missing 14 values in a statistically optimal way. Just be 15 honest about your goal. 16 He's saying here that Leapfrog's approach 17 is pretending that the missing values are being 18 imputed in a statistically optimal way; is that 19 right? 20 MS. BLAIR: Objection to form. 21 THE WITNESS: No, I don't believe that's 22 what he's saying. But you should ask him. Page 151	1 THE WITNESS: You're asking about the 2 proposed methodology or the methodology that we 3 ended up with? Because we ended up with a 4 methodology at the end of this process -- 5 BY MR. CHUNG: 6 Q. Right. 7 A. -- that is laid out quite elegantly in 8 these e-mails -- we ended up with a methodology 9 that I know he supports. 10 Q. Okay. And how do you know that he 11 supports that? 12 A. Because I know him personally, and Missy 13 has talked to him at length. He supports it. 14 I will not approve something if I have 15 any evidence that any expert panel member does 16 not approve it. 17 Q. Okay. And where was that memorialized? 18 Where was his support memorialized? 19 A. By conversations with Missy and 20 reassurances from Missy and also by sharing the 21 proposal that went out publicly for comment with 22 him and the others and, in the end, we did Page 153

1 actually do what he recommended. 2 Q. So these are verbal conversations that 3 you're referring to. 4 I asked, how was this memorialized in 5 writing? 6 A. I don't know. 7 Q. Okay. 8 A. I'm not -- it doesn't need to be. It 9 needs to be -- I need to be reassured. I'm 10 reassured from a variety of ways. 11 If any one of these expert panelists -- 12 they are not shy. If they disagreed with the 13 proposal that we put out for public comment, they 14 would tell me instantly. They would be calling 15 me. And I would be very unhappy to hear that I 16 was misled. 17 I am not misled. I have an absolutely 18 incredible survey team and staff, and they are 19 accurate to me about what the perception of these 20 expert panelists are. 21 And the -- the conversation that you have 22 in e-mail here is really -- it's good to see. Page 154	1 MR. CHUNG: Let's go to tab 14. This 2 will be Exhibit 12. 3 (Binder Deposition Exhibit 12 marked for 4 identification and attached to the 5 transcript.) 6 BY MR. CHUNG: 7 Q. So Ms. Binder, Exhibit 12 is an e-mail 8 discussing feedback on the hospital safety grade 9 changes. 10 And you see that on the second page Bates 11 ending 9812, Ms. Campione writes, We have 12 finalized the changes to the imputation 13 methodology. Both Peter and Patrick have 14 reviewed and signed off on the messaging. 15 And then she asked for your feedback; is 16 that right? 17 A. Yes. 18 Q. Okay. And this is on May 17, 2024; is 19 that right? 20 A. Yes. 21 Q. Okay. And then later that day you 22 respond that you provided some tweaks in an Page 156
1 Q. Okay. 2 A. -- because it's clearly well thought 3 through, and there's debate, there's no rubber 4 stamping here. There's a lot of thought. And we 5 ended up going with, I think, the right 6 methodology in the end. 7 Q. So just to be clear, after these 8 discussions, Leapfrog proposed an imputation 9 model where hospitals that were missing 10 historical data from the prior two rounds would 11 be given the limited achievement score for hand 12 hygiene, BCMA, CPOE, and the ICU physician 13 staffing; is that right? 14 MS. BLAIR: Objection to form. 15 THE WITNESS: I believe that's -- yeah. 16 I believe that's right. 17 BY MR. CHUNG: 18 Q. And this methodology replaced the mean 19 scores approach that had been used previously; is 20 that right? 21 A. It was -- yes. That's -- yes. 22 Q. Okay. Page 155	1 attachment; is that right? 2 A. Yes. 3 Q. Okay. So let's go to -- so the 4 attachment is actually right after the e-mail 5 chain here. It's the request for public 6 comments, planned updates, the Leapfrog hospital 7 safety grade methodology for fall 2024. 8 If you turn to Bates ending -- and this 9 is -- is this a document here, the attachment, 10 that's intended to be put on Leapfrog's website? 11 Is that right? 12 A. Yes. We have a public comment process. 13 We put it out for public comment and then we 14 adver- -- not -- we publicize the fact that it's 15 available and we -- to encourage people to look 16 at it and offer public comments. 17 Q. Okay. If you look at Bates ending 18 9184 -- this is under the background section -- 19 you'll see here that there is a sentence here 20 that's struck that reads, The collective 21 recommendation was for Leapfrog to modify its 22 current imputation approach to encourage survey Page 157

1 participation and to improve users' confidence in 2 the data that are used to calculate the score. 3 Do you see that? 4 A. Yes. 5 Q. Okay. And so the explanation that the 6 methodology change was to encourage participation 7 was struck, correct? 8 A. Yes. 9 Q. All right. And then looking back to your 10 e-mail -- so Bates ending in 9811, the very first 11 page of this document. 12 A. Yeah. 13 Q. You wrote that -- I don't think we need 14 the sentence about influencing survey 15 participation and giving people confidence and 16 validity. It sounds defensive. 17 Why did you think explaining how the 18 imputation methodology would influence 19 participation was defensive? 20 A. The purpose of the change -- proposed -- 21 at this time proposed -- to the safety grade was 22 to be as accurate as possible. And that is what Page 158	1 focusing on the e-mail here -- It's enough that 2 the expert panel advised us to do the imputation 3 in a different way and not treat older better 4 data in an equivalent way to new data. 5 A. That they did discuss at length. 6 Q. Okay. And as I think we discussed 7 earlier, in terms of the -- in terms of the 8 limited achievement proposal that eventually was 9 put into place, did you get -- did every single 10 member of the expert panel approve that 11 methodology? 12 A. Yes. 13 Q. Okay. And how did you go about getting 14 the approval of every single member? 15 MS. BLAIR: Objection to form. 16 THE WITNESS: From -- my normal way of 17 finding out for sure that the expert panel is 18 fully behind methodology, which is I ask my 19 senior vice-president for healthcare ratings and 20 our -- 21 BY MR. CHUNG: 22 Q. And that's Ms. Danforth? Page 160
1 the expert panel talked about. In all of the 2 documents that you've just provided in your 3 exhibits, they're not talking about -- the expert 4 panel is not saying, well, we're going to get 5 more participation in the survey. 6 So that was not the purpose of this 7 change. The purpose of this change was to 8 improve the accuracy. 9 Q. Okay. 10 A. So I felt that it sounds -- doesn't make 11 sense. I didn't think it made sense. 12 Q. Are you saying that it's inaccurate to 13 say that the change in the imputation model would 14 influence participation? 15 A. I don't know if it would influence 16 participation. Probably. Maybe. Depends. 17 Because if someone doesn't do well on the survey, 18 they can hurt their grade. So not necessarily. 19 It wouldn't -- certainly wouldn't be the purpose 20 for this methodology change. And nor do I see 21 that in the discussions by the expert panel. 22 Q. Okay. And then you write -- again, Page 159	1 A. Ms. Danforth. And Matt Austin. And I 2 meet with them extensively and we go over how -- 3 the perspective of each member of the panel and 4 that they've looked at it. 5 You can see from the e-mails they have 6 plenty of evidence that the expert panel was 7 behind it. 8 And in addition, I make sure that this is 9 shared with the expert panelists prior to going 10 out for public comment. And so certainly if 11 there was disagreement by any member, I would -- 12 we would have heard about it, you know, 13 instantly, because we put it out -- we gave it to 14 them prior to the public comment period. 15 Q. Okay. And so the imputation 16 methodology -- and again -- I'm going to ask 17 again, is the approval of every member of the 18 expert panel of the -- of this methodology 19 memorialized anywhere? 20 A. No. This isn't Congress. This is a 21 classic scientific expert panel. The process 22 that you see in these e-mails is exactly the way Page 161

1 the scientific process works. 2 Q. So the answer is no. 3 MS. BLAIR: Objection to form. 4 THE WITNESS: Memorialized? Other than 5 the usual method by which I know the expert 6 panelists are behind it, I -- I don't know -- 7 well, there's no vote. 8 BY MR. CHUNG: 9 Q. Okay. Now, towards the end of your 10 e-mail to Ms. Campione here you write that the 11 public comments on the methodology will give us a 12 good gauge on the extent to which we need to 13 reveal all our reasoning and whether the expert 14 panelists will truly stand up for it when push 15 comes to shove. 16 Is it fair to say at this point you were 17 not sure if the expert panel would stand up for 18 the new methodology? 19 A. Yeah. As I said earlier, for me, it's 20 very important that not only do we have the okay, 21 so to speak, from each member of the expert panel 22 that they do support it -- which I was assured of Page 162	1 change -- when was the board notified of this 2 methodology change? 3 A. I believe I previewed it with them. I'm 4 trying -- I'll have to look through -- look 5 through all the board packets. But I believe I 6 previewed it with them -- 7 Q. When was that? 8 A. -- in the spring. I believe in March. 9 And then also in June I told them about it. 10 Q. Okay. So in June -- 11 MR. CHUNG: Why don't we go to the next 12 document. 91. 13 (Binder Deposition Exhibit 13 marked for 14 identification and attached to the 15 transcript.) 16 BY MR. CHUNG: 17 Q. Okay. This is -- Exhibit 13 is the CEO 18 report -- 19 A. Yes. 20 Q. -- to the board from June 2024. 21 Is this a document that's distributed to 22 the board -- Page 164
1 and I believed strongly, and still do -- but what 2 happens when you have a methodology change like 3 this is you sometimes get very strong opposition, 4 and they will go -- the opponents, which we would 5 hear from in the public comment period, or the 6 supporters sometimes -- would go directly to 7 individual members of the expert panel. So if 8 for some reason they were to change their mind or 9 not be able to say, no, this is -- I own this, 10 this is our methodology, then I would want to 11 know that right away. I wouldn't go forward with 12 something unless I had the strongest possible 13 support, even in the face of opposition. 14 And so that is another value of the 15 public comment period and why we are so -- why 16 Leapfrog is so interested in public comment and 17 why we reach out so frequently to the larger 18 communities that we serve, to make sure we're 19 getting the right kind of feedback and insights. 20 And we often make changes as a result of those 21 insights. 22 Q. Okay. When was this methodology Page 163	1 A. Yes. 2 Q. -- in connection with board meetings? 3 A. Yes. 4 Q. Prior to the meeting or when exactly? 5 A. Like a week prior to the meeting. 6 Q. Okay. Now, we look at the first page, 7 Bates ending in 072 under hospital safety grade 8 successful spring update. 9 You write that Leapfrog published its 10 planned updates to the safety grade methodology 11 and that the update dramatically lowers imputed 12 scores for certain measures for hospitals that 13 decline to report to the survey. 14 Do you see that? 15 A. Yes. 16 Q. Okay. And it says here, This should have 17 some impact on hospital reporting to the survey, 18 correct? 19 A. Yes. 20 Q. All right. So you -- and is this the 21 first time that you're apprising the board of the 22 change in methodology? Page 165

1 A. No. 2 Q. When did you -- 3 A. I said in March. 4 Q. Okay. 5 A. And -- 6 Q. And where -- where -- would it have been 7 in the CEO report for March? 8 A. Probably. But I certainly would have 9 verbally told them that we were working on it and 10 the expert panel was meeting. 11 Q. So it should -- so it should be reflected 12 in the board minutes; is that right? 13 A. I think so. Yeah. It should be. 14 Q. Okay. 15 MR. CHUNG: Why don't we go to -- this 16 will be Exhibit 14. 17 (Binder Deposition Exhibit 14 marked for 18 identification and attached to the 19 transcript.) 20 BY MR. CHUNG: 21 Q. So Exhibit 14 are the board minutes, 22 Ms. Binder, from the March 2024 meeting. Page 166	1 A. But I did discuss it with them. 2 Q. All right. Why would that not be 3 reflected in the minutes, Ms. Binder? Isn't that 4 something of -- that's pretty important? 5 MS. BLAIR: Objection to form. 6 THE WITNESS: I don't know why it's not 7 in the minutes. 8 BY MR. CHUNG: 9 Q. Okay. And during -- let's go back to the 10 June 2024 meeting. 11 Did you explain the two steps in the new 12 method -- imputation methodology with the board? 13 A. I believe -- I don't recall exactly 14 how -- what we did. The board does not typically 15 delve into the details of any methodology, but we 16 highlight where we think there are issues that 17 they should be aware of, which is what I'm sure I 18 did. 19 And then if the board feels like there's 20 board-level issues that they should address, they 21 will ask for an agenda item and they'll ask to 22 have it formally presented and discussed. Page 168
1 Do you see that? 2 A. Yes. 3 Q. Okay. Do you see anywhere here any 4 discussion of the new methodology? 5 A. No, I don't see it. 6 Q. Okay. So fair to say that June 2024 is 7 the first time the board is apprised of the 8 change in methodology? 9 A. No. 10 MS. BLAIR: Objection to form. 11 THE WITNESS: No. I did talk to them 12 about the fact that the expert panel was meeting 13 to discuss an update to the methodology. 14 BY MR. CHUNG: 15 Q. Is that reflected anywhere in the 16 minutes, the fact -- 17 A. It's not -- 18 Q. -- of the meeting? 19 A. -- reflected in the minutes. 20 Q. It's not. 21 A. No. 22 Q. Okay? Page 167	1 They did not do so in -- at least two 2 times that I talked to the board about this. 3 Q. Okay. But you did underscore in the CEO 4 report and at the meeting that the methodology 5 change should have some impact on hospital 6 reporting -- 7 A. Yes. 8 Q. -- to the survey, correct? 9 A. Yes. 10 Q. And that was important to the board, 11 correct? 12 A. Oh, yes. 13 Q. And that's important to Leapfrog, right? 14 A. It's very important to Leapfrog. It's 15 the core of our mission. 16 Q. Right. To have as many hospitals respond 17 to the survey as possible, correct? 18 A. To have full hospital transparency. 19 Q. Right. Impact on hospital reporting is a 20 reference to participation in the hospital 21 survey -- 22 A. Yes. Page 169

1 Q. -- is that right? 2 Okay. And so that was one of the goals 3 behind this change in the imputation methodology, 4 correct? 5 MS. BLAIR: Objection to form. 6 THE WITNESS: No. 7 BY MR. CHUNG: 8 Q. All right. 9 A. No, that was not the goal of the change 10 in the imputation methodology. 11 Q. Not the goal, but you're mentioning that 12 it's going to have some impact, correct? 13 A. Yes. This is the board of Leapfrog. 14 They need to know what the implications are to 15 The Leapfrog Group. 16 Q. Okay. Did the board approve the 17 methodology change? 18 A. The board does not ask -- delegates to me 19 the authority to approve methodology changes 20 or -- of this sort or changes to the survey. But 21 I do bring forward to inform them of when these 22 are -- such changes are on the table, and I tell Page 170	1 Q. Okay. 2 A. That's how it works. 3 MR. CHUNG: So this will be Exhibit 15. 4 (Binder Deposition Exhibit 15 marked for 5 identification and attached to the 6 transcript.) 7 BY MR. CHUNG: 8 Q. So Exhibit 15 is -- it's a slide deck 9 entitled, Technical overview of the hospital 10 safety score from fall of 2012. 11 And you were CEO, what, four years in -- 12 right? -- of the organization by this time? 13 A. Three-and-a-half. Yes. 14 Q. Okay. And you'll see that Ms. Danforth 15 and Matt Austin are the authors of the document. 16 Turn your attention to the Bates ending 17 8512. So it's the fourth page. Just let me know 18 when you get there. It's entitled, Role of the 19 expert panel and Leapfrog's board of directors. 20 Do you see that? 21 A. Uh-huh. 22 Q. And under Leapfrog's board of directors Page 172
1 them what's going on and I explain what the 2 situation is and what I see as implications to 3 the organization. And if they wish, we will 4 certainly do a deep dive within the board level, 5 and they certainly have the authority to approve. 6 This is not a board of measurement 7 experts or clinicians. None of them come from 8 the healthcare industry. As I've talked earlier, 9 we're careful about the fact that the board does 10 not include industry leaders. So they really are 11 depending on the expert panel and the staff of 12 Leapfrog and Johns Hopkins to advise them. 13 Q. Okay. 14 MR. CHUNG: Let's go to tab 83. 15 BY MR. CHUNG: 16 Q. You mentioned a delegation. 17 Where is that delegation memorialized? 18 A. It's in the bylaws. The CEO is -- acts 19 on behalf of the board. 20 Q. With respect to the methodology as well? 21 A. I don't think it specifically says the 22 methodology, but I report to the board and... Page 171	1 it says, Final decisions related to measure set 2 scoring methodology. 3 Do you see that? 4 A. Yes. 5 Q. Final decisions relating to letter grade 6 assignments and oversight of all policies that 7 guide the hospital safety score. 8 A. Uh-huh. 9 Q. So isn't it correct that the board, board 10 of directors, their role includes final decisions 11 related to scoring methodology? 12 MS. BLAIR: Objection to form. 13 THE WITNESS: The board delegates to me 14 the authority to make these final decisions. 15 BY MR. CHUNG: 16 Q. Does it say that on here? 17 A. It doesn't have to. That's how it works. 18 Q. Okay. 19 A. That's how 99 percent of organizations 20 work. 21 Q. So this -- 22 A. The board does not make operational Page 173

1 decisions. And the board is informed of these. 2 And when I believe it's something that has 3 enormous need for board involvement, then they 4 make the decision. But they're informed of the 5 decisions that I'm making, and they're holding me 6 accountable for doing so in a way that makes 7 sense. 8 And this slide is meant to distinguish 9 between the role of the board and the role of the 10 expert panel. The expert panel is not a 11 governing board, is what it's trying to say. 12 Q. So this -- are you saying that this 13 document is inaccurate -- 14 MS. BLAIR: Objection to form. 15 BY MR. CHUNG: 16 Q. -- with respect to the -- 17 A. It's -- 18 Q. -- with respect to the board's role when 19 it -- 20 A. It's perfectly -- 21 Q. -- comes to -- 22 A. -- accurate. Page 174	1 board meeting minutes, there's no mention of your 2 mentioning the imputation methodology, right? 3 A. Yeah, I'd -- I should look at the full 4 agenda of that meeting. There may have been a 5 presentation on the agenda on the methodology. 6 But I definitely have discussed it with the 7 board, actually, repeatedly, board members, board 8 chair, executive committee, et cetera. It's been 9 a subject that we have discussed at length. 10 They're fully aware of it. And frankly, it's not 11 in my interest -- since they have delegated the 12 authority to me, it's not in my interest to not 13 let them know when something like this is 14 occurring and that it's important and that -- and 15 how the expert panel has advised us and what we 16 ultimately are -- and what we're learning from 17 public comment. 18 Q. Did you have separate conversations about 19 the methodology change with individual board 20 members? 21 A. Yes. 22 Q. Okay. Who did you have separate Page 176
1 Q. -- the scoring methodology? 2 A. It's accurate. 3 Q. Okay. Even though they did not make the 4 final decision with respect to the change of 5 imputation methodology in 2024; is that -- 6 A. They delegate to me the responsibility 7 for that. 8 Q. Okay. But that's not reflected on this 9 document, correct, the delegation itself? 10 A. The delegation is not reflected, no. But 11 that is assumed. 12 Q. Okay. Is it your view that the changes 13 in the imputation methodology are really 14 decisions to be made by you and the executive 15 staff of Leapfrog? 16 MS. BLAIR: Objection to form. 17 THE WITNESS: Is it -- 18 BY MR. CHUNG: 19 Q. As opposed to the board. 20 A. It's not opposed to the board. I do it 21 with the full knowledge of the board. 22 Q. Okay. And we saw that, in the March 2024 Page 175	1 conversations with? 2 A. Our board chair in particular that I 3 recall. 4 Q. Okay. And when were those conversations? 5 A. Over the course of at least March, maybe 6 earlier. Probably March -- 7 Q. Okay. 8 A. -- through -- through the later board 9 meetings where it was discussed and approved. 10 Q. And is that with Linda Schwimmer? Is 11 that right? 12 A. Yes. 13 Q. Okay. Did you have conversations with 14 Vice Admiral -- I think it's Vice Chair or Vice 15 Admiral Raquel Bono? 16 A. I'm going to assume I did. I don't 17 recall specifically. But she is on the executive 18 committee, so I definitely discussed this with 19 the executive committee, as well as the board. 20 Q. Okay. Did you have conversations with 21 Michelle Martin? 22 A. I don't recall. Page 177

1 Q. How about Sally Welborn? 2 A. She is on the executive committee, so 3 yes, I would have in the context of the executive 4 committee. 5 Q. John Zern? 6 A. He's also on the executive committee. 7 Q. Rumay Alexander? 8 A. She is on the board, so she would have 9 heard it as part of a board -- I don't recall a 10 one-on-one conversation with her about this? 11 Q. Any one-on-ones with Irene Fraser? 12 A. Not that I recall. 13 Q. Carole Hemmelgarn? 14 A. Not that I recall specifically. 15 Q. Ellen Kelsay? 16 A. Not that I recall. 17 Q. Janet Lucas-Taylor? 18 A. Not that I recall. 19 Q. Kenneth Mendez? 20 A. Not that I recall. 21 Q. Arnold Mistein [sic]? 22 A. Arnold Milstein, yes. He's on the expert Page 178	1 MS. BLAIR: I'm going to object to form 2 and instruct you not to answer any conversations 3 you had with me as your legal counsel related to 4 a change in methodology. 5 BY MR. CHUNG: 6 Q. Did you have conversations with Ms. Blair 7 in 2024 about the change in methodology? 8 A. I've been instructed not to answer that 9 by counsel. 10 Q. The question is, yes or no. 11 Did you -- 12 MS. BLAIR: You can answer yes or no. 13 THE WITNESS: Oh. Yes. 14 BY MR. CHUNG: 15 Q. Okay. Michelle Schreiber? 16 A. Yes. 17 Q. Okay. Christa-Marie Singleton? 18 A. No. 19 Q. Okay. Now -- so looking at the -- in 20 terms of just general -- taking a step back, the 21 board of directors meetings, they covered topics 22 including topics relating to Leapfrog's business; Page 180
1 panel as well as the board, and we talk 2 extensively. 3 Q. Dolores Mitchell? 4 A. Not that I recall. 5 Q. Aaron Schrader? 6 A. Not that I recall. 7 Q. Susan Sheridan? 8 A. Not that I recall. 9 Q. Karen van Caulil? 10 A. Not that I recall. 11 Q. Lina Walker? 12 A. Not that I recall. 13 Q. Kimberly Blair? 14 MS. BLAIR: Objection to form. I'm not 15 on the board. 16 BY MR. CHUNG: 17 Q. Did you have one-on-one conversations 18 about the change in imputation methodology with 19 Ms. -- 20 A. I mean, not early on -- 21 Q. -- Blair -- 22 A. -- no. Page 179	1 is that right? 2 A. Yes. 3 Q. Okay. And those matters cover -- and I'm 4 not saying every -- that's the sole function of 5 the board meetings, but they covered topics like 6 the financial updates; is that right? 7 A. Yes. 8 Q. And operations updates? 9 A. Yes. 10 Q. And -- 11 A. It's not -- they're not involved in 12 operations at any detailed level, but yes, 13 operations. Yes. 14 Q. Okay. And I think there's some long-term 15 planning discussions that happened at the board 16 meeting; is that right? 17 A. Long-term strategic intent. 18 Q. Okay. That's right. I think there's 19 some documents with that very title. 20 A. Yes. 21 Q. Do the board meetings, do they cover 22 legal advice at all? Page 181

1 A. What do you mean by that? 2 Q. Like, is there any component of the board 3 meetings where you're discussing legal matters? 4 MS. BLAIR: You can answer -- 5 THE WITNESS: Yes. 6 MS. BLAIR: -- that yes or no. 7 BY MR. CHUNG: 8 Q. Okay. Sometimes, right? At some board 9 meetings where it's relevant; is that right? 10 A. Yes. 11 Q. Okay. Would you agree that financial 12 updates to the board are not -- don't involve 13 legal advice? 14 A. I'm trying to understand. Financial -- 15 Q. Yeah. 16 A. -- updates don't involve legal advice? 17 Q. Right. 18 A. Right. 19 Q. Okay. How about the -- we mentioned the 20 operational updates to the board. 21 Do those involve legal advice? 22 A. I don't know. Page 182	1 A. I'm not certain of that, but something 2 like -- I don't know, actually. Five years? 3 Seven years? Something like that. 4 Q. Okay. So certainly before 2024. 5 A. Yes. 6 Q. Okay. Does Ms. Blair consult Leapfrog on 7 non-legal business matters? 8 A. No. 9 Q. Okay. What do you understand Ms. Blair 10 to be responsible for, then, with respect to 11 Leapfrog, other than this matter we have in front 12 of us? 13 A. Well, our board wants to know that 14 there's legal counsel at the table to assure that 15 we are compliant with all the laws. 16 Q. Okay. And that requires Ms. Blair's 17 attendance at all the board meetings? 18 A. Yes. 19 Q. Okay. What issues are you -- what laws 20 and what compliance with those laws are you 21 referring to? 22 A. I don't know, but things come up every Page 184
1 Q. Okay. Does the organization have 2 in-house counsel, like a general counsel or -- 3 A. No. 4 Q. No? Okay. Does Leapfrog use the Wilson 5 Elser firm as an equivalent to an in-house 6 counsel, though? 7 A. Yes. 8 Q. Okay. And you know that Ms. Blair 9 works -- is a partner at Wilson Elser; is that 10 right? 11 A. Yes. 12 Q. Okay. Is Ms. Blair essentially 13 Leapfrog's general counsel? 14 A. She's counsel to Leapfrog. 15 Q. Okay. But she attends board meetings, 16 correct? 17 A. Yes. 18 Q. And in fact, she attended the board 19 meetings throughout 2024, correct? 20 A. Yes. 21 Q. All right. And just generally, how long 22 has Ms. Blair been involved with Leapfrog? Page 183	1 now and then. We'll be having a conversation and 2 discussing something and it seems like, well, I 3 wonder if that's right or that's right, and we 4 want to make sure that we have counsel present to 5 advise us. 6 Q. Okay. Just in case something comes up; 7 is that right? 8 A. Yeah. It's a common practice among 9 boards. 10 Q. Okay. Does Ms. Blair advise on licensing 11 agreements? 12 A. Yes. She looks at the contracts and 13 works, I believe, with the team when a licensee 14 wants to have a change to their agreement. So 15 she'll help to make sure that the language in our 16 contracts are compliant. 17 Q. This is Mr. Banerjee's team; is that 18 right? 19 A. Mr. Banerjee and also Missy Danforth and 20 the team. 21 Q. Okay. Because Missy -- because Ms. 22 Danforth oversees the licensing team -- Page 185

1 A. Right. 2 Q. -- as well as the ratings team, correct? 3 A. Yes. It's typically Kush Banerjee who is 4 working with the contracts with individual 5 licensees. 6 Q. Okay. Does Ms. Blair advise on 990 7 filings? 8 A. No. 9 Q. Okay. How about on any sort of 10 employment issues? 11 A. Rarely. We have a -- we have a 12 contractor called Engage Healthcare that has 13 attorneys, and we typically rely on them for 14 advice regarding employment issues. 15 Q. Okay. Does Ms. Blair advise on any 16 issues relating to changes in the hospital 17 survey? 18 A. No. I don't believe so. 19 Q. Okay. How about changes with respect to 20 the scoring methodology? 21 A. No. 22 Q. Okay. Does Ms. Blair give Leapfrog Page 186	1 sorry. 2 This will be Exhibit 16. 3 (Binder Deposition Exhibit 16 marked for 4 identification and attached to the 5 transcript.) 6 BY MR. CHUNG: 7 Q. All right. Ms. Binder, did -- in the 8 fall of 2024, did Leapfrog -- did the Leapfrog 9 website have a frequently asked questions 10 section? 11 A. Yes. 12 Q. Okay. Now, I'm just going to direct your 13 attention to the very first page of the exhibit, 14 which is an e-mail. 15 And towards the bottom of the e-mail you 16 write, Are you giving more A's now because of all 17 this improvement? Explain sliding scale. A's 18 tend to be better now. 19 Do you see that? 20 A. Yes. I'm going to have to refresh my 21 memory on this. But frequently asked questions 22 on our website are different from frequently Page 188
1 business advice in any -- in any way? 2 A. Other than looking at the legal language 3 in our contracts, no. 4 Q. Okay. Does -- so Ms. Blair -- it's 5 correct that Ms. Blair attends board meetings to 6 this day, correct? 7 A. Yes. 8 Q. All right. 9 A. We've always had counsel attend board 10 meetings. 11 Q. Okay. And can you just kind of tell us 12 again, what is Ms. Blair doing at the board 13 meetings? 14 A. She is listening and assuring that our 15 deliberations and our discussions and any issues 16 that come up are compliant with the law. 17 Q. Okay. Does Ms. Blair attend any other 18 Leapfrog meetings other than the board meetings? 19 A. Once in a while she's asked to attend 20 meetings, but rarely. 21 Q. Okay. Let's go to our next document. 22 MR. CHUNG: Tab 14. Oh, tab 15, I'm Page 187	1 asked questions that we use internally for 2 spokespeople and people who are going in front of 3 the press or talking to hospitals or talking to 4 the public, et cetera. We have a set of talking 5 points to address those issues. 6 Q. But both are external facing, correct? 7 A. The frequently-asked questions, no, 8 they're not external -- there are some on our 9 website. There are actually lots of different 10 places on our website we have frequently asked 11 questions. 12 But I believe -- and I'd need to refresh 13 my memory on this particular e-mail, but I 14 believe these are internal talking points -- 15 Q. Okay. 16 A. -- frequently asked questions that we use 17 for our own internal spokespeople. I believe 18 that's what he's talking about. 19 Q. Okay. So just focusing on that sentence, 20 Are you giving more A's now because of all this 21 improvement? 22 Do you see that? Page 189

1 A. Where is that? 2 Q. In the paragraph starting, Where are we 3 seeing improvements in patient safety? 4 Do you see that paragraph? 5 A. Oh, yeah. Okay. 6 Q. If you go down four lines -- or three 7 lines. 8 A. Right. 9 Q. Do you see that? 10 A. Uh-huh. 11 Q. Was Leapfrog giving out more A grades in 12 2023 and 2024 than in prior years? 13 A. No. We've given out pretty much 14 consistently the same number of A's. 15 Q. Same -- 16 A. Slight changes up and down, up and down 17 depending on how the CMS data plays out. But 18 pretty much the same amount of A's every year. 19 Again, there are slight changes, but not 20 substantially. 21 These questions are -- this is definitely 22 for an internal document of questions that we do Page 190	1 the methodology? 2 A. Because when you're talking to a reporter 3 who is, in turn, talking to the lay public or 4 reporting for the lay public, they don't want to 5 hear about long explanations of methodology. 6 What's important about the safety grade is errors 7 and accidents and injuries and infections 8 happening in hospitals. So I want to make sure 9 that our spokespeople are continuing to talk 10 about those issues and not getting -- not going 11 on about the methodology. 12 Q. But don't reporters or even consumers 13 want to know -- the question here is -- why a 14 particular hospital got an F grade? 15 A. Uh-huh. Yeah. So what we advise people 16 to do in this case -- and I don't know, maybe you 17 have another exhibit with the final that this 18 ended up. 19 But what we advise our spokespeople to 20 say is, well, they did poorly on central 21 line infections, they were among the worst in the 22 country on patient experience reports or they -- Page 192
1 hear and -- to be prepared to answer them. 2 Q. Okay. Let's go to the actual markup of 3 the frequently asked questions document. And if 4 you go to 397096 -- do you see that at the 5 bottom? 6 A. Yes. 7 Q. It's the first page of the document. 8 At the bottom of the page -- and are 9 these markups your -- is it your markup? 10 A. It looks like it is mine. 11 Q. Okay. You added a question here that 12 reads, Why did hospital X get an F? Why did 13 hospital Y get an A? 14 A. Yeah. 15 Q. And then under that, in brackets, you 16 wrote, at least in part, Don't say how those 17 measures caused a bad grade. In other words, 18 talk about the safety measures, not the 19 methodology. 20 Do you see that? 21 A. Yes. 22 Q. Okay. Why did you not want to talk about Page 191	1 you know, to be very specific to the reasons -- 2 the specific measures of problems that happen in 3 hospitals. We should be very specific about 4 those when we're discussing the grades. 5 Q. But if it's -- but for specific measures, 6 including -- I'm focusing on the four imputed 7 metrics, which I think you testified earlier are 8 among the most important metrics; is that right? 9 MS. BLAIR: Objection to form. 10 THE WITNESS: I didn't say that. I 11 didn't testify that. 12 BY MR. CHUNG: 13 Q. All right. Well, let me put it another 14 way. 15 Are the four imputed metrics among the 16 most heavily weighted metrics in the scoring 17 methodology? 18 MS. BLAIR: Objection to form. 19 THE WITNESS: I think it depends on which 20 hospital is -- which hospital you're scoring. 21 BY MR. CHUNG: 22 Q. Okay. But specifically with respect to Page 193

1 those four imputed metrics, isn't it correct that 2 why a particular hospital got a limited 3 achievement score on that metric is because they 4 were automatically assigned that score because 5 they didn't participate? 6 MS. BLAIR: Objection to form. 7 THE WITNESS: If a reporter is to ask why 8 did that hospital get limited achievement and 9 they didn't report to the survey, and I look on 10 the website and I see that's what we say, that we 11 assigned a grade, that's what I would tell the 12 reporter. 13 But this is not what the question is on 14 here that I was editing and suggesting that the 15 team write this answer that the spokespeople at 16 Leapfrog would have, which is to have an 17 orientation toward advising reporters on what are 18 these problems in hospitals that we are noting in 19 each hospital's grade. 20 BY MR. CHUNG: 21 Q. Okay. If we -- and then under that 22 section in brackets you write, Terminology should Page 194	1 particular. 2 Q. 28 of the -- 3 A. Well, there's 32 measures in the grade, 4 so it's based on all 32 measures. But it is 5 based on the data that we have. 6 Q. But not on the four -- but not on -- 7 A. Imputed -- 8 Q. -- four, correct? 9 A. No. Imputed values are real -- that's 10 real measures to me. 11 Q. Okay. Though they're automatically 12 assigned a grade, correct, without the benefit of 13 any data on those metrics; is that right? 14 MS. BLAIR: Objection to form to the use 15 of "grade." 16 THE WITNESS: They're not assigned a 17 grade on those imputed measures at all. 18 BY MR. CHUNG: 19 Q. A score. 20 A. Each of those imputed measures, the 21 imputation is a score. 22 Q. Okay. And that score is a limited Page 196
1 say the hospital earned their grade. 2 Do you see that? 3 A. Yes. 4 Q. Why did you add that comment? Let me put 5 it another way. 6 Why was it important to use the 7 word "earned"? 8 A. Because a hospital's performance is such 9 that they earned the grade that they get. 10 Q. But hospitals that don't respond to the 11 survey are still assigned a grade, right? 12 MS. BLAIR: Objection to form. 13 THE WITNESS: They -- according to the 14 methodology and with the advice of the expert 15 panel, they are -- they get a grade that is 16 reflective of their performance. 17 BY MR. CHUNG: 18 Q. Okay. And would you say that 19 non-participating hospitals earned their grade, 20 just using the verbiage here? 21 A. Absolutely they earned their grade. And 22 it's based on 28 of the 38 -- 32 measures in Page 195	1 achievement score that is automatically assigned 2 to those metrics without the benefit of any data 3 on those metrics, correct? 4 A. If the hospital has reported to the 5 survey in the past two cycles of the grade, then 6 we will use that data. 7 Q. But absent that? 8 A. Absent that, in the step 2, they will -- 9 they are imputed with a one bar equivalent in 10 each of those four measures. 11 Q. All right. 12 A. Yes. 13 Q. And that imputation is not based on data, 14 actual data, submitted by the hospital, right? 15 A. It's based on -- 16 Q. My question is -- 17 A. -- extremely -- 18 Q. -- that imputation is not based on -- is 19 not reflective of actual data submitted by the 20 hospital, correct? 21 A. Submitted by the hospital? 22 Q. Correct. That's what I asked. Page 197

1 A. It's reflective of data from -- it's 2 reflective of data -- 3 Q. What -- 4 A. -- based on our knowledge of how 5 hospitals perform when they don't report to the 6 survey -- 7 Q. Okay. 8 A. -- and expert opinion. 9 Q. Okay. Let's turn to page 3 of the FAQ -- 10 this FAQ document, Bates ending 7098. 11 Okay? Do you see that? 12 A. Actually, I see -- 13 Q. The top number. 14 MS. BLAIR: Yeah. 15 THE WITNESS: Oh. Oh, I see. Okay. 16 Yes. 17 BY MR. CHUNG: 18 Q. So there is a question here that reads, 19 Are there methodology changes in the fall 2024 20 Leapfrog hospital safety grade. 21 Do you see that? 22 A. Yes. Page 198	1 A. Yeah. I would tweak the wording to be a 2 little bit more accurate to be clear that it's 3 those -- that it's four of the measures. 4 Q. Okay. 5 MR. CHUNG: Let's go to tab 16. 6 So this will be Exhibits 17 and 18. 7 (Binder Deposition Exhibits 17 and 18 8 marked for identification and attached to 9 the transcript.) 10 BY MR. CHUNG: 11 Q. Okay. Exhibits 17 and 18, you have got 12 an e-mail and a PowerPoint that was attached to 13 it. And let's just focus on 17 for the time 14 being. 15 A. Oh, yeah. This was my PowerPoint skills. 16 Q. Okay. And just looking at the e-mail -- 17 so Bates ending 0327 -- this is an e-mail from 18 you to a Paul Alper who I understand is a 19 consultant -- 20 MS. BLAIR: Wait. 21 THE WITNESS: I don't think I have that. 22 MS. BLAIR: 0327? We don't have that Page 200
1 Q. All right. And it says -- under that 2 question you wrote, In line with recommendations 3 from the national expert panel and Johns Hopkins 4 advisors, Leapfrog changed the way it estimates 5 performance for hospitals that declines to report 6 to the Leapfrog hospital survey; is that right? 7 A. Yes. 8 Q. Okay. Now, looking at the second half of 9 that sentence, is it correct that -- does it ever 10 -- is it correct that the change in methodology 11 is to estimate performance for hospitals that 12 decline to report to the hospital survey? 13 A. This is a draft, and I corrected their 14 draft. 15 Q. Okay. 16 A. So I probably would word that -- and it's 17 not the final. I'm sure it's not the final 18 because that is not quite how we would word it. 19 Q. Okay. 20 A. Changed the way it to... 21 Yeah. 22 Q. All right. Page 199	1 one. That's not what we have. 2 MR. CHUNG: Just a moment. 3 THE WITNESS: I have 2499. 4 MR. CHUNG: Just a moment. 5 BY MR. CHUNG: 6 Q. Ah. Okay. So Exhibit 17. We're looking 7 at the e-mail Bates ending 2499. 8 Are we now looking at the same thing? 9 Yes. 10 A. Yes. 11 Q. Okay. So let's look at the second 12 page of the document, Bates ending 2500. 13 A. Uh-huh. Yes. 14 Q. And you're writing to Ms. Bailey, who's 15 director of communications at this time; is that 16 right? 17 A. Yes. 18 Q. Okay. This Leapfrog 101 presentation 19 that's being referenced here, what is -- who's 20 the audience for this presentation? 21 A. I can't exactly recall. We do a lot of 22 Leapfrog 101 presentations. I can't recall what Page 201

1 this one was meant for. 2 Q. Well, let's go back to the e-mail. Just 3 going down to Bates ending 2500, it's the 4 paragraph starting, First, the most important 5 things to convey in this speech are -- and then, 6 going down a few bullets -- Why the imputation 7 strategy is controversial -- right? 8 Do you see that? 9 A. Yes. 10 Q. All right. What do you mean here? What 11 did you mean? 12 A. Why we're sitting here today is it's 13 controversial to hospitals that don't report -- 14 decline to report to the survey. 15 It's also controversial, and has been in 16 the past, the imputation strategy, to hospitals 17 that do report to the survey and have expressed 18 their concern that we are inflating these scores 19 for hospitals that don't report. 20 Q. Okay. The next bullet point, The levers 21 we pull to get hospitals and ASCs to participate. 22 A. Yes. Page 202	1 we would like to see that data publicly reported. 2 So that's a lever. We use -- like any 3 organization -- really, any organization of any 4 sort -- we use whatever we have in terms of our 5 influence to see change and to meet our mission. 6 Q. Okay. That's an example of one lever. 7 A. Yes. 8 Q. Is another lever the imputation strategy 9 itself in that it gets hospitals to participate 10 in the survey? 11 A. No. That's not the purpose of the 12 imputation strategy. We didn't see it that way. 13 Because the imputation strategy actually -- it 14 doesn't help or hurt the participation in the 15 survey necessarily. It can for some hospitals; 16 it cannot for others. 17 Q. But isn't it correct that in discussions 18 with members of your own expert panel, that the 19 experts themselves believed that this imputation 20 strategy was, at least in part, designed to get 21 more hospitals to participate that formerly were 22 not participating? Is that correct? Page 204
1 Q. In terms of in terms of the levers -- 2 right? -- is one of those levers the risk of a 3 failing grade to a hospital that doesn't 4 participate? 5 MS. BLAIR: Objection to form. 6 THE WITNESS: Well, first of all, 7 participation in the survey is not the same as 8 getting a hospital safety grade. 9 BY MR. CHUNG: 10 Q. Right. 11 A. So no. 12 Q. So what do you -- what do you mean by 13 levers here? 14 A. Well, we -- like any organization, we 15 have to find ways to influence the public in ways 16 that meet our mission. So one lever is, for 17 instance, our work with regional leaders who are 18 typically business groups on health. They have 19 memberships consisting of employers and other 20 purchasers in their community. And those 21 purchasers are the ones that ask hospitals to 22 please participate in the Leapfrog survey because Page 203	1 MS. BLAIR: Object to form. 2 THE WITNESS: I saw Patrick Romano 3 discuss that. But other than him, I don't think 4 they were seeing it that way. I think they did 5 see implications that they felt were of 6 importance for hospitals that declined to 7 participate. They definitely saw that as a 8 signal of performance in some way, and they 9 talked about that. 10 But that's -- you know, again, what I'm 11 concerned about is that -- from the expert panel 12 is that they agree with the ultimate 13 recommendation, and they did. 14 BY MR. CHUNG: 15 Q. Okay. I'm going to direct your attention 16 to the next page, Bates ending 2501. 17 There's a paragraph that starts, There 18 needs to be a slide about what Leapfrog does to 19 grade a hospital when they decline to report to 20 the survey. 21 Do you see that paragraph? 22 A. Yes. Page 205

1 Q. Okay. I think it's very important for 2 the board to understand that we moved over time 3 toward imputing the lowest level of performance 4 when we don't have recent Leapfrog data. In 5 other words, the slide should not detail the 6 step-by-step imputation process. It should 7 summarize the strategic import of the imputation 8 process. This has been a shift over time and one 9 with significant policy ramifications for the 10 organization. 11 A. Uh-huh. 12 Q. This is the second time we're seeing 13 you're saying that we shouldn't get into the 14 methodology. In this case, it's, we should not 15 detail the step-by-step imputation process. 16 With respect to the board, why isn't it 17 important to detail the step-by-step imputation 18 process? 19 MS. BLAIR: Object to form. 20 BY MR. CHUNG: 21 Q. You can answer. 22 A. So you're saying, with respect to the Page 206	1 step 1, step 2 imputation, they go -- they're not 2 necessarily going to realize what happened and 3 how this has evolved over time and why, and 4 why -- and the explanations that the expert panel 5 gave us for why that was important. 6 Q. So are you saying that board members, the 7 new board members, will not understand the 8 imputation process? 9 A. No. I just think that they -- they will 10 understand it, for sure, but this presentation 11 has 30 slides with 30 different areas of import. 12 And in this context, that would not convey the 13 message appropriately. 14 Q. Okay. 15 A. When you're speaking to people who -- 16 you're trying to give them a broad overview of 17 everything that's going on, and I want to make 18 sure that they understand this very important 19 thing. That's how I felt was the best strategy 20 to do it in this context. 21 Q. Okay. Let's actually go to the slide 22 presentation itself. So if you go to Bates Page 208
1 board, why is it important not to detail the 2 imputation process? 3 Q. Why -- why -- why is it not important -- 4 right? -- to share with them the steps in the new 5 imputation process? 6 A. Well, in the context of this 7 presentation, which I believe -- I would like to 8 know which we were talking about, but I believe 9 this was to new members of the board. I think 10 this was their orientation. 11 So this is a slide presentation that's 12 probably 30 slides. And this is -- these are new 13 members of the board who are not measurement 14 scientists or clinicians and they're not engaged 15 in the healthcare world, so they will not see the 16 forest for the trees. They won't understand 17 what's important about this. 18 It's very important to me to be as candid 19 and absolutely blunt as possible in our 20 communications so that they understand what's 21 most important about this. If you showed board 22 members who are, like, laypeople, here's this Page 207	1 ending in 104. It's 1104. And the slide is 2 titled, How the Survey Compares to Other 3 Measurement Programs. 4 A. Oh, I'm sorry, where is that then? It's 5 not this? 6 MS. BLAIR: It is. 7 MR. CHUNG: It is, yeah. 8 MS. BLAIR: It looks like this. It's 9 1104. 10 MR. CHUNG: Yeah. Exhibit 18. 11 THE WITNESS: Oh. 12 MR. CHUNG: Okay. 13 THE WITNESS: 1104? Okay. 14 BY MR. CHUNG: 15 Q. And the title of the slide is, How the 16 Survey Compares to Other Measurement Programs. 17 Do you see that? 18 A. Yes. 19 Q. Okay. And this includes -- shows a chart 20 listing Leapfrog, CMS, TJC, clinical registries, 21 and health plans; is that correct? 22 A. Yes. Page 209

1 Q. Okay. And what are these -- we know what 2 Leapfrog is. 3 CMS is -- what are these other entities 4 and why are they included here in this chart? 5 A. I think that people who are not immersed 6 in the measurement world will say, well, how is 7 Leapfrog different from the Joint Commission or 8 from all these registries, from all the other 9 stuff that hospitals are doing when they are 10 reporting on their quality and safety? Or how is 11 it different from what health plans do? 12 And so we're trying to sort of lay that 13 out, why we needed Leapfrog, because it plays a 14 very unique role amid all of those other efforts 15 at assessing and reporting on quality and safety. 16 Q. Okay. Now, it says here, under TJC and 17 then clinical registries, that one can opt out. 18 Do you see that? 19 A. Yes. 20 Q. Okay. And so, according to this chart, 21 hospitals can opt out of reporting to TJC and 22 these clinical registries; is that right? Page 210	1 the survey? 2 MS. BLAIR: Object to form. 3 THE WITNESS: An exemption for completing 4 the survey? 5 BY MR. CHUNG: 6 Q. From completing the survey. 7 A. They just don't report. It's -- you 8 know, it's voluntary. 9 Q. Okay. And you're aware that the 10 plaintiff hospitals in this matter, they sought 11 to opt out of participating in the survey; is 12 that right? 13 A. They don't participate in the survey. So 14 they didn't just seek to opt out; they didn't -- 15 Q. They just didn't, right? 16 A. Uh-huh. 17 Q. Okay. 18 A. Though I do see from some of the 19 discovery materials that they were interested in 20 reporting, but were told they couldn't, which was 21 interesting. 22 Q. The last row in the chart is a -- the Page 212
1 A. No. It's tied to -- the row is publicly 2 reports by facility. They can opt out of 3 publicly reporting their Joint Commission 4 results. 5 Q. Okay. Does Leapfrog allow hospitals to 6 opt out of that? 7 A. If they report to our survey? If they 8 submit to our survey, they attest to the veracity 9 of the survey and they submit it. It is publicly 10 reported. That is our core mission. 11 Q. So the question is, can a hospital opt 12 out of that public disclosure, that public 13 reporting of that data? 14 A. By not reporting to the survey, they can 15 opt out. 16 Q. Okay. After submitting the data, can 17 they opt out? 18 A. No. 19 Q. Okay. 20 A. Of reporting their performance, I might 21 add. Their scores by Leapfrog. 22 Q. Can they get an exemption for completing Page 211	1 five-step verification process. 2 Do you see that? 3 A. Yes. 4 Q. Okay. And Leapfrog has an X in the 5 column next to it, right? 6 A. Yes. 7 Q. And does this mean that the other surveys 8 on this slide don't verify their data? 9 MS. BLAIR: Objection to form. 10 THE WITNESS: No, that's not what this 11 means. 12 BY MR. CHUNG: 13 Q. Okay. It just means that they don't have 14 the five-step verification process that Leapfrog 15 has? 16 A. Exactly. 17 Q. Okay. 18 A. But they each have their own processes, 19 I'm sure. 20 Q. The -- we're going back to -- earlier in 21 the morning we were discussing ways that Leapfrog 22 does and does not verify the data that it -- that Page 213

1 it receives from the hospitals. 2 Does Leapfrog visit hospitals that do not 3 participate in the survey and receive limited 4 achievement scores? 5 MS. BLAIR: Objection to form. 6 THE WITNESS: Visit for what purpose? 7 BY MR. CHUNG: 8 Q. Just for any purpose. 9 A. No formal visits, but I've certainly been 10 to hospitals and visited hospitals that don't 11 report to the survey. 12 Q. Okay. All right. 13 MR. CHUNG: We've been going a while. 14 We're going to the next section. 15 So why don't we -- should we break for 16 lunch now? 17 MS. BLAIR: Sure. Yeah. 18 MR. CHUNG: Why don't we do that. 19 VIDEO TECHNICIAN: The time is 12:54 p.m. 20 This ends unit 2. We're off the record. 21 (A recess was taken.) 22 VIDEO TECHNICIAN: The time is 1:52 p.m. Page 214	1 right this second. 2 Yes. Okay. 3 Q. All right. So by this time, is it right 4 that the methodology -- the imputation 5 methodology that we've been discussing all day so 6 far was put into effect? 7 A. I believe by July 15th, yes, I believe 8 so. 9 Q. Okay. And you're writing to Mr. Alper 10 that it would change the methodology so that 11 hospitals that don't report to the Leapfrog 12 survey this year or last year will be imputed 13 with the lowest score on hand hygiene and I'm 14 sure the survey team has a slide on that. 15 And then you continue to write, But 16 please be sure you thoroughly understand this 17 change and the talking points around it if you 18 decide -- if you do decide to use it. It's a 19 very big deal to hospitals and a major incentive 20 to report to the survey and you could easily get 21 a question on it. 22 So you wrote that the methodology change Page 216
1 This begins unit number 3. We're on the record. 2 (Binder Deposition Exhibits 19 and 20 3 marked for identification and attached to 4 the transcript.) 5 BY MR. CHUNG: 6 Q. So Ms. Binder, our next document, 7 Exhibits 19 and 20, are an e-mail chain and short 8 attachments from July 15 of 2024. And I want to 9 direct your attention to -- you mentioned -- who 10 is Paul Alper? 11 A. He is a consultant to Leapfrog. 12 Q. Okay. And it appears that he sent a set 13 of slides or a slide for you to review; is that 14 right? 15 A. I believe so. I have to refresh my 16 memory on this e-mail. 17 Q. Okay. Just take a moment to review it. 18 Ms. Binder, I'm just going to ask a few 19 questions about that last bullet point in the 20 e-mail that starts with, We did change the 21 methodology for fall 2024. 22 A. Okay. I'm just getting to reading that Page 215	1 was a major incentive to report -- for these 2 hospitals to report to the survey; is that 3 correct? 4 A. It's a very big deal to hospitals and a 5 major incentive to report to the survey. Yes -- 6 Q. Right. 7 A. -- I wrote that here. 8 Q. And it would be a major -- it is a major 9 incentive for these hospitals to report to the 10 survey because they would face a higher risk of 11 receiving a low grade if they did not report; is 12 that right? 13 A. Not necessarily. 14 Q. But that was behind your comment here 15 that it would be a major incentive for hospitals 16 to report to the survey; is that right? 17 A. For some hospitals to report to the 18 survey because, if they do well -- particularly I 19 think he was at a conference where he was 20 speaking about hand hygiene, so he was going to 21 be speaking to hospitals that are very actively 22 involved in hand hygiene work. And so to that Page 217

1 audience, they would want to be able to report 2 that performance so they would -- you know, that 3 would help their grade. 4 For a lot of hospitals, they -- reporting 5 to the survey doesn't help their grade because 6 they don't do well. 7 Q. Okay. But that was -- that was one of 8 the kind of effects -- right? -- of this change 9 in the methodology that more hospitals would 10 respond to the survey, correct? 11 MS. BLAIR: Objection to form. 12 THE WITNESS: It's potentially an effect, 13 but -- 14 BY MR. CHUNG: 15 Q. Right. 16 A. -- potentially not an effect. 17 Q. And, in fact, that was a purpose of -- 18 one of the purposes of the imputation methodology 19 change; isn't that right? 20 A. No, that wasn't -- 21 MS. BLAIR: Objection to form. 22 THE WITNESS: -- the purpose of the Page 218	1 survey this year or last year will be assigned 2 the lowest score on hand hygiene, right? There's 3 no mention of the step 1 here, correct? 4 A. I didn't go into the full details of the 5 methodology. I told him to go and get that 6 information to make sure it's accurate. 7 Q. And your testimony is that it was not a 8 purpose at all behind the change in the 9 imputation methodology to encourage more 10 hospitals to respond to the survey. Not at all. 11 A. The purpose was to not overinflate -- you 12 asked me if -- 13 Q. If you can answer the question. All 14 right? 15 Are you testifying that it was not a 16 purpose at all -- right? -- whether it's one of 17 the purposes or the purpose, to encourage 18 hospitals to report to the survey? 19 MS. BLAIR: Object to form. 20 THE WITNESS: We always want hospitals to 21 report to the survey. Like a hundred percent 22 participation in the survey. But that was not Page 220
1 methodology change. 2 BY MR. CHUNG: 3 Q. Well, does -- okay. Just to summarize, 4 Leapfrog assigns the limited achievement score 5 for a non-participating hospital on the imputed 6 metrics under this methodology change; is that 7 right? 8 A. Well, what I didn't say in this 9 paragraph was that there's also the -- if they 10 report -- you know, there's a step 1 where, if 11 they report in the prior year, they can get 12 scored from the prior year survey. 13 I didn't -- so I didn't go into the 14 details of it. I did tell him to go to the 15 survey team and get briefed and get the 16 information. 17 Q. Right. And you actually told him, be 18 sure you thoroughly understand this change, 19 correct? 20 A. Exactly. 21 Q. All right. But in this e-mail, you're 22 telling him that those that don't report to the Page 219	1 the reason that we set out to change this 2 methodology. 3 BY MR. CHUNG: 4 Q. Okay. But did it at least become a 5 purpose or a reason to use this methodology? 6 MS. BLAIR: Objection to form. 7 THE WITNESS: No. 8 BY MR. CHUNG: 9 Q. So your -- the organization's desire to 10 have as many hospitals participate in the survey 11 as possible is completely divorced from this -- 12 from the change in imputation methodology. They 13 have no relationship to each other whatsoever; is 14 that right? 15 MS. BLAIR: Objection. Form. 16 THE WITNESS: You're saying the 17 imputation methodology has no relationship to the 18 survey participation? 19 BY MR. CHUNG: 20 Q. I'm asking you, based on your testimony 21 so far, are you saying that there is absolutely 22 no relationship, no connection, between Page 221

1 Leapfrog's wish to have as many hospitals 2 participate in the survey as possible and the 3 change in this imputation methodology. 4 A. Certainly they're related. Absolutely 5 they're related. I just said they're related. 6 But it's not the purpose of changing the 7 methodology. 8 Q. Right. Despite your saying to Mr. Alper 9 that it's a -- the change in methodology is a 10 major incentive for hospitals to report to the 11 survey, correct? 12 A. That was the implication of this change, 13 but that was not the purpose of the change to the 14 methodology. 15 Q. Let's put it another way: Was it 16 contemplated, was it expected -- was it 17 contemplated that, in coming up with this 18 imputation methodology change, that it would be a 19 major incentive for hospitals to respond to the 20 survey? 21 MS. BLAIR: Objection to form. 22 THE WITNESS: It wasn't the purpose. I Page 222	1 Q. Are you aware that there have been 2 criticisms from hospitals that it was penalizing 3 hospitals with insufficient resources? 4 A. I don't recall a particular public 5 comment to that effect, but there may have been 6 one. 7 Q. Okay. How about criticisms that the 8 public, the consumers, would not understand nor 9 dig into the change in methodology? Are you 10 aware of any criticisms along those lines? 11 A. That I'm not aware of. 12 Q. Okay. Are you aware of any criticisms 13 that hospitals -- from hospitals that the change 14 in methodology would cause hospitals with 15 insufficient resources to complete the survey? 16 A. It would cause hospitals with 17 insufficient resources to complete the survey? 18 Q. To divert -- to divert resources toward 19 complete the survey. 20 A. No, I haven't heard that criticism. 21 Q. All right. Have you heard the criticism 22 that, according to this imputation methodology, Page 224
1 mean, it wasn't the centerpiece or the purpose. 2 That wasn't what prompted it; that wasn't the 3 purpose. 4 BY MR. CHUNG: 5 Q. No, my question was, did Leapfrog 6 contemplate that the change in methodology, this 7 new methodology, would be a major incentive for 8 hospitals to report to the survey? 9 A. Yeah, we looked at it. We looked at that 10 issue. Certainly. It's right here. Definitely 11 looked at it. 12 Q. Okay. Are you aware of criticisms from 13 various hospitals about the change in the 14 imputation methodology? 15 A. I'm aware of hospitals critical on -- 16 about the change from both a positive and a 17 negative way. 18 Q. Are you aware of criticisms from 19 hospitals that the change was unnecessarily 20 punitive? 21 A. I believe there were a couple of public 22 comments to that effect. Page 223	1 that hospitals would be falsely represented with 2 a lower grade? 3 A. I have heard that criticism in public 4 comments. 5 Q. Okay. How about criticisms that the 6 change in methodology would result in an 7 inaccurate portrayal of the actual status of 8 patient safety at a hospital? 9 A. I've heard that comment from hospitals 10 that report to the survey as well as those that 11 don't. 12 Q. Okay. Do you recall, from your June 2024 13 CEO report that we saw before to the board, that 14 the change in the imputation methodology should 15 have some impact on hospital participation in the 16 survey? 17 Do you remember that comment? 18 A. Yes. 19 Q. All right. Are you aware that there is 20 not a single non-participating hospital in 21 Florida that received an A during the spring 2024 22 grade release? Page 225

1 A. In the State of Florida? 2 Q. Yes. 3 A. Yes. 4 Q. Okay. So you're aware of no A-hospitals 5 that were non-participants, correct? 6 A. In the State of Florida. Florida has a 7 high participation rate in general. 8 Q. Okay. 9 (Binder Deposition Exhibits 21 and 22 10 marked for identification and attached to 11 the transcript.) 12 BY MR. CHUNG: 13 Q. So Exhibits 21 and 22. 14 MS. BLAIR: Are you done with 20? 15 MR. CHUNG: Yes. 16 MS. BLAIR: Okay. 17 BY MR. CHUNG: 18 Q. So if you can look first, Ms. Binder, at 19 Exhibit 22, which is the standalone letter from 20 you to Kenneth Sands at HCA. 21 Do you see that? 22 A. Yes. I see that. Page 226	1 participate in the 2023 survey, Dr. Sands was not 2 allowed to serve on the hospital advisory 3 committee? 4 A. I'm trying to think if it's '23 or '24. 5 Probably '23 survey -- 6 Q. Yeah. 7 A. -- that we would have written on 8 March 29th. Yeah, sounds right. 9 Q. Okay. So why was it necessary to remove 10 him from the committee? 11 A. Well, Leapfrog has a hospital advisory 12 committee that actually is competitive to get on. 13 A lot of hospitals submit nominations to get 14 themselves onto that committee. It is -- advises 15 Leapfrog and our board on -- as I said earlier, 16 about hospital industry trends in quality and 17 safety, long-term issues that they would advise 18 us to be looking forward to. 19 It's just a very important committee to 20 us and it's a very important committee, I think, 21 to hospitals just from the nominations we get. 22 So this letter -- the members of the Page 228
1 Q. All right. So directing your attention 2 to the fourth paragraph that starts, Our 3 successful partnership. 4 Do you see that? 5 A. Yes. 6 Q. All right. Our successful partnership is 7 why this letter is particularly difficult to 8 write. Unfortunately, you are no longer 9 qualified to serve on Leapfrog's hospital 10 advisory committee. 11 A. Right. 12 Q. And then, in the next sentence, you 13 write, Because of the board requirements, members 14 of the committee have to come from basically 15 hospitals that have participated in the most 16 recent survey; is that right? 17 A. Yes. 18 Q. Okay. And because HCA hospitals did not 19 participate in the 2023 survey, you're no longer 20 eligible. 21 A. Correct. 22 Q. So is it correct that because HCA did not Page 227	1 hospital advisory committee are hospitals -- are 2 from hospitals that report to the Leapfrog 3 hospital survey. 4 Q. So why was it necessary to remove 5 Dr. Sands from that committee? 6 A. Because his hospital system, all of them 7 stopped reporting to the Leapfrog survey in the 8 prior year. 9 Q. Okay. So was this a way of kind of 10 penalizing HCA for not participating in the 11 survey the prior year? 12 A. No, it's not penalizing. It's just 13 saying you're no longer. He's not qualified. We 14 want -- our hospital advisory committee should be 15 hospitals that participate in the survey. 16 Hospitals that don't participate clearly don't 17 want to be part of Leapfrog, but we certainly 18 welcome them if they want to participate in the 19 survey. But those are the folks that we need to 20 be working closely with. 21 Q. Okay. 22 MR. CHUNG: All right. This will be Page 229

1 Exhibit 23. 2 (Binder Deposition Exhibit 23 marked for 3 identification and attached to the 4 transcript.) 5 BY MR. CHUNG: 6 Q. So Exhibit 23, Ms. Binder, is a Slack 7 chat from October 4 of 2023 between Alexandra 8 Campione and Paige Lipscomb, who are both 9 employees of Leapfrog; is that right? 10 A. Paige is a former employee. But yes, 11 they were at the time. 12 Q. Okay. And I want to direct your 13 attention to page 2, Bates ending 0361. 14 A. I don't believe I've seen this one. I'm 15 going to need to read it. 16 Q. Okay. You're not on this chat. You're 17 not -- 18 A. Right. 19 Q. It's just between the two ladies. 20 And so Paige writes, Why are convos so 21 bizarre? 22 Alex responds, This was the last meeting, Page 230	1 A. Yes. They've -- yes. 2 Q. Okay. Why would the new scoring 3 methodology here penalize HCA? 4 A. I don't know. 5 Q. Okay. Well -- 6 A. I can tell you why HCA -- why they paused 7 participation, because they told me. 8 Q. Okay. Well, let's finish with this 9 document here and then we will get into that. 10 A. Okay. 11 Q. So Ms. Lipscomb, Paige, writes, I hate 12 that we don't do our ting -- or thing -- like we 13 manipulate everything. 14 Is it fair to say that she's referring to 15 the scoring methodology that Ms. Campione had 16 just mentioned? 17 MS. BLAIR: Objection to form. 18 THE WITNESS: I really don't know. I 19 haven't seen this before and I don't know. 20 BY MR. CHUNG: 21 Q. Okay. And then Ms. Campione responds, 22 Leah keeps grudges. Page 232
1 in a nutshell. 2 And then Alex continues, We were talking 3 about changing the scoring methodology to 4 penalize HCA? 5 So HCA refers to HCA Healthcare; is that 6 right? Or the HCA group of hospitals? 7 A. HCA Healthcare. Yes. The group. 8 Q. And these are hospitals, the HCA 9 hospitals, that had participated in the Leapfrog 10 surveys in the past, right? 11 A. Yes. 12 Q. Okay. But -- 13 A. And they do now. 14 Q. But per the letter we saw earlier from 15 Dr. -- to Dr. Sands, they had stopped -- they had 16 not participated in the 2023 Leapfrog survey; is 17 that right? 18 A. I believe it was the '23. They paused 19 participation for one year. 20 Q. Right. And I think they eventually 21 rejoined, right? Or responded to surveys in the 22 future? Page 231	1 Do you think that she is referring to 2 you? 3 A. Yeah. 4 Q. Okay. And -- 5 A. I'm not sure -- yeah. 6 Q. And what grudges is she talking about 7 here, so far as you understand it? 8 A. I have no idea. 9 Q. Is it a grudge -- 10 A. I don't keep grudges. 11 Q. Is it a grudge -- you do not keep 12 grudges? 13 A. No. 14 Q. Okay. Is it a grudge against HCA for not 15 participating in the survey in 2023? 16 MS. BLAIR: Objection to form. 17 THE WITNESS: I don't know what she's 18 referring to. 19 BY MR. CHUNG: 20 Q. Okay. Well, you had just -- you 21 eventually, some months later, removed Dr. Sands 22 from the hospital advisory committee, correct? Page 233

1 A. He was no longer eligible to be on it, so 2 yes, I told him he cannot be on it -- 3 Q. Right. 4 A. -- in a letter that was quite 5 conciliatory and open. 6 Q. But -- and then, during that same time, 7 the -- Leapfrog was discussing or contemplating a 8 change in the imputation methodology, correct? 9 A. Same time as what? 10 Q. As the time when you removed Dr. Sands 11 from the hospital advisory committee. 12 A. I don't recall -- 13 MS. BLAIR: Objection to form. 14 THE WITNESS: -- the date. 15 BY MR. CHUNG: 16 Q. Okay. The -- you mentioned -- 17 A. Something around there. 18 Q. The requirements to be qualified on the 19 hospital advisory committee, Ms. Binder, are 20 those enumerated somewhere? Memorialized 21 somewhere? 22 A. I'm sure there are. Page 234	1 hospitals. It's quite explicit about that. 2 I mean, we've had a lot of documents like 3 that -- 4 BY MR. CHUNG: 5 Q. Okay. 6 A. -- but I obviously can't pull them out 7 right now. 8 Q. So just going back to the Slack chat that 9 we just discussed between Ms. Lipscomb and 10 Ms. Campione. 11 Do you recall any discussions with either 12 of them about penalizing HCA for not 13 participating in the 2023 survey? 14 A. I'm sorry, can you say that again. 15 Q. Yeah. Do you recall any discussions or 16 conversations you had with Ms. Lipscomb or 17 Ms. Campione around this time about punishing or 18 penalizing HCA for not responding to the 2023 19 survey? 20 A. No. I don't talk about penalizing 21 anyone. 22 Q. Okay. Page 236
1 Q. Okay. Where would they be memorialized? 2 A. In the file for the hospital advisory 3 committee, probably from whenever it was formed. 4 We've always opened it up to representatives from 5 hospitals that report to the survey. 6 Q. So what did you refer to -- it sounds 7 like you're not sure if or where it's 8 memorialized. 9 What did you refer to when removing 10 Dr. Sands from the hospital advisory committee? 11 What document containing the qualifications were 12 you relying on? 13 MS. BLAIR: Objection to form. 14 THE WITNESS: I don't have it in front of 15 me, but we have lots of documents that discuss 16 the hospital advisory committee, its purpose, why 17 it was formed, why the board formed it, and who's 18 on it. And it does say that it is hospitals that 19 report to Leapfrog. It talks about there needs 20 to be, you know, a range of members from 21 different parts of the country from different 22 size of hospitals, from different roles within Page 235	1 A. And certainly not hospitals. That's not 2 my -- that's not language I use. 3 Q. HCA, the -- HCA Healthcare is a 4 relatively large group of hospitals; is that 5 correct? 6 A. Yes. 7 Q. So they were -- until he was removed, 8 HCA, would you say, is among the bigger kind of 9 hospital systems that were -- that participated 10 in the survey? 11 A. Among participants in the survey, I think 12 they would be among the larger ones, I guess. 13 But in general, they're a very large health 14 system. 15 Q. Okay. So when they declined or did not 16 participate in the 2023 survey, did you view that 17 as kind of a loss to Leapfrog in terms of 18 hospital participation in the survey? Just given 19 the relative size. 20 A. Yeah. I mean, in terms of the hospital 21 participation numbers, it was maybe, like, a 22 3 percent drop for the year. But that's not Page 237

1 definitive of anything. I mean, I certainly 2 would want -- what I really wanted was HCA to 3 continue to participate because they had a 4 hundred percent participation for many, many 5 years, and, you know, we were very proud of them 6 for that. 7 Q. Did it upset you when they told you that 8 they weren't going to participate in the 2023 9 survey? 10 A. It was -- sure. I was very disappointed. 11 Because, again, they've been participating every 12 year at a hundred percent. And it's also been, 13 for me, inspiring that they participate like that 14 because they participate even though some of 15 their hospitals don't actually do that well in 16 the survey, but they're publicly reporting; 17 they're transparent to me. That is just a really 18 inspiring sign that the hospital industry 19 believes in transparency and really wants to do 20 something about patient safety. 21 So for me, they were inspirational. They 22 were an important player. Page 238	1 the Leapfrog hospital survey on nursing 2 workforce, which was causing -- they felt could 3 cause them some problems with some unions. 4 So they, you know, had said they wanted 5 us to take that off or reframe that question, 6 et cetera. We did not do that in the end and -- 7 because we are independent, we didn't do it. And 8 they still came back, which -- to their credit. 9 Q. Okay. 10 A. But that is the sole reason that they 11 suspended their participation, at least according 12 to them. 13 Q. Okay. Just one moment. 14 We're now going to move on to the 15 websites, Leapfrog's websites, that is. And 16 that's one of the topics that you've been 17 designated to testify as a representative from 18 Leapfrog. 19 A. Yes. 20 Q. How many websites does Leapfrog operate? 21 A. Two. 22 Q. Two. And those are -- Page 240
1 In terms of participation in the survey, 2 it caused a slight drop, but it wasn't anything 3 noticeable in terms of any -- it was noticeable 4 but it wasn't a big deal in terms of 5 participation. But in terms of our mission and 6 inspiration and really wanting role-model 7 hospitals involved in the survey, it was 8 disappointing. 9 Q. So was their declining to participate in 10 2023 one of the reasons that Leapfrog decided to 11 change its imputation methodology? 12 A. No. 13 Q. Okay. Did you, in fact, hold a grudge 14 against HCA for this period of time for not 15 participating in the survey? 16 A. No. 17 Q. Disappointed, but not a grudge? 18 A. Right. I talked to them a few times. I 19 actually met with them and -- to find out -- to 20 understand what the suspension was. I know what 21 it was. They told me what it was repeatedly, and 22 that is that they did not like the new measure on Page 239	1 hospitalsafetygrade.org is one of them, and then 2 the second one is leapfroggroup.org? 3 A. Yes. 4 Q. Is there another one called ratings.org? 5 A. Ratings.org is incorporated into 6 leapfroggroup.org. 7 Q. Okay. Do you know roughly how many views 8 each of these websites receives annually? 9 A. Yes. Since I prepared because I am the 10 34 -- what is it? 340(b)? Is that what I'm 11 called? 12 MS. BLAIR: 30(b)(6). 13 MR. CHUNG: 30(b)(6). 14 THE WITNESS: 30(b)(6), sorry. 15 Okay. So The Leapfrog Group website got 16 915,000 views from September 24 to September 25. 17 The Hospital Safety Grade website got 2.5 18 million in that same time period. 19 BY MR. CHUNG: 20 Q. Okay. Ms. Binder, so the notebook in 21 front of you contains -- is it notes to kind of 22 aid your testimony here today? Page 241

1 A. To prepare, yeah -- 2 Q. Okay. 3 A. -- for things I thought you would ask me, 4 particularly around -- in my role as 5 spokesperson -- 6 MR. CHUNG: We're going to ask your 7 counsel to make a copy of those -- 8 MS. BLAIR: Absolutely. 9 MR. CHUNG: -- and produce thereafter. 10 THE WITNESS: Happy to do that. 11 MS. BLAIR: Absolutely. 12 BY MR. CHUNG: 13 Q. Okay. Are you aware that, upon a Google 14 search of the words "hospital safety grade," 15 these are the two top website hits that come up: 16 Hospitalsafetygrade.org first and then followed 17 by leapfroggroup.org? 18 A. I think it depends on who's Googling. 19 Right? But -- 20 Q. Do you know? 21 A. Usually I see leapfroggroup first, but -- 22 I don't know. Page 242	1 18-or-so-page methodology document? 2 MS. BLAIR: Objection to form. 3 THE WITNESS: The methodology document 4 is -- I don't know how many pages it is, but it's 5 the document that's on the website. 6 BY MR. CHUNG: 7 Q. Okay. Has Leapfrog ever received 8 feedback from members of the public that the 9 scoring methodology for the hospital safety grade 10 is difficult to understand? 11 A. I don't recall any -- I don't recall 12 anybody complaining about that. 13 Q. Okay. Have either or both of the 14 websites been assessed by a low literacy or a 15 digital literacy expert? 16 A. The hospital safety grade website, yes, 17 has been. 18 Q. When was that? 19 A. When we launched it in about 2014. 20 Q. Okay. 21 A. And then it's -- every year periodically 22 we assess it ourselves and -- to see the literacy Page 244
1 Q. Okay. 2 A. One of them. 3 Q. Do either or both of Leapfrog's 4 websites -- those two -- provide an explanation 5 of Leapfrog's methodology behind its scoring? 6 A. I'm confused. So -- which one? Which 7 scoring? 8 Q. The scoring methodology. 9 A. For what? For the safety grade or for 10 the hospital -- the survey? Or -- 11 Q. The hospital safety grade. 12 A. So do either of the websites offer -- 13 Q. An explanation -- 14 A. -- of the scoring -- 15 Q. -- of that scoring -- 16 A. -- of the -- 17 Q. -- methodology. 18 A. -- hospital safety grade? The Hospital 19 Safety Grade website has the methodology spelled 20 out, and it has links to the methodology in 21 numerous places on the website. 22 Q. Okay. And the methodology is the Page 243	1 level that the site is appearing at. 2 Q. How do you assess it yourself? 3 A. You can -- you can run through a series 4 of questions about the literacy level and figure 5 it out to be, like, eighth grade or something, I 6 think, was the last one. 7 Q. Who does that from Leapfrog? 8 A. Trying to -- I think our communications 9 team looks at it. 10 It's not a -- they're not experts in low 11 literacy, so we don't have the funds to do a full 12 expert analysis, but it was designed by a low 13 literacy expert, who then taught us how we can 14 assess our site to make sure that it continues to 15 function at that level. 16 Q. Has an expert reviewed either or both of 17 the websites after the fall 2024 imputation 18 methodology change? 19 MS. BLAIR: I'm just going to object to 20 form. If you're asking about the expert in this 21 litigation or just any -- 22 MR. CHUNG: Any expert. Page 245

1 MS. BLAIR: Oh. 2 BY MR. CHUNG: 3 Q. A literacy or a digital -- low literacy 4 or digital literacy expert. 5 A. Well, for this litigation, we did have a 6 digital literacy expert -- 7 Q. Apart from this litigation, sorry. 8 MR. CHUNG: Thank you. 9 THE WITNESS: Apart from when we founded 10 it in 2014? 11 BY MR. CHUNG: 12 Q. Correct. 13 A. No. 14 Q. Okay. 15 MR. CHUNG: Let's get the next couple of 16 exhibits. 17 (Binder Deposition Exhibits 24 and 25 18 marked for identification and attached to 19 the transcript.) 20 BY MR. CHUNG: 21 Q. All right. So Ms. Binder, the next 22 couple of exhibits, which are Exhibits 24 and 25, Page 246	1 Q. Okay. And then you have to close out of 2 that pop-up box to view the information behind 3 it. Is that kind of the function -- 4 functionality of the website? 5 A. I believe so. 6 Q. Okay. Now, turning to the next exhibit, 7 25, the next one in front of you. 8 A. Oh. 9 Q. And this is what the page on 10 leapfroggroup.org looks like for Delray Medical 11 Center after you've closed out the pop-up box; is 12 that right? 13 A. Yes. 14 Q. Okay. And then it shows -- this 15 page shows that Leapfrog does not have enough 16 information to rate the hospital, correct, on 17 each of the metrics; is that right? 18 A. It shows they declined to respond. 19 Q. Right. Are there any footnotes or 20 asterisks next to any of the metrics? 21 A. No. 22 Q. Okay. And then the webpage says that the Page 248
1 are just -- they're printouts from the 2 leapfroggroup.org website. 3 Do they look familiar to you? 4 A. Yes. 5 Q. Okay. Terrific. 6 Now, on the Leapfrog -- just looking at 7 Exhibit 24 first -- all right? 8 A. Okay. 9 Q. And that's a screenshot of Delray Medical 10 Center's entry, right, or page from the 11 leapfroggroup.org website. 12 Do you see that? 13 A. It's a pop-up. 14 Q. Pop-up. Yes. Exactly. 15 And so on The Leapfrog Group website, 16 Leapfrog immediately shows a pop-up box, right, 17 notifying a user when a hospital has declined to 18 respond to the survey; is that right? 19 A. Yes. 20 Q. And when it says, Declined to respond, 21 what does that mean? 22 A. They declined to respond to the survey. Page 247	1 hospital, like you said, declined to respond next 2 to each and every one of those metrics, correct? 3 A. Right. 4 Q. And then -- but there's no safety grade 5 A, B, C, D, or F presented on the page, correct? 6 A. For the survey, we rate the 7 performance -- 8 Q. The question is, is there a safety 9 grade -- 10 A. No -- 11 Q. -- present on the page? 12 A. -- because we don't grade on the survey. 13 Q. Okay. So let's turn to the next couple 14 of exhibits. 15 MR. CHUNG: This will be 26. 16 (Binder Deposition Exhibit 26 marked for 17 identification and attached to the 18 transcript.) 19 BY MR. CHUNG: 20 Q. Now we're going to turn to pages from the 21 other website, hospitalsafetygrade.org website. 22 A. Yes. Page 249

1 Q. Do you recognize that kind of snapshot? 2 A. Yes. 3 Q. Okay. Unlike on the leapfroggroup.org 4 website, this website does not immediately show a 5 pop-up box indicating that a hospital did not 6 provide data, right, to Leapfrog, correct? 7 A. Yes. Because we have data for this 8 hospital for the safety grade. 9 Q. All right. But for the -- but it doesn't 10 show -- well, it doesn't the same pop-up that we 11 see -- that we saw with the leapfroggroup.org 12 website, correct? 13 A. Right. Because no one responds to the 14 survey, so -- I mean, to the grade. So -- and we 15 have lots of measures to grade the hospital. 16 Q. Okay. So you chose not to do a pop-up 17 for the hospitalsafetygrade.org website? 18 MS. BLAIR: Objection to form. 19 THE WITNESS: A pop-up to say what? 20 BY MR. CHUNG: 21 Q. That the hospital did not respond to the 22 hospital survey. Page 250	1 Q. -- this website. 2 And for the imputed metrics, like 3 handwashing, for example, they're set to the 4 lowest possible value, correct? 5 A. Yes. 6 Q. But they're not -- what you don't see 7 there is any sort of question mark with a decline 8 to report icon; is that right? 9 A. That's right. 10 Q. All right. But in fact, for those 11 imputed metrics, Delray, for example, declined to 12 report, right, those -- the metrics that normally 13 would be scored there, correct? 14 A. That's correct. And it's reported here 15 on the website. 16 Q. All right. And in fact, it's at the 17 bottom of the page, kind of below the fold, and 18 in footnotes, where Leapfrog discloses that the 19 hospital did not provide data to Leapfrog, 20 correct? 21 A. It's referenced through an asterisk 22 that's very large, and it's in red, so it's Page 252
1 A. Right. So we're not going to do a pop-up 2 since we have lots of measures on how this 3 hospital has done on patient safety. 4 Q. Okay. 5 A. So we don't need to say they declined 6 on -- 7 Q. This webpage, though, shows a safety 8 grade for the hospital, right? 9 A. Yes. 10 Q. And in this case, an F for Delray; is 11 that right? 12 A. Yes. 13 Q. And then it shows a score for each of the 14 imputed metrics, correct? The four out of the 15 30 -- 16 A. Uh-huh. 17 Q. -- imputed metrics? All right. Is that 18 a yes or no? 19 A. Yes. I'm sorry. Yes. 20 Q. And then there are these gas gauge scores 21 on -- 22 A. Yes. Page 251	1 pretty prominently displayed. 2 Q. Okay. So bottom of the page, correct? 3 A. Well, the asterisk is on the top of the 4 page, and the worst hospital score is also on the 5 top of the page. 6 Then the bottom of the page, which is 7 also fully on display on this page -- 8 Q. Yes. 9 A. -- is in bright red type. 10 Q. Okay. And that footnote says, The 11 hospital declined to report their performance on 12 this measure, so a score was assigned to reflect 13 the lack of information available; is that right? 14 A. Yes. 15 Q. Okay. It doesn't say how that score was 16 assigned, does it? 17 A. That is how it was -- that's how it was 18 done. It was assigned. 19 Q. But my question is, it doesn't say how -- 20 it says a score was assigned, correct? 21 A. That's how we got their score. 22 Q. But it doesn't say how the score was Page 253

1 assigned, correct? 2 MS. BLAIR: Objection to form. 3 THE WITNESS: That is how it was 4 assigned. That is how we got to the 15. It was 5 assigned. The hospital declined to report, so a 6 score was assigned to reflect the lack of 7 information available. That's how we got to 15. 8 BY MR. CHUNG: 9 Q. Okay. Let me put it another way. 10 That footnote does not explain or in any 11 way try to summarize, right, or distill the 12 imputation methodology by which the limited 13 achievement score was assigned for that metric, 14 correct? 15 MS. BLAIR: Objection to form. 16 THE WITNESS: That line does not describe 17 the imputation methodology, but it's certainly 18 well reported on the website. 19 BY MR. CHUNG: 20 Q. Is there a link to the survey methodology 21 next to this footnote anywhere? 22 A. I can't see below there, but no, not on Page 254	1 score; is that right? 2 MS. BLAIR: Objection to form. 3 THE WITNESS: It's the worst hospital 4 score. 5 BY MR. CHUNG: 6 Q. Yeah. 7 A. Those that report to the survey would get 8 a 15 if they did not meet the standard. It's an 9 extremely high standard. 10 Q. Does Leapfrog know that 15, this score, 11 is an actual reflection of Delray's CPOE score? 12 MS. BLAIR: Objection to form. 13 THE WITNESS: We imputed it based on 14 advice from the expert panel and our own 15 experience and knowledge of reporting on the 16 survey. 17 BY MR. CHUNG: 18 Q. Okay. Did Leapfrog or any of its 19 representatives visit Delray prior to issuing 20 this spring 2025 score? 21 A. No. 22 Q. And just -- Page 256
1 this page. 2 Q. Okay. 3 A. But there -- it's in plenty of other 4 places. 5 Q. So just kind of as an example for the 6 hand hygiene score, Delray here, for that imputed 7 metric, is it correct that they received a score 8 of 15? Is that right? 9 A. For -- 10 Q. Actually -- 11 A. It doesn't say -- 12 Q. Actually, a -- doctors order medications 13 through a computer. 14 A. Yeah. 15 Q. That one, they were scored a 15, correct? 16 A. Yes. 17 Q. And that's the limited achievement score, 18 right? 19 A. Yes. 20 Q. Okay. And is that the CPOE score? 21 A. Yes. 22 Q. All right. And 15 is the worst possible Page 255	1 A. We don't visit hospitals. 2 Q. And just -- you do not visit hospitals, 3 correct? 4 A. I don't personally visit hospitals 5 routinely. 6 Q. Okay. 7 A. Nor do most -- except to verify data, as 8 we described earlier. In our verification 9 process, we don't do routine visits. I actually 10 do a lot of visits in general with some of our 11 regional leaders to see hospitals. 12 Q. But for purposes of verifying data, no, 13 correct? 14 A. Right. No. 15 Q. All right. And then Leapfrog has not 16 received data from Delray on the CPOE metric, 17 correct? 18 A. Well, in the past we did. 19 Q. For purposes of this round. 20 A. No, we have not received data, nor have 21 they taken the test that we give hospitals that 22 report to the survey to determine if their CPOE Page 257

1 system is safe for their patients. That is an 2 intensive test that most hospitals, when they 3 first go in, don't pass. So we haven't had -- 4 they haven't taken that test either. 5 Q. So does Leapfrog -- just standing here 6 today, does Leapfrog believe 15 is an accurate 7 score for Delray's CPOE? 8 MS. BLAIR: Objection to form. 9 THE WITNESS: We believe in the -- we 10 believe the imputation -- the imputation is the 11 most accurate information available on this 12 hospital's performance on this measure. 13 BY MR. CHUNG: 14 Q. So the question is, does Leapfrog believe 15 15 is an accurate score for Delray's CPOE? 16 MS. BLAIR: Objection to form. 17 THE WITNESS: We believe it is the most 18 accurate possible. 19 MR. CHUNG: Okay. This will be 20 Exhibit 27, Ms. Binder. 21 22 Page 258	1 wants something else that makes it sound like the 2 data we imputed wasn't random. 3 Is Ms. Campione correct that this is what 4 you wanted -- 5 MS. BLAIR: Object to form. 6 BY MR. CHUNG: 7 Q. -- that you wanted something else that 8 makes it sound like the data we imputed wasn't 9 random? 10 A. The wording is off, but she was going in 11 the right direction in terms of what I expect in 12 terms of all public reporting efforts. 13 Q. So -- 14 A. I don't believe the data is random, and I 15 wouldn't have used that word, but I do want 16 absolute clarity and bluntness for the public so 17 they understand that this data was not 18 calculated. I think that was what Paulina was 19 suggesting. And I didn't want that because that 20 would be an inaccurate assessment of what the 21 imputation was. 22 Q. Okay. Now I'm going to direct your Page 260
1 (Binder Deposition Exhibit 27 marked for 2 identification and attached to the 3 transcript.) 4 BY MR. CHUNG: 5 Q. Now, is -- this is an e-mail thread from 6 June of 2024. 7 Is this a discussion about the appearance 8 of the footnote on the Hospital Safety Grade 9 website? 10 A. I believe that's what it is. Yes. 11 Q. Okay. I'm going to direct your to 12 attention to page 3 of the document. It's Bates 13 ending 7865. It's an e-mail from Paulina Litter 14 to Ms. Campione. 15 And she asked about this language and she 16 writes, Maybe we can change it to say, so a score 17 was calculated using imputation for the measure. 18 Do you see that? 19 A. Yes. 20 Q. All right. And then in the preceding 21 page, Bates ending 7864, Ms. Campione responds, 22 That was the language Missy wanted, but Leah Page 259	1 attention to page 1 of the document, Bates ending 2 7863. 3 And you see that Ms. Campione is 4 responding to suggestions for language from 5 Ms. Litter by explaining that we can't say 6 external data sources because we're arbitrarily 7 assigning them points associated with the bottom 8 scoring category. 9 And then she continues: Leah wants us to 10 make it sound like the expert panel approved it 11 and the assigning of these points was legitimate. 12 Do you agree with Ms. Campione that 13 Leapfrog's imputed metrics in this new 14 methodology did, in fact, assign the lowest 15 available score? 16 A. As step 2 we did. 17 Q. Right. Step 2. 18 A. And -- but it's not arbitrary. I don't 19 agree with the word "arbitrarily." 20 Q. She -- well, she used the word 21 "arbitrary," so -- 22 A. I disagree with her use of the word Page 261

1 "arbitrary." 2 Q. Okay. Why do you disagree with her use 3 of the word "arbitrary"? 4 A. It wasn't arbitrary. It was very 5 well-thought-through. 6 Q. Right, but it is -- 7 A. And very carefully vetted with experts 8 and 20 years of experience with hospital surveys 9 and hospitals. 10 So we put a lot of thought into how this 11 was done. It wasn't arbitrarily assigned. 12 Q. But it is a score, the limited 13 achievement score, that is automatically assigned 14 to -- 15 A. No. 16 Q. -- non-participating hospitals, correct? 17 A. Yes. 18 Q. Okay. 19 A. Well, non-participating hospitals that 20 don't have any data to give us from the year 21 prior. 22 Q. Yeah. Always got to remember step 1. Page 262	1 A. Well, she's doing a very good job of 2 editing the language that would ultimately appear 3 on our website. I think she did a great job here 4 in working with Paulina to try to get at this 5 rather difficult-to-word statement to make 6 certain that it's clear and precise and that the 7 public can understand it. So she did a good job 8 with that. 9 Q. So putting the discussion aside, why 10 doesn't Leapfrog use the same disclosures related 11 to non-participating hospitals on both of the 12 websites, Hospital Safety Grade and Leapfrog 13 Group? 14 MS. BLAIR: Object to form. 15 THE WITNESS: The same which disclosures? 16 BY MR. CHUNG: 17 Q. Relating to non-participating hospitals. 18 A. So -- we do. We say declined to -- for 19 the measures that hospitals declined to respond 20 to, we put that on the safety grade website for 21 those measures. But those are a subset of the 22 many more measures that we are grading. Page 264
1 A. Yes. 2 Q. And do you agree with Ms. Campione that 3 you wanted to make it sound like the expert panel 4 approved this methodology? Right? 5 A. Well, the wording on this is also 6 something -- you know, I wouldn't have -- it 7 isn't ideal, but it's what happens when people 8 are just quickly e-mailing each other. Because 9 it is, in fact, the case that the expert panel 10 approved this, and assigning these points was 11 completely valid. 12 So I -- but I also want our communication 13 of this to be clear to the lay public. 14 Q. Okay. 15 A. So I don't -- the wording here makes it 16 sound like I'm trying to fake something. I'm 17 not. I don't -- it's the opposite. I want us to 18 be very upfront and very clear with the public on 19 what we're doing and why we're doing it. 20 Q. Were your employees, like Ms. Campione, 21 concerned that Leapfrog was not being transparent 22 using this methodology? Page 263	1 On the Leapfrog survey, it's everything, 2 because they don't respond to the entire survey. 3 So therefore, it's a different way of portraying 4 that message. But it is -- "declined to report" 5 is on both websites. 6 Q. Let me kind of slice it a little finer. 7 A. Okay. 8 Q. So given that the leapfroggroup.org 9 website doesn't have the grades for the 10 hospitals, the health safety grades for the 11 hospitals, nor does it show any imputation of 12 scores for those non-participating hospitals -- 13 that's one, right? But on the other hand, the 14 hospitalsafetygrade.org website shows a hospital 15 safety grade for a hospital and, for a 16 non-participating hospital, shows the limited 17 achievement score -- right? -- for the imputed 18 metrics, isn't Leapfrog confusing visitors to 19 both websites about how it scores hospitals that 20 did not participate in the hospital survey? 21 MS. BLAIR: Objection to form. 22 THE WITNESS: We're doing the opposite. Page 265

1 We're being extremely blunt and extremely 2 transparent. We are showing all of the measures 3 that are used and -- to calculate the hospital 4 safety grade, of which the vast majority we do 5 have data from CMS for. And for those that we 6 impute, we're very blunt about that. You can see 7 it immediately. 8 Most -- in fact, I don't know of any 9 other public reporting ratings in healthcare that 10 offers that level of transparency of giving you 11 every single measure and how the hospital did on 12 every single measure. 13 So we are -- we go out of our way to be 14 extremely transparent. 15 BY MR. CHUNG: 16 Q. Okay. I'm not sure that's responsive to 17 the question. 18 Do you acknowledge that there are those 19 differences, however, for a non-participating 20 hospital, how they're presented between the 21 Hospital Safety Grade dot [sic] website and the 22 Leapfrog Group website? Page 266	1 BY MR. CHUNG: 2 Q. Yeah. Has Leapfrog ever considered 3 standardizing or harmonizing the disclosures 4 relating to non-participating hospitals between 5 the two websites? 6 MS. BLAIR: Objection to form. 7 THE WITNESS: So can you give me an 8 example of what you might mean by that? 9 BY MR. CHUNG: 10 Q. Do you -- let me put it this way. Do you 11 see any inconsistency between the two websites 12 with regard to how non-participating hospitals 13 are presented? 14 A. They are two different programs, so we 15 communicate performance of hospitals two 16 different ways. But we use the same term, 17 "declined to participate," as it applies to the 18 measures that we ask for in the survey. We do 19 that on the website for the survey and we do that 20 for the measures, applicable measures, on the 21 hospital safety grade. 22 Q. Okay. And is that clear -- are you -- is Page 268
1 MS. BLAIR: Objection to form. 2 THE WITNESS: Well, they're two different 3 things, so they're -- but the words "declined to 4 report" are applied appropriately. 5 BY MR. CHUNG: 6 Q. Okay. They're two different things. 7 A. Well, the survey is a voluntary survey 8 that they can choose not to participate in or to 9 participate in. If they decline, then we are 10 just saying, overall, they declined. 11 Whereas the hospital safety grade is 32 12 measures and, for most of them, we have data and 13 we are grading them. 14 Q. Has Leapfrog ever considered 15 standardizing the disclosures or the presentation 16 of information regarding non-participation -- 17 non-participating hospitals between the two 18 websites? 19 MS. BLAIR: Objection to form. 20 THE WITNESS: I'm not really clear on 21 that. Can you -- 22 Page 267	1 that distinction made clear to the consumer? 2 A. It's clear on the website -- on the 3 Hospital Safety Grade website, it's very clear. 4 Q. Okay. How about on the leapfroggroup.org 5 website? 6 MS. BLAIR: Objection to form. 7 THE WITNESS: So -- 8 BY MR. CHUNG: 9 Q. Let me put it this way: Is it your 10 expectation that a low literacy consumer -- 11 right? -- visitor to the websites will understand 12 that distinction? 13 MS. BLAIR: Objection to form. 14 THE WITNESS: They will understand 15 "declined to report" and they will understand, 16 for each of the measures, how we got them. 17 BY MR. CHUNG: 18 Q. Okay. But that would require -- that 19 would require this -- the low literacy consumer 20 to visit both websites, correct? 21 MS. BLAIR: Objection to form. 22 THE WITNESS: No. They can visit just Page 269

1 the Hospital Safety Grade website? Is that the 2 one you're focused on right now? Or which one do 3 you want me to answer to? 4 BY MR. CHUNG: 5 Q. Well, if they visited both websites -- 6 right? -- is the expectation that they would -- 7 they would not be confused -- right? -- by the 8 different information covered between the two 9 websites? 10 A. It's not different information, for one 11 thing. But the second thing is most -- the 12 Hospital Safety Grade website was designed for 13 the purpose of consumers doing their own personal 14 research. The hospital -- the leapfroggroup.org 15 has not been designed for consumers primarily. 16 It's designed for -- particularly for purchasers. 17 Q. But -- 18 A. So they're designed for different 19 purposes. But that said, I think it's very clear 20 to anyone who visits those sites exactly where we 21 got the data, or didn't. 22 Q. Okay. I'm going to move on to another Page 270	1 sources of revenue. Yes. 2 Q. Okay. Let's turn to -- and what, 3 generally speaking, has been the total revenue 4 for Leapfrog this past year? 5 A. It was around -- I think around 6 8 million. 7 Q. Okay. And has that -- has there been, 8 like, an increase over time since you've been 9 CEO? What's been the trend in terms of total 10 revenue? 11 A. The average increase in revenue has been 12 11.5 percent. 13 Q. So that's year over year, there's been an 14 increase of about 11.5 percent. 15 A. On average, yes. 16 Q. To what revenue sources do you attribute 17 that kind of year-over-year increase? 18 A. Really, all of them. We've had a major 19 increase in every single category of revenue. 20 But the largest bump came when we launched the 21 hospital safety grade and we began selling the 22 accolade license. So when hospitals get an A, Page 272
1 topic. Leapfrog's revenue sources is topic 8 2 among the 30(b)(6) topics. 3 I think you testified earlier -- and you 4 can correct me if I'm wrong -- but the most 5 significant sources of data today, and for some 6 period of time, have been the accolade licensing 7 program and the data licensing program; is that 8 correct? 9 A. Not sources of data. 10 Q. Source -- I'm sorry, revenues. 11 A. Revenues. 12 Q. Revenue sources. 13 A. The largest source -- well, I testified 14 about -- you asked me about the first year of -- 15 that I was at Leapfrog? I think. 16 Q. Yes. Well, let me just ask it another 17 way. 18 So are accolades licensing -- are the 19 accolades licensing and the data licensing 20 programs the two most significant sources of 21 revenue for the organization today? 22 A. Right now, those are the two largest Page 271	1 they can purchase -- for their own commercial 2 purposes, they're allowed to use the -- under 3 strict rules, they're allowed to use the A logo. 4 Q. Okay. 5 MR. CHUNG: Let's go to 27 and 27a. 6 Exhibit 28 and Exhibit 29. 7 (Binder Deposition Exhibits 28 and 29 8 marked for identification and attached to 9 the transcript.) 10 BY MR. CHUNG: 11 Q. So Ms. Binder, Exhibit 28 is an e-mail 12 chain from about April of 2024, and then there's 13 an attachment with some tables in it. 14 I'm going to be asking questions, really, 15 mainly about the e-mail, so if you want to take a 16 look at that. 17 A. Okay. 18 Oh, yeah. Okay. Yeah, I remember this. 19 Q. Okay. So who is Ben Choi? 20 A. He was an advisor on finance for Leapfrog 21 for about a year. 22 Q. Okay. Am I right that he was the interim Page 273

1 CFO for a period of time? 2 A. That was not his title, but he functioned 3 in some ways as a -- almost like a CFO. Maybe 4 not quite that significant a role, but he was -- 5 he was the key finance person. 6 Q. Okay. And Josh Berlin, who is that? 7 A. Josh is the president of the consulting 8 firm that Ben came from. And Josh also has 9 consulted with us and advised us on sort of 10 different projects and strategies. 11 Q. Okay. Now, just turning to the second 12 page of the document, Bates ending 8279. Just 13 looking at Mr. Choi's e-mail to you, under 14 recommendation -- under realistic views, Mr. Choi 15 writes that they are forecasting to fall short on 16 top-line revenue by \$540,000. 17 Do you see that? 18 A. Yes. 19 Q. Okay. Then directing your attention to 20 the recommendations section toward the bottom of 21 the page -- 22 A. Yes. Page 274	1 Why do you want managers focused on 2 revenues 24/7? What is that comment? 3 A. So the survey and the hospital safety 4 grade are extremely expensive. They are -- and 5 from my perspective as the CEO of the 6 organization, I see them on the expense 7 line entirely. They are -- they're very, very 8 expensive to do them the way we do them, which is 9 first class. 10 So in order to maintain -- when you have 11 ups and downs and the exigencies of life, we will 12 not compromise on the integrity and the 13 excellence of our surveys and our hospital safety 14 grade. So my job is to make sure that we have 15 the funding to do that. 16 He talks about how we could cut staff 17 lunches or something like that. And I was like, 18 no, no, we've got to look at how we raise the 19 money that we need to maintain and sustain the 20 survey in a year when we had a contract that was 21 delayed that -- and another one that we canceled. 22 So there were just a couple of things Page 276
1 Q. -- he writes, Push really hard on 2 high-yield revenue opportunities. 3 And he lists membership, accolades, 4 annual meeting sponsorships. 5 Do you see that? 6 A. Yes. 7 Q. What does membership refer to here? Is 8 that the partners advisory committee? 9 A. Yes. 10 Q. Okay. And then accolades here refers to 11 what you testified to, the accolades licensing 12 program -- 13 A. Yes. 14 Q. -- is that right? 15 All right. And then directing your 16 attention to the first page, you respond, If we 17 move toward cost reduction as the primary 18 strategy, it will be much more severe than this, 19 but I'm not going there for now. We can address 20 incremental spending issues, but let's not lose 21 focus on what managers should be thinking about 22 24/7, which is revenues. Page 275	1 that were blips in the road. In the end, we 2 broke even at the end of the year. But I will 3 say that, for me, it was just we've got to raise 4 the money because we're not going to compromise 5 on the survey or the safety grade, which are 6 costs to us. 7 Q. All right. So the focus, just given the 8 expenses that you outline here, is that the 9 managers should be focusing on how to generate 10 revenues, correct? 11 A. They should -- everyone in the 12 organization, everyone in any nonprofit 13 organization, as to be thinking about fundraising 14 and revenue generating because that's how we 15 survive. 16 Q. Okay. And then you continue by saying 17 that you want managers focused on where they can 18 generate bookable revenues, and then you list a 19 number of bullet points, I think, are your ideas. 20 Do you see that? 21 A. Oh, yeah. Yeah. 22 Q. Okay. What do you mean by bookable Page 277

1 revenue? 2 A. Revenues that we -- that we can 3 incorporate into our statement at -- statements. 4 Q. Okay. 5 A. Bookable meaning, like, from an 6 accounting point of view, they are -- they meet 7 accounting principles for what we can -- what we 8 can recognize. 9 Q. Okay. And then you see there is a second 10 bullet point here: I have a nuclear strategy for 11 the CPOE report sales, which I will tell you 12 about tomorrow. 13 Are the CPOE reports part of the kind of 14 data licensing program? 15 A. They didn't exist then and they still 16 don't but -- well, not really. My thought had 17 been we have a lot of information on how 18 hospitals do on the CPOE test. We talked about 19 earlier where we test hospitals on how good a job 20 their systems do in alerting physicians to errors 21 that they may be making in their prescribing. 22 These are errors that would result in death or Page 278	1 use their grade in their own, you know, 2 advertising or other commercial purposes. 3 So what I was suggesting is, let's have a 4 sale and discount -- let's try to really improve 5 the sales of the accolades for that particular 6 time period, given this is a challenging year. 7 Q. Okay. So it's through the use of 8 discounts and sales that you'll be pushing more 9 accolade sales during this time period; is that 10 right? 11 A. We would be -- I'm not sure what you mean 12 by pushing, but we would be offering discounts 13 to -- 14 Q. I'm just using your language here. 15 A. I don't say pushing, do I? 16 Q. Pushes. Yeah. 17 A. Oh, okay -- 18 Q. Special discounts. 19 A. Okay. Discounts and sales. Yeah, 20 discounts and sales strategy to try and improve 21 our sales on accolades. 22 Q. Okay. There is a -- expand marketing Page 280
1 really harm to the patient. It's a great test. 2 And my nuclear strategy, it turns out we 3 were already doing it. So actually, when I look 4 at it, I'm, like, oh, geez -- 5 Q. Okay. 6 A. -- embarrassed because we already were 7 doing it. Which is -- I said, let's just give 8 the hospitals -- let's give them their own 9 results for free. Just give it out. 10 Q. So a few bullet points down, We should 11 plan for special discounts or sales, pushes 12 around accolade sales to get more in late May and 13 June. 14 What did you mean there? 15 A. Well, we issue safety grades twice a 16 year. So we issued -- when was this dated? So 17 we issued the update to the safety grade probably 18 right around the time -- probably after this, 19 somewhere around when this e-mail was written. 20 And when we're issuing the safety grade 21 update, that's when we sell to hospitals that get 22 an A. We offer them an opportunity to buy and Page 279	1 around the certified coach program. 2 A. Uh-huh. 3 Q. Can you descibe -- tell us what you were 4 referring to there? 5 A. Just do additional marketing to encourage 6 enrollment in the certified coach program. 7 Q. Okay. And this was another revenue 8 generator? 9 A. It was a strategy that we could think 10 about for generating more revenue. 11 Q. Okay. And can you -- how much -- what 12 are the fees or the charges associated with the 13 certified coach program? 14 A. I think it's, like, \$900 or something per 15 participant. 16 Q. Okay. And then the last bullet point, 17 There's a lot of attention to us around the 18 hospital safety grade release. How do we harness 19 that? More for marketing. 20 What did you mean there? 21 A. We get a lot of exposure and attention, 22 so we -- this would give us an opportunity -- for Page 281

1 instance, when we get a lot of exposure and 2 attention on anything we do, we'll get interest 3 in all of our programs. We'll suddenly start to 4 get interest in our partnership programs or our 5 annual meeting enrollments or registrations. It 6 just gins up a lot more interest. And we should 7 make sure we're strategic about that. 8 Q. And does that include more interest 9 around the hospital safety grade -- the accolade 10 licensing program as well? 11 A. Oh, yeah. 12 Q. Okay. And for the data licensing 13 programs as well? 14 A. Yeah, we usually get inquiries to the 15 data licensing program if we get a lot of 16 attention. 17 Q. Okay. And as part of that -- the -- part 18 of the marketing strategy that -- with the 19 release of hospital safety -- hospital safety 20 grades, is part of the marketing strategy to -- 21 to let the public know how many hospitals have 22 received hospital survey grades -- hospital Page 282	1 that right? 2 A. Yes. 3 Q. Right? And -- 4 A. Well, no, on accolade sales. 5 Q. Right. And so TelAffects does market the 6 hospital safety grade program, correct? 7 A. Yes. Yes. 8 Q. Right. So it's not just publicizing the 9 hospital safety grade program; they actually do 10 market the hospital safety grade program; is 11 that -- 12 A. They don't publicize it. They market. 13 And they're kept as arm's lengths from us for 14 that very reason. We on the Leapfrog side, and 15 with our PR firm, we publicize it; we try to get 16 conversations going about patient safety and 17 awareness around patient safety and the 18 importance of it. That is -- and that's central 19 to our mission as well. 20 Q. But TelAffects works for Leapfrog, 21 correct? 22 A. Yes. Page 284
1 safety grades, I'm sorry? 2 A. We don't market the hospital safety grade 3 to the public. 4 Q. Okay. Do you -- 5 A. We publi- -- 6 Q. How is that? 7 A. Well, we publicize it. 8 Q. What's the -- 9 A. That's different. 10 Q. -- difference between marketing and 11 publicizing? 12 A. Well, marketing is when you run an ad or 13 you send out an e-mail that's from you saying, 14 you know, buy this, or something like that. 15 PR is when you go to the press and you 16 say, here's a great story, and they cover it on 17 their own. So it's different. 18 Q. Am I right that you have a vendor -- a 19 marketing or a telemarketing vendor called 20 TelAffects? 21 A. Yes. 22 Q. That assists you on various marketing; is Page 283	1 Q. You pay TelAffects to market it, the 2 accolade licensing program. 3 A. Yes. We're really proud of that program. 4 It's very successful. And it's accomplished -- 5 what's great about it is that it raises money for 6 us, which is very important, because we don't 7 survive without that. No money, no mission, if 8 you've ever heard that phrase. 9 But at the same time, even as it's 10 raising money for us, it's serving the mission 11 directly. Because when hospitals advertise an A 12 and tout their record on patient safety, both 13 externally to their community and internally to 14 their staff and their -- often they'll use it, 15 for instance, for nurses week. When they do 16 that, we are calling attention to the importance 17 of patient safety in brand new ways, and it's, I 18 think, it's very powerful and something that 19 we're proud to see happening. 20 Q. And when the hospitals tout their 21 grades -- typically it's an A grade that they 22 tout, right? Page 285

1 A. Yeah. Usually. 2 Q. And that's actually -- when hospitals do 3 that, that's actually good for Leapfrog's brand 4 as well. 5 Would you agree with that? 6 A. Yeah. 7 Q. Okay. 8 A. Well, it's mostly good for our mission. 9 Q. Right. Well -- okay. 10 And would it be fair to say that the more 11 hospitals that -- tout their grades, the better 12 it is for Leapfrog's brand? 13 A. I've never thought of it that way, but 14 maybe. 15 Q. Okay. I mean, that goes hand in hand 16 with -- you've testified to this at least a few 17 times already, that it's -- Leapfrog wants as 18 many hospitals to participate in the survey as 19 possible, correct? 20 A. Well, that's a different -- that's a 21 different issue. 22 Q. Right. Page 286	1 BY MR. CHUNG: 2 Q. So Ms. Binder, Exhibit 30 is a document 3 entitled, Leapfrog long-range strategic intent 4 for fiscal year 2026 to '32. 5 A. Yes. 6 Q. Board approved, September 2024. 7 Have you seen this document before? 8 A. Yes, I have. 9 Q. Okay. 10 A. The part that's board approved is the 11 first page. 12 Q. All right. Were you involved in putting 13 together this document? 14 A. Yes. 15 Q. All right. Now, if you turn to the 16 second page, Bates ending in 7794, you'll see 17 that, up top, objective 1 is to scale resources 18 to the capacity needed to make giant leaps for 19 patient safety and stop avoidable death and 20 suffering. 21 Do you see that? 22 A. Yes. Page 288
1 A. Because the hospital safety grade is 2 different. We give a grade to every hospital 3 that's qualified, for one, regardless of whether 4 they report to the survey. So it's a separate 5 issue. 6 Q. Right. But hospitals -- for those that 7 choose to respond, hospitals that respond to the 8 hospital survey, that data is used -- it's not 9 the only source of data -- is used to generate a 10 hospital safety grade for that hospital, correct? 11 A. It's certainly part of their grade. Yes. 12 Q. Okay. 13 A. And that's good or bad. So if they don't 14 do well on the survey -- which is a high bar, so 15 a lot of hospitals don't do well -- it could have 16 caused them to have a lower grade. 17 Q. Okay. 18 MR. CHUNG: Let's go to tab 28b. 19 Exhibit 30. 20 (Binder Deposition Exhibit 30 marked for 21 identification and attached to the 22 transcript.) Page 287	1 Q. And then, within that first objective, 2 there are a series of goals underneath, correct? 3 A. Yes. 4 Q. In the left-hand column. It says goal up 5 top. 6 A. Right, right. 7 Q. Yeah. And then the first, quote/unquote, 8 goal is to expand revenue from existing sources, 9 and then it goes through a series of revenue 10 sources, correct? Is that right? 11 A. Yes. 12 Q. Okay. So increasing Leapfrog's revenue 13 is at least the first mentioned goal behind this 14 objective, right? 15 A. Yes. 16 Q. All right. So under that, there are a 17 number of benchmark indicators there. Just 18 looking through, are those still accurate in 19 terms of the revenue? 20 A. These -- the benchmark indicators were 21 not actually finalized, so -- but they're 22 relatively accurate. Page 289

1 Q. Okay. How are they determined? 2 A. They were proposed by the management 3 team. We asked them to look at this, and then we 4 had an iterative process to consider at the 5 senior management team. 6 But as I said, I don't believe they're 7 final. In fact, I know that they're not final. 8 Q. Okay. Are these goals, the benchmark 9 indicators, are they communicated to Leapfrog 10 staff? Are they communicated to Leapfrog staff 11 generally? 12 A. We shared -- again, I don't know if this 13 is the final benchmark indicator as I look at it, 14 but we share whatever the board approves or the 15 board determines, yes. 16 Q. Okay. They may not be final, but I think 17 your testimony is that they're generally what you 18 understand the relevant benchmarks to be, 19 correct? 20 A. Relatively, yes. 21 Q. All right. So we've got September 2025, 22 \$9 million in revenue. And then, three years Page 290	1 program, given that it's, you know, the most 2 significant revenue source? 3 A. Well, I think if you look at the goal 4 itself, we've talked about having less dependence 5 on accolade revenue as a percent of overall 6 revenue. 7 Q. Right. 8 A. Our board believes strongly in the 9 program and that it is serving our mission to 10 have the accolade program, that it's very 11 successful in terms of raising money. But they 12 want us to have other -- just diversify our 13 revenue sources over time so that we are less 14 dependent on that one source. 15 Q. Okay. Let's move on to -- if you look at 16 objective 3. So this goes to page -- the Bates 17 ending 7797. 18 A. Okay. 19 Q. Okay. And then you'll see, under the 20 goal here, the general public create 21 communication strategies that make the hospital 22 safety grade and Leapfrog itself household names. Page 292
1 later, a benchmark of 12 million. And then, 2 three years later for 2031, a benchmark of 3 \$18 million. 4 Do you see that? 5 A. Yes. 6 Q. Okay. How do these goals, the benchmark 7 indicators, influence -- you know, going up 8 3 million -- roughly 3 million per year, how do 9 they influence how you approach changes to the 10 hospital safety grade program? 11 MS. BLAIR: Objection to form. 12 THE WITNESS: I don't think of those in 13 the same way. So as I said, the hospital safety 14 grade program is expensive. So what -- the 15 influence I see is raising money to be able to 16 sustain it and do it in better and better ways. 17 BY MR. CHUNG: 18 Q. Right. And the safety -- if the hospital 19 safety grade program is -- actually, let me put 20 it another way. 21 How do these -- how do these goals 22 influence how you approach the accolade licensing Page 291	1 Do you see that? 2 A. Yes. 3 Q. Okay. And so that's -- is another way of 4 putting that coming up with strategies with the 5 general public that increase or elevate the brand 6 of Leapfrog in the hospital safety grade? 7 A. We're just trying to make people aware of 8 the hospital safety grade. 9 Q. To the point where they're household 10 names; is that right? 11 A. Yes. 12 Q. Okay. And then one way to do that, or at 13 least one of the metrics, is just the number of 14 annual visits to the websites; is that right? 15 A. Right. 16 Q. Okay. And the goals here, the proposed 17 metrics, are to increase by 30 percent by 2028 18 and then by 100 percent for 2031. 19 Do you see that? 20 A. Yes. 21 Q. And how did you arrive at those goals? 22 A. As I said, I think this is an earlier Page 293

1 draft which kind of says X number, so that tells 2 me it's a draft -- 3 Q. Yeah. 4 A. But -- and so there's -- it's just -- 5 we're trying to set a six-year target for the 6 organization and then monitor that progress over 7 time. That's the purpose of the intent. 8 Q. Okay. Now, if you go down a few more 9 cells, under goal, it says, Purchasers/employers: 10 Enable purchasers and their contractors to tie 11 Leapfrog ratings to payment decisions. 12 A. Yes. 13 Q. Do you see that? 14 A. Uh-huh. 15 Q. All right. Now, in order to accomplish 16 this particular goal, isn't it correct that 17 Leapfrog has to convince purchasers and employers 18 that the Leapfrog ratings have value? 19 A. We have hundreds, if not thousands, of 20 employers and purchasers that are part of this 21 movement, so they are already -- not only do they 22 see value, they feel like they're part of Page 294	1 So we have the engagement. But one of 2 the things that we always want to encourage more 3 employers to do is to think about how they are 4 contracting and paying for care in such a way 5 that they are incentivizing patient safety and 6 quality. 7 Q. Right. So in order -- so in order for 8 purchasers and employers to continue to be 9 engaged, is it fair to say that it's important 10 for Leapfrog to maintain or increase the value of 11 its ratings programs? 12 MS. BLAIR: Objection to form. 13 THE WITNESS: In what way do you mean 14 increase value? 15 BY MR. CHUNG: 16 Q. Convince -- basically convince -- 17 increase value by at least maintaining or even 18 increasing the number of hospitals that 19 participate in the survey. 20 MS. BLAIR: Objection to form. 21 THE WITNESS: That has -- that has not 22 been something we've tied to the Page 296
1 creating it. 2 So certainly we've got to engage as many 3 employers and purchasers as we can, but we have a 4 lot of them involved, which is what has been a 5 key success factor for the organization. 6 Q. But Ms. Binder, this is not -- this is 7 enumerated as a goal, not as the status quo, 8 right? The goal is to enable purchasers and 9 their contractors to tie Leapfrog ratings to 10 payment decisions, right? 11 A. Right. It's a long-term strategic 12 intent, and we want to always expand on how 13 purchasers and influencers use Leapfrog data. 14 We have purchasers -- we don't need to 15 convince them that Leapfrog is important. That 16 is -- I mean, there's always going to be 17 additional purchasers, I'm sure, we could bring 18 into the fold. But we have a lot of them already 19 engaged. They are the ones asking hospitals to 20 please report to the survey. They are very 21 actively involved with Leapfrog. They founded 22 Leapfrog. Page 295	1 purchaser/employer strategy. 2 BY MR. CHUNG: 3 Q. Okay. So under health plans, if you go 4 down a couple more cells, it reads, Pressure 5 plans to tie Leapfrog ratings to payment 6 decisions. 7 What does that mean? 8 A. Employers in particular have been vocal 9 with us on the need for them to come together 10 through Leapfrog to get health plans to tie 11 Leapfrog ratings, such as on patient safety and 12 quality, to its payment decisions. And one 13 employer will have a very difficult time having 14 any influence at all on a health plan, so they 15 look to Leapfrog as part of our core mission to 16 be able to be the voice for health plans getting 17 pressure from their own clients on the importance 18 of not just paying fee for service but actually 19 paying for excellence that you're looking for. 20 Q. So how does Leapfrog pressure plans to 21 tie Leapfrog ratings to payment decisions? 22 A. We bring employers together to say, we Page 297

1 want to see this and, what are you doing for it? 2 Q. Okay. Is the goal here to steer health 3 plans away from hospitals that do not participate 4 in the hospital survey? 5 A. No. That's not the goal, no. 6 Q. Has Leapfrog been successful in 7 pressuring these health plans to tie Leapfrog 8 ratings to payment decisions? 9 A. In some cases, but not -- not in an 10 overwhelming way. 11 Q. Okay. 12 MR. CHUNG: Let's go to tab 29b. 13 This will be Exhibit 31. 14 (Binder Deposition Exhibit 31 marked for 15 identification and attached to the 16 transcript.) 17 BY MR. CHUNG: 18 Q. All right. Ms. Binder, Exhibit 31 is a 19 memorandum to the board of directors' executive 20 committee dated February 25 of 2024. 21 A. Okay. 22 Q. Okay. Page 298	1 Q. Okay. 2 A. We were not satisfied with the way they 3 were portraying those hospitals and how they were 4 doing it, so we ended up -- we ended the 5 contract. 6 We are extremely picky about how those 7 things get done. 8 Q. Okay. 9 A. And so we ended that contract. 10 And then the other -- 11 Q. Actually, I was going to -- 12 A. Oh. 13 Q. We don't need to go over the other ones. 14 But going down a couple of paragraphs 15 starting with -- the paragraph starting, We have 16 areas of challenge ahead with regard to licensure 17 of our data and continuing growth of development 18 revenues. 19 Do you see that? 20 A. Yes. 21 Q. And why were you facing challenges along 22 these lines? Page 300
1 A. Let me just refresh my memory reading 2 through this. 3 Q. Sure. 4 A. Okay. 5 Q. Okay. Did you write this document? 6 A. Yes. 7 Q. All right. And in the second 8 paragraph you write that revenues were lower than 9 what we originally budgeted; they exceeded 10 expenses. 11 A. Yeah. 12 Q. And you cite, Ending the Money contract, 13 continuing delays in the Defense Health Agency 14 contract and struggles with Cigna. 15 A. Uh-huh. 16 Q. What is the Money contract referring to? 17 A. We had a contract with the -- it's like a 18 website called Money. It used to be Money 19 Magazine in the old days. And they asked us to 20 help them to issue an accolades program. So in 21 other words, Money top hospitals and things like 22 that. Page 299	1 A. Raising money is always a challenge in 2 any nonprofit. So in particular, in our case, 3 licensure of the data -- I think we'd had -- we 4 had a contract drop. We usually -- for licensure 5 contracts, we have very, very little churn. We 6 have very little dropouts. And Cigna had dropped 7 out. It was very disappointing to us. So I 8 think I was probably referring to that. 9 And in addition, we would really like to 10 see the growth in our licensure program. We're 11 really proud of that program too. That one is 12 extremely important to our mission because it 13 gets -- all of the data that we're collecting 14 through the survey, it gets -- when it's licensed 15 by other entities, we're able to put it in front 16 of millions, if not tens of millions, more 17 people. So it is very important to us to try to 18 get that program moving. It's also a very good 19 way for us to raise money. 20 And then -- you asked about the other -- 21 what was the other one? 22 Q. Growth of development revenues. Page 301

1 A. Yeah. We have a development program 2 which is to ask for donations from individuals. 3 And that has just -- that's a fairly new program, 4 and it's been slowly growing. 5 Q. Okay. Now, almost to the end of this 6 document, at the bottom it says, So despite my 7 impatience to accelerate the pace of growth 8 strategies, I remain optimistic we're poised for 9 expansion that will impact patient safety if we 10 play our cards strategically. 11 A. Yeah. 12 Q. So the pace of growth -- this language 13 here, pace of growth strategies, that's focused 14 on the pace of -- growth -- the growth of 15 revenue; is that correct? 16 A. Well, it's everything. 17 Q. What do you -- 18 A. If you have more -- 19 Q. -- what are you really -- 20 A. Because revenue -- 21 Q. What are you really focusing on here 22 with -- what do you really -- Page 302	1 that. And -- 2 Q. More staff -- 3 A. Well, it would require -- 4 Q. -- would that be part of pace of growth 5 or kind of the aspirational pace of growth here? 6 A. To accomplish particular goals. 7 Q. Okay. 8 A. Yes. 9 Q. All right. And then does the pace of 10 growth here also involve getting more hospitals 11 involved with Leapfrog? 12 A. That has not -- 13 MS. BLAIR: Objection to form. 14 THE WITNESS: That has not been on the 15 list. It's not here that -- 16 BY MR. CHUNG: 17 Q. Why not? 18 A. Well, we want hospitals to report to the 19 survey. So that's always been on the list for 20 that. But as I said, that's a cost that we have 21 to pay for. More hospitals means more cost. 22 Q. All right. But -- Page 304
1 A. Growth of -- 2 Q. -- mean by -- 3 A. -- the organization overall. So when we 4 are able to get more revenue through development 5 or all those other sources -- they talk about 6 several of them here -- when we're able to get 7 more revenue in, we then can invest that revenue 8 in expanding our programs which have been so 9 successful, such as the hospital safety grade, 10 the surveys, and then other surveys that we 11 are -- we've considered, such as nursing home 12 surveys or something like that. 13 There's other ways that we can impact 14 patient safety in places other than hospitals. 15 There's just a lot of things we could be doing if 16 we had more revenue. 17 Q. So more programs -- 18 A. You could also -- 19 Q. So more programs is part of the pace of 20 growth? 21 A. Maybe a low literacy expert to go over 22 our website. You just said that. I would love Page 303	1 A. So I see it as a cost. Raising money as 2 a separate issue so that we can afford to run 3 this first-class survey. 4 Q. Okay. 5 A. And if I can add one thing in terms of 6 revenue. If our goal was just revenue for the 7 sake of revenue, we would have a lot more money 8 and we probably would only focus on accolades. 9 We've been very successful with accolades. We'd 10 probably give every hospital an A if that was our 11 goal. That's not our goal. 12 Our goal is to improve patient safety -- 13 Q. Well, you are a 501(c)(3) organization, 14 correct? 15 A. Yes. Our goal -- that's our goal; it's 16 our mission to improve patient safety. 17 Q. So if you were to focus just giving out 18 all A's in the accolades licensing program, that 19 would be a problem for -- 20 A. Yes. 21 Q. Your 501(c)(3) registration, correct? 22 A. -- that would not be -- that's why we Page 305

1 don't do it -- 2 Q. Okay. 3 A. -- and we wouldn't do it. But that's -- 4 what I'm trying to say is that's why we focus on 5 revenue, is because we want to afford to pay for 6 the extremely important work we are doing, which 7 is making enormous progress on patient safety and 8 saving lives. 9 Q. Okay. 10 MR. CHUNG: Why don't we take a short 11 break here. We're on to the next topic in a 12 little bit. 13 THE WITNESS: Okay. 14 VIDEO TECHNICIAN: The time is 3:20 p.m. 15 This ends unit 3. We're off the record. 16 (A recess was taken.) 17 VIDEO TECHNICIAN: The time is 3:47 p.m. 18 This begins unit number 4. We're on the record. 19 BY MR. CHUNG: 20 Q. Ms. Binder, before the break we were 21 discussing how Leapfrog is a 501(c)(3) 22 organization, right? Page 306	1 compensation structure, so I wanted to ask: How 2 does Leapfrog set compensation for its executive 3 staff? 4 A. We do research on form 990s, which is the 5 tax form that is completed by nonprofit -- by 6 501(c)(3)s, typically, nonprofit organizations. 7 They're all required to disclose the annual 8 compensation of their highest paid employees and 9 I believe employees who earn over \$100,000 a 10 year. 11 So that gives us a very strong set of 12 competitive and comparative data that we can use 13 to figure out if we're -- if we're competitive in 14 terms of paying our executives. 15 Q. Who is the "we"? Who is getting and 16 reviewing this data and making decisions? 17 A. So -- well, I do it in partnership with 18 the manager who is -- when we're setting 19 compensation for the manager who has direct 20 reports. So for instance, for Missy Danforth, 21 Katie Stewart's compensation, we review her 22 compensation. We do this every year. We review Page 308
1 And has Leapfrog ever been audited to 2 determine whether its activities comply with its 3 501(c)(3) status? 4 A. We have an annual audit by an independent 5 firm. And I believe they look at all aspects of 6 compliance with key legal requirements and 7 accounting principles, and that would be included 8 in that. 9 Q. Okay. Other than the annual audit, have 10 there been any other audits or investigations of 11 Leapfrog as it relates to whether its activities 12 comply with its 501(c)(3) status? 13 A. Well, other than the annual audit? No. 14 Q. Okay. Has anyone within Leapfrog ever 15 complained that its revenue-generating activities 16 do not further its charitable purpose? 17 A. No. 18 Q. Any complaints from the outside -- 19 outside of Leapfrog in that vein? 20 A. No. Not to my knowledge. 21 Q. Topics 9 and 14 on the 30(b)(6) notice 22 have to do principally with Leapfrog's Page 307	1 the compensation to ensure that it remains 2 competitive. And I'll do that with Missy. 3 We also call on Engage PEO. I think I 4 mentioned that they are the HR services firm that 5 we work with. And they give us benchmarking data 6 as well for our executives, and for all levels, 7 really, of employee so that we can gauge from 8 that as well. 9 And then -- I think that's the -- and 10 then we have a recruiter also who gives us -- who 11 does give us insights as well. 12 Q. Okay. Is compensation for any of the 13 executive staff tied to any performance goals? 14 A. So increases in compensation on the 15 annual review period is -- two things. One is 16 the performance of the organization against its 17 key benchmarks; and two is their own personal 18 performance towards their own job description. 19 Q. Okay. And who sets those goals, the 20 personal goals? 21 A. They're based on the job description, so 22 the supervisor of the person. So in my case, for Page 309

1 example, Missy Danforth has a job description. 2 We review the job description prior to the review 3 each year to make sure it's still accurate. And 4 then the employee self-reports how they believe 5 they are doing on these goals for their -- which 6 are in their job description. And then the 7 supervisor responds to those comments. 8 Q. Are the goals for any of these executive 9 staff for purpose of compensation, are there any 10 revenue goals among those goals? 11 A. In some cases, yes. 12 Q. Okay. Can you -- how about for you? 13 A. For my -- well, for my goals, not so 14 much. They want to know that the organization is 15 growing, so they will look at overall growth of 16 the organization in all forms. 17 I think in the earlier exhibit I touched 18 on a lot of the metrics that they're looking at. 19 So they certainly do want to know that I'm 20 raising money. 21 They also want to know that we're getting 22 the kind of traction we want in the market around Page 310	1 Q. Okay. And who are those? 2 A. Karen. She's our development director. 3 So she -- so we are looking -- as part of her job 4 description, we are looking at, are you raising 5 money in the development campaign and are you 6 raising money in generating additional 7 sponsorships for the annual meeting? 8 And some of the revenue goals we've set 9 for her in terms of fundraising. 10 Q. This is Karen Jupiter? 11 A. Yes. Karen Jupiter. 12 Q. Okay. And who else? 13 A. I'm not sure. 14 Q. Melissa Danforth? Given that she 15 oversees the licensing programs, is she one? 16 A. Yeah, that was more of a temporary thing, 17 though, that she took on, because she had so much 18 turnover in trying to get the marketing 19 leadership correct and haven't been able to do 20 that. 21 Q. So the question is, are her -- is her 22 compensation tied to any revenue-based Page 312
1 improving patient safety. So they want to know 2 both the revenue generation and the effectiveness 3 of our mission. 4 Q. So just to be clear, for your 5 compensation, there are no revenue-based 6 performance goals that you have to meet? 7 A. Well -- 8 Q. Yes or no? 9 A. No. 10 Q. No? Okay. 11 A. But -- 12 Q. But you mentioned that there are examples 13 of revenue-based performance goals. 14 Is this for other members of the 15 executive staff? 16 A. No. I'm primarily evaluated on the basis 17 of the organization's performance. 18 Q. I'm asking -- the question I just asked: 19 Are there other members of the executive staff 20 who do have revenue-based performance goals for 21 their compensation? 22 A. Yes. Yes. Page 311	1 performance goals? 2 A. Only inso- -- it's not in her specific 3 personal job description, so no, it is not, on a 4 personal level. But as I said, for the executive 5 team, their bonus levels are determined also, in 6 part, in consideration of the organization's 7 overall performance on our metrics, and those 8 include revenue. 9 Q. Okay. So not personal, but 10 organization-wide, their bonus depends on how the 11 overall organization does in terms of revenue; is 12 that right? 13 A. How -- 14 MS. BLAIR: Objection to form. 15 THE WITNESS: Not in terms of revenue. 16 Just how the overall organization does. That 17 includes revenue, but it's not only revenue. 18 BY MR. CHUNG: 19 Q. Okay. How about Mr. Banerjee? Does 20 his -- 21 A. No, his is not -- 22 Q. Is his compensation, any part of it tied Page 313

1 to revenue-based performance goals? 2 A. No, it's not. 3 Q. Okay. So it's just Ms. Jupiter or is 4 there anyone else? 5 A. Well, all of the senior team is 6 compensated based on the performance of the 7 organization and -- in terms of their bonus, is 8 compensated in terms of the performance of the 9 organization and their performance on their 10 particular job description. 11 So the entire senior team, then, would be 12 compensated on the performance of the overall 13 organization, so that would include revenue in 14 that respect. 15 But you asked me about specifically on 16 the job descriptions. That's where I immediately 17 think of Karen Jupiter, since that is 18 fundamentally her job, to raise money for the 19 organization. 20 Q. Okay. Your -- am I right that your 21 compensation, at least for 2024, was about 22 \$760,000? Is that right? Page 314	1 Q. But is it fair to say that your 2 compensation over time since you started as CEO 3 in about 2012 has increased? 4 A. Yes. 5 Q. Okay. 6 (Binder Deposition Exhibit 32 marked for 7 identification and attached to the 8 transcript.) 9 BY MR. CHUNG: 10 Q. Exhibit 32. Key elements of requested 11 changes to the CEO employment contract. 12 Do you see that? 13 A. Yes. 14 Q. Okay. And this is for a date of July 12, 15 2024. 16 Did you author this document? 17 A. Yes. 18 Q. Okay. And this is addressed to The 19 Leapfrog Group executive committee, correct? 20 A. Yes. 21 Q. All right. You write here -- what's the 22 purpose of this document? Page 316
1 A. I don't believe that's exactly right. 2 But the base is 575. And two years ago I believe 3 I had a bonus of \$100,000. 4 And then I think on the 990s, they also 5 account for benefits, so, like, health benefits, 6 all that value. So that's where it gets to 760. 7 Q. Okay. 8 A. Last year I made much less. And that's 9 not -- I don't believe it's out on the 990s yet, 10 but -- 11 Q. Last year meaning -- what's the year? 12 A. So the fiscal year that's ending as of 13 June 30th, which would be fiscal year 2025. 14 Q. Okay. 15 A. My compensation last year was 575, and I 16 asked the board to not give me a bonus because I 17 wanted to preserve the bonus pool for my 18 executive team. They had done an incredible job, 19 and I wanted to maintain it for them. 20 So that, plus what's going to be on the 21 990 for that, is the 575 plus -- plus the value 22 of the health benefits and retirement benefits. Page 315	1 A. My contract is renewing as of this '25 2 fiscal year, which this is the beginning of 3 that '25 fiscal year. I wanted to give them time 4 to think through what to do about my 5 compensation. 6 Q. Okay. 7 A. And I made the case -- I looked at the 8 comparables in the nonprofit world to give them 9 an assessment of how competitive my compensation 10 is and also some of the history of my 11 compensation. 12 Q. So you write toward the top there, second 13 sentence under the CEO position of my value, 14 Recruitment for this position, as well as other 15 senior positions, will include talent from 16 larger, better financed organizations, given the 17 need for experienced leadership and the level of 18 scrutiny Leapfrog is under. 19 What did you mean about the level of 20 scrutiny that Leapfrog was under? And this is -- 21 A. Well, we're very -- 22 Q. -- July 2024. Page 317

1 A. I mean, we get tens of thousands of press 2 citations and public attention. I'm on the 3 speaking circuits, speaking to thousands of 4 people every year. We are a very high-profile -- 5 exceptionally high-profile organization for our 6 financial size. 7 Q. Okay. And then you write your 8 performance -- My performance in this position 9 has been a significant asset to the organization, 10 and over the past decade we have grown Leapfrog's 11 visibility and influence while also growing our 12 revenues by an average of 10 percent per year. 13 So you're including here, as part of 14 the -- kind of the pitch here, that you've been 15 responsible for growing Leapfrog's brand as well 16 as the revenues, correct? 17 A. Yeah. The next sentence talks about the 18 low staff turnover and expansion -- 19 Q. I'm just focusing on what I just read. 20 Is that correct, that -- 21 MS. BLAIR: Objection to form. 22 Page 318	1 meant to go into effect? 2 A. When we conclude the renewal of my 3 contract. 4 Q. Okay. And then in the next paragraph on 5 the same page you write that your base and bonus 6 request would get your compensation above the 7 median for similarly sized organizations. 8 Do you see that? 9 A. Depending on bonus, yeah. 10 Q. Yeah, depending on bonus. 11 So why did you think your compensation 12 should be above the median for similarly sized 13 organizations? 14 A. Because I've been at Leapfrog for 15 18 years and we are considered by many one of the 16 most successful nonprofit organizations in the 17 country. 18 Q. Okay. And part of that -- would you say 19 part of -- at least in light of your kind of -- 20 your contributions here, part of that would be 21 the revenue generation as well, correct? 22 MS. BLAIR: Objection to form. Page 320
1 BY MR. CHUNG: 2 Q. -- your -- all right. I'll move on -- 3 A. Which sentence? Over the past decade, we 4 have grown -- 5 Q. Yeah. 6 A. -- Leapfrog's visibility and influence 7 while also growing our revenues by an -- yes, 8 that's true. 9 Q. Yes -- okay. 10 So I'm going to direct your attention to 11 the second page. 12 And under compensation request, you ask 13 for a bonus target of 15 to 25 percent of the 14 base. 15 Do you see that? 16 A. Yes. 17 Q. And then the dollar amount is set forth 18 there, 101,250 to 168,750. 19 What was the previous bonus target? 20 A. The previous bonus target was anywhere 21 from zero to \$100,000. 22 Q. Okay. And when was this new bonus target Page 319	1 THE WITNESS: It's both revenue and 2 accomplishment of mission, but mostly mission. 3 BY MR. CHUNG: 4 Q. Okay. But you -- 5 A. The whole purpose of revenue is mission. 6 Q. Right. But you do underscore that 7 revenue has grown while you've been CEO, correct? 8 A. Yes. 9 Q. All right. And that's a reason -- that's 10 one of the reasons for this request and the 11 increased compensation, correct? 12 A. Well, mainly it's the factors that I lay 13 out here on -- 14 Q. I'm asking, is it one of the reasons 15 that's the grounds for your request for increase 16 in compensation? 17 A. Sure, it's one of the reasons. 18 Q. Okay. Would you say that Leapfrog's 19 success depends on participation by hospitals? 20 MS. BLAIR: Objection to form. 21 THE WITNESS: No. 22 Page 321

1 BY MR. CHUNG: 2 Q. How is that? 3 A. Well, we -- there are many factors that 4 would determine success, but the most important 5 one is that we see improvement in patient safety. 6 Q. What would happen to Leapfrog if all 7 hospitals decided to stop responding to the 8 hospital survey? 9 MS. BLAIR: Objection to form. 10 THE WITNESS: I guess we'd be -- we'd try 11 another strategy to improve patient safety. 12 BY MR. CHUNG: 13 Q. Okay. But what would happen to Leapfrog 14 if all hospitals decided to stop responding to 15 the hospital survey? 16 A. We'd pursue -- 17 MS. BLAIR: Objection. 18 THE WITNESS: -- a different strategy to 19 improve patient safety. 20 BY MR. CHUNG: 21 Q. Would you be concerned -- I mean, isn't 22 the foundation -- the foundational program of Page 322	1 A. Yes. 2 Q. But the hospital survey preceded your 3 time as CEO, correct? 4 A. Yes. 5 Q. So the hospital survey has been part of 6 Leapfrog -- has it been since the founding? 7 A. Yes. 8 Q. Okay. So I'm just going to ask the 9 question again: Does Leapfrog's success depend 10 on -- as it's currently put together, depend on 11 participation by hospitals? 12 MS. BLAIR: Objection to form. 13 THE WITNESS: Our current -- in our 14 current strategic design -- 15 BY MR. CHUNG: 16 Q. Yeah. 17 A. -- we rely on hospital transparency to 18 drive a market for improved patient safety. That 19 is our strategy right now. Yes. 20 Q. Okay. Does Leapfrog provide any form of 21 public recognition such as awards or distinctions 22 to hospitals that participate in the survey? Page 324
1 Leapfrog the hospital survey? 2 A. It was the first program we launched, and 3 it's certainly key to our strategy of 4 transparency in an open marketplace, an open and 5 transparent marketplace in healthcare. We 6 certainly want that. 7 Q. Okay. Would you say it is -- the 8 hospital survey is necessary for Leapfrog's 9 survival? 10 MS. BLAIR: Objection to form. 11 THE WITNESS: No. We'd find some other 12 way to do it. But -- it's not going to go away. 13 But we would try another strategy. We've been 14 successful at pursuing various strategies over 15 our 25-year history. And we would do that 16 because patient safety is not going to wait. 17 People are -- it's third leading cause of death 18 in this country. 19 BY MR. CHUNG: 20 Q. The hospital survey, however -- we talked 21 about the hospital safety grade program 22 starting -- I think it was 2012, right? Page 323	1 A. Yes, we do. 2 Q. All right. And what are the criteria for 3 that type of -- for those recognitions? 4 A. So we have a top hospitals program and we 5 award based on a variety of factors such as they 6 have to have achieved a certain level of 7 performance in each one of the categories within 8 the Leapfrog hospital survey. 9 Q. Okay. 10 A. So they have to be among the top in 11 those -- it's a whole methodology, and we 12 publicly report that as always. 13 Q. Does Leapfrog ever engage with hospital 14 leadership or hospital administrative staff to 15 encourage participation in the survey? 16 A. Yes. 17 Q. Okay. How does it go about doing that? 18 A. Well, a whole variety of ways, but one is 19 that we work with our regional leaders and we 20 support them, and they are really the main voice 21 for Leapfrog in their communities, meeting with 22 hospitals, talking with hospitals, engaging Page 325

1 hospitals on behalf of their employer members. 2 That's one way. 3 The other way is what I would just call 4 sort of -- it's not informal, but it's anecdotal, 5 so to speak, is when myself and other leaders at 6 Leapfrog travel across the country and meet with 7 various hospitals and -- as well as our regional 8 leaders and others in conferences, et cetera. 9 So we have a number of general 10 strategies. I make it a point myself to visit at 11 least three to five hospitals every year, get a 12 tour, find out where the real challenges are. 13 There's really nothing like being on site and 14 really talking to these leaders personally. 15 So we do that, and a number of 16 Leapfrog -- the Leapfrog team does it. Sometimes 17 our board members as well go for tours and 18 conversations with hospital leaders. 19 Q. Are there any partnerships with employers 20 or insurers that use Leapfrog participation -- 21 hospital participation in Leapfrog survey as a 22 criterion for contracting or inclusion in the Page 326	1 hospitals -- 2 Q. Okay. 3 A. -- that cause -- that cause participation 4 rates to increase. 5 Q. Including changing the imputation 6 methodology last year; is that right? 7 MS. BLAIR: Objection to form. 8 THE WITNESS: That was not the purpose of 9 the change in the imputation. 10 BY MR. CHUNG: 11 Q. Okay. But it had the impact? 12 A. I don't know. Honestly don't know. 13 Q. Okay. You were hoping for that impact, 14 correct? 15 MS. BLAIR: Objection to form. 16 THE WITNESS: No. That was not the 17 purpose of the -- the imputation had a purpose: 18 Was for consumers so that they would not -- we 19 were not overstating the performance on safety of 20 any hospital. That is not -- we'd never want to 21 be doing that. It's not safe for consumers. 22 Page 328
1 network? 2 A. I don't know. I know that some health 3 plans have put Leapfrog participation in their 4 initial -- in the initial contracts that they 5 present to hospitals, but my understanding is 6 often those are negotiated out before they 7 actually take place. 8 So I don't think there are any that have 9 stayed in place, but I don't know entirely. 10 Q. Okay. Does Leapfrog track hospital 11 participation rates over time? 12 A. Yes. 13 Q. Okay. And what trends has Leapfrog 14 identified in the participation rates? 15 A. They've been growing every year. 16 Q. Okay. And that's as part of kind of the 17 efforts that you just described; is that right? 18 A. Which efforts? 19 Q. The efforts that you just described about 20 the engagement with hospitals. 21 A. Oh. Well, there's a whole variety of 22 reasons besides direct engagement with Page 327	1 BY MR. CHUNG: 2 Q. Has Leapfrog ever analyzed whether survey 3 participation improves a hospital's safety grade? 4 A. Not the way you described it. 5 Q. I'm sorry? 6 A. Not the way you just described it. 7 Q. Okay. Well, how have -- how has Leapfrog 8 analyzed or studied -- 9 A. We've looked at patterns on survey 10 participants versus non-participants in a whole 11 variety of areas, including their safety grades, 12 but also their particular performance on certain 13 CMS metrics. 14 Q. Well, what have you observed in terms of 15 the analysis of survey participants and 16 non-participants as it relates to their safety 17 grades? 18 A. Non-participants tend to not have as high 19 a grade. 20 Q. Okay. And is that -- is that recent data 21 after the imputation methodology change in 2024 22 or just more -- over a longer time period? Page 329

1 A. That's been consistent. 2 Q. Okay. 3 A. But let me just add that they -- 4 non-participants have also consistently been able 5 to do well. So it isn't -- but in terms of 6 correlating or looking at the patterns between 7 the two kinds of hospitals, like the participants 8 and non-participants, there is generally, on 9 average, higher grades by participating 10 hospitals. 11 Q. Okay. So we're going to move on to 12 Leapfrog's marketing, which is another 30(b)(6) 13 topic. 14 How large is Leapfrog's marketing team? 15 A. We don't have anyone dedicated to just 16 marketing. We have -- I mean, Kush does mostly 17 contracting and responding to inquiries, so 18 that's partly marketing. 19 We have a lot of people who partly work 20 on marketing. 21 Q. And who are those people? 22 A. Kush, Missy, myself. Page 330	1 in marketing. 2 So smaller contracts like that. But the 3 main one is TelAffects. 4 Q. Okay. And I'm aware that Leapfrog also 5 uses an outside service, CURA Strategies. 6 A. Yes. 7 Q. What do they do? 8 A. They're our public relations firm. So 9 they handle -- they handle informing the media 10 when Leapfrog has news and making sure that -- or 11 trying to get it covered. 12 Q. Okay. In terms of Leapfrog's marketing 13 strategy, how does the -- how do the hospital 14 safety grades fit into Leapfrog's marketing 15 strategy? 16 A. Well, for the accolades program, we -- we 17 have a number of strategies to -- aimed entirely 18 at hospitals for each round of the grade that 19 earn an A, which is a subset of them. We have a 20 number of strategies to try and engage them and 21 interest them in purchasing that logo and touting 22 their A. So those would be e-mails that are Page 332
1 I'm trying to think. I think some of our 2 communications team will help with some, so Karen 3 Jupiter and Lauren Bailey do particularly 4 marketing around our partners program to try to 5 attract more partners and sponsorships. 6 Q. Okay. So you have communications 7 personnel working on marketing as well; is that 8 right? 9 A. For the partners program. And for the 10 annual meeting in particular. Actually, she 11 works a lot on attracting sponsors and interest 12 and registrations for the annual meeting. 13 Q. Do you know how much Leapfrog spends 14 on -- do you also use outside marketing firms to 15 help with marketing? 16 We mentioned TelAffects earlier, correct? 17 A. Yes. TelAffects is the main one that we 18 use for marketing purposes. 19 Q. Any others? 20 A. We have a design -- a designer, graphic 21 designer. We have a videographer that does some 22 video for our annual meeting that we then can use Page 331	1 directed at those A-hospitals. We do -- 2 actually, it's mainly e-mails. We do some other 3 kinds of mailings, I guess, but that's mainly it. 4 Q. Okay. Does Leapfrog pay for search 5 engine optimization for any of its websites as 6 part of the marketing program? 7 A. We've dabbled in that with -- we got a 8 grant from -- a grant from Google that they give 9 to some non-profits to allow them to dabble in 10 search engine optimization, paying for some -- 11 paying to be on the top of a search. And so 12 we -- it's a very small amount, but we've done 13 that. 14 And that's just dabbling. We don't have 15 the funds to really do that kind of SEO, really 16 sophisticated strategy. 17 Q. Okay. So just some specific questions 18 about how Leapfrog markets the hospital safety 19 grades to consumers. 20 How does Leapfrog decide how to describe 21 and explain the hospital safety grades in its 22 marketing? Page 333

1 A. We don't really market the hospital 2 safety grades except we market the accolade for 3 hospital safety grades. 4 Q. So how does it go about doing that? 5 What -- how do you decide -- how do you describe 6 the hospital safety grades when you're marketing 7 the accolades program? 8 A. We send e-mails that say, you got an A, 9 you know, you should be proud. 10 And some of the ways that hospitals that 11 earn an A, how they've been able to tout it in 12 their communities, with their boards, with 13 their -- just internally, externally. 14 We try to give them ideas. And -- that's 15 how we do it. 16 Q. And in fact, it's the licensing team 17 that's the first -- they're the first folks from 18 Leapfrog that notify a hospital of an A grade; is 19 that right? 20 A. No. We send a letter to the CEO signed 21 by me, and it's sent FedEx, so it's a hard copy, 22 sent to the CEOs that congratulate them on their Page 334	1 Q. Okay. Does Leapfrog try to convince 2 consumers that its grading methodology is 3 unbiased? 4 A. Yes. 5 Q. Okay. And you said independent? 6 A. Yes. 7 Q. All right. Why not objective? 8 A. I don't know -- 9 Q. Is it because there are elements of the 10 scoring methodology that are subjective? 11 MS. BLAIR: Objection to form. 12 THE WITNESS: No, it's just -- it's just 13 not a great word. 14 BY MR. CHUNG: 15 Q. Why not? 16 A. Because in the scientific method, we're 17 always evolving and updating it, and it's not 18 commonly used in even scientific discussions to 19 say, well, this is objective, so this is it. 20 You -- it's just not a word that's used in an 21 evidence-based scientific environment, so we 22 tended to not use the word "objective." Page 336
1 A. 2 Q. Is that the very first correspondence? 3 A. That they got an A? Yes. 4 Q. Okay. Isn't it -- doesn't the licensing 5 team send an e-mail, electronic communication, to 6 the hospital notifying them of the A first? 7 A. They also send a note. But the first 8 thing is the letter to the CEO, the hard copy 9 FedEx letter to the CEO. 10 Q. Okay. 11 A. But, I mean, CEOs don't always, you know, 12 let everyone know in five seconds, so we also 13 communicate with others at the hospital to make 14 sure they're aware and have time to consider how 15 they want to promote their A, which they can do 16 for free. And we make that clear in all of our 17 correspondence as well. 18 Q. Okay. Does Leapfrog try to convince 19 consumers that its grading methodology is 20 objective? 21 A. I don't know that we've used the 22 word "objective." Independent. Page 335	1 Q. Okay. Is that a word that your expert 2 panelists have cautioned against using? 3 A. I don't think they've ever brought it up, 4 but it's just not a word that's commonly used in 5 any kind of scientific discourse. 6 Q. Okay. Does Leapfrog try to convince 7 consumers that the hospital safety grades are not 8 influenced by a hospital's participation or lack 9 of participation in the survey? 10 A. Do we try to convince people that it is 11 not influenced by the survey? 12 Q. Right. 13 A. No. 14 Q. All right. Is it true that a hospital's 15 lack of participation does not affect the 16 hospital's safety grade? 17 A. No. That's not true. And we don't say 18 that. That I know of, anyway. 19 Q. Okay. So it is true that a hospital's 20 lack of participation does affect its safety 21 grade? 22 MS. BLAIR: Objection to form. Page 337

1 THE WITNESS: It can affect their safety 2 grade for sure, up or down. 3 BY MR. CHUNG: 4 Q. Okay. Isn't it true that Leapfrog's 5 published hospital safety grades could cause 6 members of the public or patients to delay 7 necessary medical care? 8 MS. BLAIR: Objection to form. 9 THE WITNESS: Highly doubtful. 10 BY MR. CHUNG: 11 Q. Is it possible? 12 A. I don't know. 13 Q. You don't know? Is that your testimony, 14 you don't know whether it's possible? 15 A. I don't know if people would delay needed 16 medical care because of the hospital safety 17 grade. I've never heard of that ever happening. 18 Q. Okay. Well, take a member of the public 19 with Leapfrog grades, you know, in their mind. 20 Is it possible that they might drive past 21 a D- or an F-hospital and make a much longer 22 drive to an A-, B-, or C-hospital? Page 338	1 Q. Okay. And they might do so even if the 2 D- or F-hospital has a type of unit or specialty 3 that the further-away hospital does not? 4 MS. BLAIR: Objection to form. 5 THE WITNESS: Well, it's not what we 6 advise, so we're very clear about advising that 7 you should take a look at the safety grade first, 8 because safety comes first. But then there are 9 other sources of information for other kinds of 10 quality metrics that you should also look at 11 regarding a hospital. 12 We're pretty clear about the fact that 13 you need to look at a variety of sources to 14 really evaluate where you want to seek care. 15 BY MR. CHUNG: 16 Q. Where is that made clear, what you just 17 articulated? 18 A. It's in our talking points. I believe 19 it's on our website. It's various places. 20 We're -- 21 Q. What are the talking points? Where are 22 the talking points located? Page 340
1 A. Is that -- 2 MS. BLAIR: Objection to form. 3 THE WITNESS: Sure. 4 BY MR. CHUNG: 5 Q. Is there a risk there, is what I'm 6 asking? 7 A. The risk is if they go to a hospital 8 that's not safe. That's the risk. 9 Q. I'm asking you, is there a risk -- 10 right? -- is a -- let's say a particular member 11 of the public, a consumer, with Leapfrog grades 12 in mind, might drive past a D- or F-hospital and 13 just drive further to an A-, B-, C- -- A-, B-, or 14 C-hospital based on their viewing of the grades? 15 MS. BLAIR: Objection to form. 16 THE WITNESS: Sorry, are you saying in an 17 emergency or are you just saying in general? 18 BY MR. CHUNG: 19 Q. In general. 20 A. I would think that they might not want to 21 go to a -- they'd want to -- prefer an 22 A-hospital. Sure. Page 339	1 A. I'm not sure exactly how to get there on 2 the website, but they're -- we -- it's a talking 3 point that we've used repeatedly. 4 Q. Okay. And what specifically is the 5 talking point that's on the website? 6 A. That you should consider -- it's probably 7 on the safety grade website, too. 8 That you should consider the safety of a 9 hospital first, because safety comes first, and 10 then you should be looking at other sources of 11 information. This is a common point that I've 12 made many times myself as well. 13 Q. Okay. But do the talking points on this 14 website go into these circumstances where, if a 15 hospital with a lower grade has a type of unit or 16 specialty that a further-away hospital with a 17 higher grade does not, that they should consider 18 the distance when deciding -- or consider whether 19 the hospital has the type of unit or specialty 20 that they need? 21 A. We don't talk about the distance, per se. 22 We do talk about looking at a variety of ratings Page 341

1 to understand how a hospital is doing on the 2 services that they provide. 3 Q. Okay. Are you aware of instances of 4 patients avoiding a D- or F-hospital only to be 5 sent back to that hospital because the A- or the 6 B-hospital they went to originally didn't have 7 the proper specialty for them? 8 MS. BLAIR: Objection to form. 9 BY MR. CHUNG: 10 Q. Have you heard of those instances? 11 A. I haven't. 12 Q. You have not? 13 A. I have not heard of them. 14 Q. Okay. Would it concern you if you heard 15 of those instances? 16 A. I mean, there's a lot of -- people go 17 from one hospital to another all the time for all 18 kinds of reasons -- 19 Q. So you're not? 20 A. -- so I guess I wouldn't see that as a 21 particular red flag. The red flag is if they're 22 going to a hospital and they get harmed. That's Page 342	1 important, based on that, that Leapfrog's 2 hospital safety grades are accurate; is that 3 right? 4 MS. BLAIR: Objection to form. 5 THE WITNESS: It's always been important 6 for all kinds of reasons. 7 BY MR. CHUNG: 8 Q. Okay. Because if the hospital safety 9 grades are not accurate, Leapfrog could be 10 running the risk of influencing a patient or a 11 family member to go to an unsafe hospital; is 12 that right? 13 A. But that's -- 14 MS. BLAIR: Objection to form. 15 THE WITNESS: That's why we don't want to 16 inflate the performance of hospitals. We try not 17 to inflate their performance, and that's why we 18 err on the side of not inflating their 19 performance. 20 BY MR. CHUNG: 21 Q. Okay. Similar question: If the grades 22 are not -- if the hospital grades are not Page 344
1 the stories I hear every day. 2 Q. Okay. Is it fair to say that Leapfrog 3 wants to influence where patients choose to 4 receive care? 5 MS. BLAIR: Objection to form. 6 THE WITNESS: We want to give consumers 7 information so they can make a good choice for 8 themselves and their families. Period. We're 9 not trying to do anything to or for hospitals. 10 We are about consumers. 11 BY MR. CHUNG: 12 Q. No, I'm not asking whether you're 13 influencing a patient to go to a specific 14 hospital -- right? But isn't it fair to say that 15 Leapfrog -- part of its mission is to influence 16 where patients choose to receive their care? 17 MS. BLAIR: Objection to form. 18 THE WITNESS: We're trying to influence 19 them to seek care at the safest, highest-quality 20 cases. 21 BY MR. CHUNG: 22 Q. Okay. So it's important -- so it's Page 343	1 accurate, then there's the risk of steering 2 patients away from safe hospitals, correct? 3 A. They are accurate, so I can't answer 4 that. 5 Q. All right. But if they're not accurate, 6 if the hospital safety grade is not accurate, 7 then there's a risk of steering them away from 8 actually safe hospitals, correct? 9 MS. BLAIR: Objection to form. 10 THE WITNESS: If we overstate the safety 11 of a particular hospital, there is the risk they 12 will go to a hospital that is less safe than they 13 thought. 14 BY MR. CHUNG: 15 Q. Okay. 16 A. That's the biggest risk. 17 Q. And if the hospital safety grade -- if a 18 hospital safety grade for a particular hospital 19 is not accurate, there's a risk that Leapfrog 20 could be influencing consumers to make decisions 21 about their healthcare that are actually 22 detrimental to their health; is that right? Page 345

1 MS. BLAIR: Objection to form. 2 THE WITNESS: No. 3 BY MR. CHUNG: 4 Q. That's not right? 5 A. No. As I said, the biggest risk is if we 6 were to inflate the performance of a hospital and 7 they go and it's not as safe as they hoped or 8 deserve. That's a risk. 9 Q. Okay. 10 A. To the consumer, that's the biggest risk. 11 Q. So it's not a risk if -- if a hospital 12 safety grade for a particular hospital is not 13 accurate, it's not a risk that Leapfrog could be 14 steering a consumer or influencing a consumer to 15 make a decision that's actually detrimental to 16 their health? 17 MS. BLAIR: Objection to form. Double 18 negative. 19 You can answer it if you know. 20 THE WITNESS: Can you restate it or say 21 it again? 22 Page 346	1 correction or a retraction of a hospital safety 2 grade after learning that the grades may have 3 misrepresented a hospital's actual safety or 4 quality of care? Has that ever happened? 5 A. We have pulled down grades when -- very 6 rarely, but we have pulled down a hospital's 7 grade entirely if we are given evidence that 8 form -- some part of the data was inaccurate. 9 This typically is brought to our 10 attention by a hospital, and they will say that 11 there was some inaccuracy which we get confirmed 12 from the data source, i.e., CMS. In that case, 13 we will bring down the grade entirely. We will 14 never change a grade. 15 Q. What do you mean by bring down the grade? 16 A. We'll take it down from public reporting. 17 Q. Okay. So that -- so essentially the 18 hospital does not get a grade; is that right? 19 A. Right. 20 Q. Okay. 21 A. But again, it's very rare, but it's when 22 there's evidence that something is wrong from the Page 348
1 BY MR. CHUNG: 2 Q. Right. If a hospital safety grade is not 3 accurate -- right? -- for a particular hospital, 4 isn't there a risk that Leapfrog could be 5 influencing a patient to make a decision about 6 their health that's detrimental to their health? 7 MS. BLAIR: Objection to form. 8 THE WITNESS: If it's not accurate -- 9 you're saying if it's not accurate, which I 10 contend, of course, that it is accurate. But if 11 it's not accurate, could they be making a 12 decision that's detrimental to their health? 13 BY MR. CHUNG: 14 Q. Yes. 15 A. The risk is that it would be inaccurate 16 to the extent of overstating the hospital's level 17 of safety. That would -- and then -- then the 18 consumer goes to that hospital thinking that they 19 should -- that they feel safe there and they are 20 too complacent about the safety, and that is a 21 major, major risk to consumers. 22 Q. Okay. Has Leapfrog ever issued a Page 347	1 data source. 2 Q. When is the last time that that happened? 3 A. I can't remember. Maybe a year ago. 4 Q. Okay. And which hospital? 5 A. I don't remember the hospital. 6 Q. Okay. Approximately how many times has 7 it happened during your time at Leapfrog? 8 A. Eight to ten times in my time at 9 Leapfrog. I worked -- since the safety grade 10 launch. 11 Q. Can you think of a particular hospital -- 12 maybe not the most recent one -- where this 13 actually happened? 14 A. Well, it happened a lot when we had AHA 15 data. Not a lot. I mean, obviously, only eight 16 to ten times in 13 years, so it's not a lot. But 17 it was a particular issue with AHA data because 18 the hospitals would say, oh, that's wrong, AHA 19 reported the data to you, it was incorrect. And 20 we'd go back to AHA and they wouldn't -- AHA 21 would need to correct it. We would not correct 22 it unless AHA, the data source, corrected it. Page 349

1 And so AHA, if they didn't correct it 2 or -- then AHA would come back late in the 3 process and try to correct it. And in that case, 4 when we have, from the data source, information 5 that this was -- this particular measure was 6 incorrect, we would -- that's when we would pull 7 down the grade. 8 Q. Okay. Has Leapfrog ever considered the 9 potential public health risks associated with 10 publishing safety grades for hospitals where it 11 just doesn't have data? 12 A. We don't publish safety grades for 13 hospitals for which we do not have data. 14 Q. Okay. Has Leapfrog ever considered the 15 potential public health risks associated with 16 publishing safety grades for hospitals where it 17 doesn't have data for a number of metrics? 18 MS. BLAIR: Objection to form. Asked and 19 answered. 20 THE WITNESS: We don't publish safety 21 grades that we don't stand behind. Our criteria 22 for publishing the -- Page 350	1 faces at any hospital. 2 Q. So the answer is -- 3 A. So that's what -- that's the public 4 health risk that we are most concerned with and 5 we believe people deserve to know. They deserve 6 to know about the risks that they face and where 7 we believe the risks are highest. 8 Q. So the answer is no. 9 MS. BLAIR: Objection to form. Asked and 10 answered. 11 MR. CHUNG: Hasn't answered the question. 12 MS. BLAIR: I think she's answered it 13 four times. 14 MR. CHUNG: Hasn't answer the question. 15 MS. BLAIR: That's the answer. 16 BY MR. CHUNG: 17 Q. So is the answer no? 18 A. No, we have not considered the public 19 health risks of going to a hospital that gets a 20 poor grade and -- or -- what is your question, 21 actually? Better say it again because I don't 22 understand it. Page 352
1 BY MR. CHUNG: 2 Q. That's not my question, Ms. Binder. Let 3 me put it another -- 4 A. Well, I'm answering your question the way 5 I've interpreted it. 6 Q. Has Leapfrog ever considered the 7 potential public health risks associated with 8 publishing hospital safety grades for hospitals 9 where it doesn't have data for a number of 10 metrics? 11 MS. BLAIR: Objection to form. 12 BY MR. CHUNG: 13 Q. Have you ever -- has Leapfrog ever 14 considered the risks associated with that? 15 A. We look at the public health risks of 16 patient safety itself, which is, no matter what 17 the grade of the hospital, is a very significant 18 risk. It's the third leading cause of death, and 19 one in four patients admitted to a hospital 20 suffers an adverse event. 21 That is a major public health risk that 22 every one of us in this room and every American Page 351	1 Q. Has Leapfrog ever considered the 2 potential public health risks associated with 3 publishing a safety grade for a hospital where it 4 just lacks data for a number of metrics? 5 MS. BLAIR: Objection. Asked and 6 answered. 7 THE WITNESS: We don't do that, so... 8 MR. CHUNG: Okay. We got an answer 9 finally. 10 MS. BLAIR: Yeah, I think she said that 11 originally, they don't grade hospitals without 12 data. 13 MR. CHUNG: No. Okay. 14 All right. Let's go to tab 9. This will 15 be Exhibit 33. 16 (Binder Deposition Exhibit 33 marked for 17 identification and attached to the 18 transcript.) 19 BY MR. CHUNG: 20 Q. So Ms. Binder, this is -- we looked at a 21 couple of documents earlier about HCA. This is, 22 I think, another one. Page 353

1 A. Yeah. 2 Q. But a different topic. 3 So it's an e-mail chain from 2023. 4 And I first want to direct your attention 5 to the second page, Bates ending in 1650. And 6 then Ms. Harmon writes that Leapfrog has received 7 a media request from a small local watchdog 8 investigative news outlet. 9 A. Wait, I don't have 1650. I have -- oh, 10 I'm sorry. I'm looking at the wrong number. 11 Q. It's the top one. 12 A. The top one. Okay. Yeah. Okay. 13 Q. And you'll see here that -- just at the 14 top of that second page, Ms. Harmon writes that 15 Leapfrog has received a media request from a 16 small local watchdog investigative news outlet 17 about Mission Hospital, which is purchased by 18 HCA. 19 A. Uh-huh. 20 Q. First of all, who is Elizabeth Harmon? 21 A. She was -- she is -- she's left Leapfrog 22 now, but she was the senior communications Page 354	1 So they are not exactly the same. 2 So that's why I -- I believe Mission 3 Hospital, subsequent to this, but I'm not 4 positive, but I believe, subsequent to this, 5 their grade declined. 6 But this is exactly what I mean by risk 7 to consumers that we see. The biggest risk is 8 inflating or overstating the performance of a 9 hospital. So this is a case in point of where, 10 given the data that we had and the methodology 11 that we have, which we do stand behind, there's 12 going to be problems every now and then where 13 somebody -- we've had to overstate because we're 14 using data that's, you know, six months to a year 15 old or we're -- just various reasons. The data 16 is not perfect -- 17 Q. Okay. 18 A. -- the methodology is not perfect, so we 19 end up with a situation like this which we really 20 don't like, but -- 21 Q. So -- 22 A. And that's what I've said in this e-mail. Page 356
1 specialist. 2 Q. Okay. And then if you go further down to 3 the middle of the -- further down the page, 4 you'll see that the request from the reporter 5 notes that Mission gets only two stars from CMS 6 for patient experience but that Leapfrog 7 regularly gives them an A safety grade. 8 Do you see that? 9 A. No -- 10 Q. In the penultimate -- 11 A. Oh, I see it now. Yeah. 12 Q. Yeah, the penultimate paragraph. 13 So my question is, do you know why 14 Leapfrog assigned an A grade to Mission Hospital 15 regularly while CMS rated the hospital with two 16 stars? 17 A. We follow the methodology, and the 18 methodology looks at their CMS -- their CMS 19 measures that are related to patient safety. CMS 20 Star program is a variety of measures, including, 21 but not only, patient safety. In fact, patient 22 safety is a smaller portion of the Star rating. Page 355	1 Q. So moving further down the page, the 2 reporter requests to know how much of Leapfrog's 3 annual revenue is earned from fees that hospitals 4 pay for using its rating in their marketing. I'd 5 also like to learn if there are other ways in 6 which Leapfrog earns fees from the hospital that 7 it rates. 8 Is there any connection between 9 Leapfrog's revenue sources and the way it grades 10 hospitals? 11 A. No. 12 Q. Okay. I want to -- 13 A. Those are kept separate. But the -- 14 there's no -- this reporter, we would have given 15 them the answer. We would also have pointed to 16 it on the website. 17 We are open about how much we charge for 18 the accolades. 19 Q. You said you would have or did you? 20 A. Well, I don't recall it precisely, but -- 21 Q. So let's go to the first page, your 22 response here. Page 357

1 A. Because we already make public what we 2 charge for accolades. So it would have been 3 there. 4 Q. Okay. But in your reply to Ms. Harmon's 5 e-mail, you state that this is officially a 6 serious PR issue; do you -- 7 A. It is -- 8 Q. -- do you see that? 9 A. -- yes. 10 Q. Okay. Is this a serious PR issue because 11 you've heard from other sources that Leapfrog is 12 pay to play and that these information requests 13 bear on that? 14 A. No, absolutely not. 15 Q. Okay. Why was it a -- was this not a 16 serious issue -- 17 A. Because we -- 18 Q. -- with the hospital survey? 19 A. No. 20 Q. How about with the hospital safety grade? 21 A. This is a serious issue of us overstating 22 the performance of a hospital through the Page 358	1 A. Yes. 2 Q. Okay. So if you look at the bottom of 3 page 3 of the document Bates ending 9322, the -- 4 Lula Hailesilassie, I think from CURA, writes 5 that an ex-employee exposed St. Luke's Hospital's 6 rusty and damaged equipment that is being used on 7 patients, and that St. Luke received an A grade 8 in the spring 2023 safety grade cycle. 9 Does Leapfrog take into account feedback 10 or stories like this when it computes the 11 hospital safety grade? 12 A. We don't look at this particular kind of 13 whistleblowing story. We can't -- there's no 14 reliable way to do that. There's no reliable way 15 to compare hospitals against each other on the 16 number of whistleblowers who come forward. 17 Pretty much every hospital will have some pretty 18 awful stories to tell from whistleblowers that we 19 do see -- 20 Q. Every hospital? What's your basis for 21 that? 22 A. Oh, just general -- just my general Page 360
1 hospital safety grade -- 2 Q. Right. 3 A. -- but that is what's going to happen in 4 imperfect rating systems of all sorts. And that 5 is what we feared. That's the public health 6 problem. 7 Q. Okay. 8 MR. CHUNG: Let's go to tabs 10 and 10a. 9 (Binder Deposition Exhibit 34 marked for 10 identification and attached to the 11 transcript.) 12 BY MR. CHUNG: 13 Q. All right. This is Exhibit 34. It's an 14 e-mail thread discussing what looks like a media 15 story about St. Luke's Hospital, Ms. Binder. 16 Do you see that? 17 A. Yes. 18 Q. All right. And it received an A safety 19 grade in the spring 2023, but then there's a 20 report of a former employee describing rusty and 21 damaged equipment being used on patients. 22 Do you see that? Page 359	1 knowledge from 18 years at Leapfrog. We see it 2 all the time, that there's problems at every 3 hospital. 4 So, you know, our methodology is -- we're 5 using the best publicly available data that's 6 fair to compare hospitals against each other on. 7 And -- so that does not always include what a 8 whistleblower might -- might bring up. 9 Q. But -- so do you not consider or factor 10 in these reports at all in determining the 11 hospital safety grade for a particular hospital? 12 A. We have to use reliable, risk-adjusted 13 measurement. We have to use a measurement 14 process to offer a reliable grade that compares 15 hospitals against each other. Hospitals, I 16 think, would not respond well if we said, well, 17 this one had three whistleblowers, this one had 18 two, so this one gets a higher grade or 19 something. 20 That -- it's not justifiable and we 21 can't -- it doesn't have an evidence base for 22 grading. Page 361

1 Q. Okay. So none of that figures into the 2 hospital safety grade, is your testimony? 3 A. Well, it figures into Leapfrog. I mean, 4 we care deeply about these reports, and we -- 5 it's very upsetting. 6 Q. Okay. Are you aware of any evidence that 7 Leapfrog's hospital safety grades have caused 8 reputational harm to hospitals? 9 A. We don't track that, so I don't know. 10 Q. Okay. Now, would you agree that before 11 Leapfrog issues a hospital safety grade to a 12 particular hospital, that hospital has a 13 preexisting reputation? Would you agree with 14 that kind of basic proposition? 15 A. Yes. 16 Q. Okay. And that reputation could be good 17 or bad or somewhere in the middle, right? 18 A. Yeah. 19 Q. Okay. For example, a hospital could have 20 a five-star CMS rating. And would you agree that 21 that's likely to positively impact a hospital's 22 reputation? Page 362	1 BY MR. CHUNG: 2 Q. Okay. Exhibit 35, Ms. Binder, it's an 3 e-mail chain, I think principally between you and 4 Ms. Danforth. And you'll see that it has to do 5 with the Keck Medical Center. 6 Do you see that? 7 A. Yes. 8 Q. Okay. 9 A. But I don't recall this e-mail chain, so 10 I will need to read it. 11 Q. Yeah, please take a look. 12 I first want to direct your attention -- 13 it's really the sixth page -- 14 A. I'm not finished. 15 Okay. 16 Q. All right. So in Bates ending 861, Ling 17 Zheng from Keck writes to Ms. Danforth basically 18 requesting that Leapfrog suppress its PSI 90 19 score based on a change in how CMS evaluates 20 certain metrics. Is that what she's kind of 21 getting at? 22 A. Uh-huh, yes. Page 364
1 MS. BLAIR: Objection to form. 2 THE WITNESS: It depends. I mean, if 3 there's other ratings or other kinds of things 4 that make them look bad or they have 12 5 whistleblowers who have just come forward and are 6 on the front page of the paper, it's not going to 7 help that much. 8 BY MR. CHUNG: 9 Q. Okay. Receiving an A Leapfrog grade for 10 that same hospital would, would you say, help 11 that five-star CMS hospital's reputation? 12 MS. BLAIR: Objection to form. 13 THE WITNESS: Again, I would think so. 14 Maybe. But in the context of a variety of other 15 kinds of reputational issues, it would -- I'm not 16 sure which would -- could be pointed to as the 17 key thing. 18 MR. CHUNG: Okay. Let's go to tab 88. 19 This will be Exhibit 35. 20 (Binder Deposition Exhibit 35 marked for 21 identification and attached to the 22 transcript.) Page 363	1 Q. And if you look at page 3 of the 2 document, Bates ending 858, there's a follow-on 3 from a Ms. Hall where she writes, We feel that 4 this seriously misrepresents to the public the 5 safety at Keck Hospital of USC when, in fact, 6 there's been no clinical or outcome changes, 7 merely the application of a new AHRQ methodology 8 to historical data. We remain concerned that 9 this unfairly harms our reputation. 10 So is it fair to say that Keck was 11 concerned that a lower safety grade here would 12 negatively impact its reputation in its market? 13 MS. BLAIR: Object to form. 14 THE WITNESS: I don't know. They don't 15 talk about that particular issue. 16 BY MR. CHUNG: 17 Q. Well, she says -- we just read it here: 18 We remain concerned that this unfairly harms our 19 reputation. 20 How do you read that statement? 21 A. Oh, so they're concerned about -- yeah, 22 then they are concerned about their -- Page 365

1 Q. Okay. 2 A. -- grade as a result of this one measure. 3 Q. So looking at the next page, Bates ending 4 857, you write, just to Ms. Danforth, as a follow 5 on, I don't like their language about reputation. 6 How did this change affect their letter grade? 7 Why didn't you like their -- Ms. Hall's 8 language about reputation? 9 A. I don't recall why I said that, but... 10 Q. Okay. What did this -- what about the 11 language stood out to you, if you remember? 12 A. I don't recall. 13 Q. Okay. Did you disagree with the 14 connection that Ms. Hall was drawing between a 15 lower safety grade and the institution's 16 reputation? 17 A. I don't recall why I said it that way. I 18 think -- I can see that they might feel that 19 their reputation is at stake with any kind of 20 scoring system. So I can see that. But I think 21 what is clear -- 22 Q. Well, they're focusing specifically on Page 366	1 exactly -- this was, like, two years ago. 2 Q. Has Leapfrog received any feedback from 3 hospitals regarding the accuracy or fairness of 4 their assigned safety grades? 5 A. Sure. 6 Q. Okay. From who? 7 A. We value that -- we ask for them -- 8 Q. So the -- 9 A. -- to come to us with -- 10 Q. -- question is, from who? 11 A. From hundreds of hospitals, both positive 12 feedback and negative feedback. We get lots of 13 both. We ask for it. That's why we have a 14 public comment period. That's why we have a 15 whole variety of mechanisms that we use all the 16 time to encourage feedback. 17 Q. In terms of the negative feedback -- 18 A. Yes. 19 Q. -- regarding the fairness and the 20 accuracy of an assigned safety grade, what's the 21 most prevalent feedback you hear? 22 VIDEO TECHNICIAN: Ms. Binder. Page 368
1 the Leapfrog hospital safety grade here. 2 Are they talking about other scoring 3 systems? 4 A. No. They're talking about Leapfrog -- 5 Q. Right. 6 A. -- and they're talking -- this is not a 7 marketing person who's writing to Leapfrog. This 8 is -- it looks like their quality -- their chief 9 medical officer. 10 Q. Right. 11 A. So their chief medical officer is 12 concerned about the risk adjustment on this one 13 measure, which further -- it seems like further 14 analysis was done. And it seems like that was -- 15 that happened throughout a bunch of large 16 teaching hospitals and their PSI rate. 17 So compared to others, they were not 18 unduly harmed, so to speak. Their grade -- their 19 particular performance on this one measure was 20 not particularly harmed, it looks like. 21 But I'm not the expert on this. I would 22 definitely talk to Missy because I can't remember Page 367	1 THE WITNESS: Oh, sorry. 2 Well, they don't like the low grade. 3 That's the -- they don't -- hospitals that get 4 lower grades will say it's not -- we don't agree 5 with the methodology. 6 BY MR. CHUNG: 7 Q. Okay. And how does Leapfrog respond to 8 that type of feedback? 9 A. We spend a lot of time, actually, 10 talking -- personally talking with hospitals that 11 get a low grade and going through the measures 12 that led to it and how it applied to the 13 methodology, et cetera, and helping them to set 14 goals to -- for their improvement. We don't tell 15 them how to improve, but we definitely can say, 16 here's an area where you have some shortcomings 17 that if you put a focus on -- for instance, you 18 have a very low -- a very high rate of central 19 line infections; here -- you know, you should 20 really focus on that. And -- among other things. 21 And we'll just take them through it. 22 We spend a lot of time with hospital CEOs Page 369

1 in particular that are unhappy with the grade 2 and, you know, that's -- we always do that for 3 free. We do it all the time. We spend more time 4 on -- with hospitals that have lower grades 5 typically because they -- it's -- you know, it's 6 upsetting to them, and we understand that. 7 I will tell you that we do see 8 improvement in those hospitals, and it's 9 incredibly gratifying. It's one of the best 10 parts of my job, frankly, is when I see a 11 hospital that's gone from, you know, an F or a D 12 to an A. And I see it all the time, and it's 13 really, really impressive. 14 Q. Are you -- 15 A. Hospitals can do this. 16 Q. Are you aware of any cases where 17 Leapfrog's safety grades have conflicted with 18 other hospital quality ratings? 19 A. Yes. 20 Q. Okay. And how has Leapfrog addressed 21 those types of conflicts? 22 MS. BLAIR: Objection to form. Page 370	1 measures we do, but they put less of a weight on 2 those. Of course, for us, it's a heavy weight. 3 For them, it's a much smaller weight. So 4 therefore, they will sometimes have a 5 different -- they're often correlated, but 6 sometimes, for a particular hospital, there may 7 be some difference. 8 Q. Okay. And we're looking in particular at 9 the CMS Star -- 10 A. Yes. 11 Q. -- rating system, correct? 12 So that just given the different factors 13 and the weightings and the focus for one 14 particular hospital, what you're saying is that 15 the ratings can be very different between the 16 two, between Leapfrog and CMS; is that -- 17 A. On occasion that will happen because CMS 18 is looking at a -- they're not looking at safety 19 measures the same way we are. 20 Q. Okay. 21 A. But we are looking at the same safety 22 measure -- many of the same safety measures. Page 372
1 THE WITNESS: We point out how -- well, 2 it depends, actually. It just sort of depends on 3 what context. 4 So if a reporter is asking me about it, 5 they're saying, like, your example, they got five 6 stars from CMS but you gave them a C. Why? I 7 will say, because we are focused on patient 8 safety, and the five stars from CMS has less of a 9 focus on safety. 10 BY MR. CHUNG: 11 Q. Okay. So in those -- I'm glad that you 12 raised that example. 13 In response to a reporter who identifies 14 that sort of discrepancy or conflict -- 15 A. Uh-huh. 16 Q. -- what you underscore for the reporter 17 is that CMS and Leapfrog are measuring different 18 things; is that right? 19 A. Well, some of the same things. There is 20 overlap. 21 Q. Right. 22 A. They do look at the same patient safety Page 371	1 Q. Okay. 2 MR. CHUNG: Why don't we take a break 3 here. We in the next topic. 4 MS. BLAIR: Sure. 5 VIDEO TECHNICIAN: The time is 4:52 p.m. 6 This ends unit 4. We're off the record. 7 (A recess was taken.) 8 VIDEO TECHNICIAN: The time is 5:22 p.m. 9 This begins unit number 5. We're on the record. 10 (Binder Deposition Exhibit 36 marked for 11 identification and attached to the 12 transcript.) 13 BY MR. CHUNG: 14 Q. All right. We're now going to put 15 Exhibit 36 in front of you, which is Leapfrog's 16 answer to the plaintiffs' amended complaint, and 17 this is topic 15 among the 30(b)(6) topics that 18 you've been designated for, Ms. Binder. 19 A. Yes. 20 Q. And you're familiar with Leapfrog's 21 answer here? 22 A. Yes. Page 373

1 Q. Okay. So we're going to look first -- 2 we're going to go through a number of, basically, 3 Leapfrog's denials of various allegations here, 4 and then I'll ask you questions about those. 5 So, first, paragraph 2. So if you look 6 at page 3, paragraph 2, in Leapfrog's answer, it 7 denies the allegations that until last year TLG 8 continued to assign grades to plaintiffs based on 9 how similarly situated participating hospitals 10 performed on standard metrics. 11 But isn't it true that, until the fall of 12 2024, Leapfrog did grade the plaintiff hospitals 13 using an imputation method that assigned the mean 14 score of similarly situated hospitals? 15 A. Okay. I'm -- your question is kind of a 16 long one, so I got lost in the middle of it. 17 Sorry. 18 Q. Okay. So I'm just asking for the basis 19 for this denial here. 20 A. Well, the line Leapfrog continued to 21 assign grades to plaintiffs based on how 22 similarly situated participating hospitals Page 374	1 MS. BLAIR: I think you misread it. 2 MR. CHUNG: Okay. 3 THE WITNESS: It says -- 4 MS. BLAIR: -- we assigned grades. 5 MR. CHUNG: I'm not reading it -- 6 MS. BLAIR: Oh, I'm sorry. 7 THE WITNESS: We assign -- until last -- 8 it says -- this is what we denied: Until last 9 year, Leapfrog continued to assign grades to 10 plaintiffs based on how similarly situated 11 participating hospitals performed on standard 12 metrics. 13 BY MR. CHUNG: 14 Q. Okay. So why are -- 15 A. I'm saying similarly situated 16 participating hospitals is not well defined. And 17 that's not -- that's not referring to imputation 18 or anything else in that particular sentence. 19 It's just a very questionable way of describing 20 our methodology. 21 Q. Okay. Let's move on to paragraph 22. 22 So direct -- I specifically wanted to ask Page 376
1 performed on standard metrics. 2 Q. Yes. So why deny that? 3 A. I'm just going to re-read this 4 paragraph to be clear on this. 5 Because we -- we are arguing about 6 similarly situated participating hospitals, what 7 that definition would be. And that's not a 8 good -- good characterization of our methodology, 9 as it was in that time period. 10 Q. Okay. So that's just incorrect, is what 11 you're testifying? 12 A. We're denying it, yes. 13 Q. Okay. So it's not correct that, until 14 the fall of 2024, Leapfrog graded plaintiff 15 hospitals using an imputation method that 16 assigned the mean score of similarly situated 17 hospitals? 18 MS. BLAIR: Objection to form. I think 19 you misread that sentence. 20 THE WITNESS: It says -- 21 BY MR. CHUNG: 22 Q. I'm just reading it back to you. Page 375	1 you about the last sentence in the paragraph: It 2 specifically explained its 2024 change was 3 designed to prevent non-participating hospitals 4 from inadvertently benefitting, compared to 5 hospitals that self-report, even though TLG has 6 no data to show how non-participation could 7 benefit a hospital. 8 Do you see that? 9 A. I don't, actually. That's paragraph -- 10 Q. 22. 11 A. -- 22? I've got page 13? 12 Q. Yes. Going on to the next page. So the 13 last sentence. 14 It specifically explained... 15 A. Oh, yeah. 16 Q. Do you see that? If you can read that 17 sentence. 18 A. We deny that the purpose of the change in 19 2024 was to prevent non-participating 20 hospitals -- 21 Q. Okay. 22 A. -- from anything. That was not the Page 377

1 purpose of the change. 2 Q. Well, I'm going to show you a document 3 titled, Final Updates to the Leapfrog Hospital 4 Safety Grade Methodology. 5 MR. CHUNG: This will be Exhibit 37. 6 (Binder Deposition Exhibit 37 marked for 7 identification and attached to the 8 transcript.) 9 BY MR. CHUNG: 10 Q. Okay. And if you look at the second 11 page, Ms. Binder, under responses to public 12 comments -- do you see that? 13 A. Yes. 14 Q. Okay. Under 4, comment or supported the 15 change to the imputation methodology, the second 16 sentence reads, Hospitals that choose not to 17 complete the survey should not inadvertently 18 benefit from hospitals that continue to strive to 19 make improvements and maintain Leapfrog 20 standards. 21 So given what this document says 22 regarding the change in the imputation Page 378	1 The plaintiffs' allegation here is that, 2 for the four imputed measures -- CPOE, BCMA, IPS, 3 and hand hygiene -- if a hospital does not 4 participate in TLG's survey, TLG assigns a point 5 value that is equivalent to receiving limited 6 achievement for this measure, its lowest possible 7 score, without any factual basis. 8 Do you see that? 9 A. Yes. 10 Q. All right. And the next sentence is, The 11 result is that hospitals who elect not to 12 participate in TLG's survey receive only 60 out 13 of 400 possible points in these four categories. 14 What's the basis for denying this 15 allegation? 16 A. The last sentence in this -- in 17 paragraph 24, it says, TLG has no basis to assign 18 that low value. 19 We have a basis to assign the low value. 20 Q. Okay. Paragraph 25, the next one: 21 Leapfrog denies that TLG's imputation model for 22 ranking non-participating hospitals directly Page 380
1 methodology, what's your basis for denying the 2 sentence -- the last sentence of paragraph 22? 3 A. It says -- 4 MS. BLAIR: Objection to form. 5 THE WITNESS: It says it was 6 specifically -- it was designed to prevent. This 7 is a response to a comment that we agree that 8 there should not be an inadvertent benefit from 9 not reporting. That said, it is not -- it was 10 not the design -- it was not the centerpiece or 11 the purpose or the design of and the reason 12 for -- the fundamental reason for us to pursue 13 this methodology. 14 BY MR. CHUNG: 15 Q. Okay. 16 A. Fundamental reason -- 17 Q. That's the basis -- 18 A. -- is consumers -- 19 Q. -- for your denial here; is that correct? 20 A. I believe so. 21 Q. Okay. Going to paragraph 24 in the 22 answer. Page 379	1 conflicts with TLG's own national expert panel's 2 guidance. 3 Do you see that? 4 A. Yes. 5 Q. All right. And then as TLG explains, not 6 all hospitals have enough data publicly available 7 to be eligible for a grade. 8 Why deny that? 9 A. We didn't deny that not all hospitals 10 have enough publicly available data to be 11 eligible for a grade. 12 Q. Okay. You're just denying the previous 13 sentence; is that right? 14 A. We deny -- let's see. 15 MS. BLAIR: I'll just object to form, 16 that it mischaracterizes the answer on page 16. 17 THE WITNESS: We admit to the allegations 18 that state, TLG explains not all hospitals have 19 enough data publicly available to be eligible for 20 a grade. 21 And we also admit to this allegation: As 22 per the national expert guidance, Leapfrog has Page 381

1 requirements for the minimum amount of data it 2 needs to issue an accurate grade. 3 So we admit to those. 4 BY MR. CHUNG: 5 Q. Okay. 6 A. And then we also admit to, you know, 7 hospitals missing more than six process measures 8 are not graded. 9 Q. Okay. 10 A. So the issue is imputed data, and we 11 count imputed data as data. 12 Q. Okay. Let's go to paragraph 26. 13 And Leapfrog denies the sentence: In 14 response, TLG falsely states the hospital safety 15 grade reflects how well a hospital does on 16 safety, not whether they complete the hospital 17 survey. 18 Does Leapfrog admit that it made that 19 statement? 20 MS. BLAIR: Objection to form. 21 THE WITNESS: The statement the -- which 22 statement? Page 382	1 Q. Okay. So it looks like Leapfrog admits 2 the first part of the allegation, which is 3 plaintiffs are among the many hundreds of 4 hospitals across the country who choose not to 5 participate in the survey. 6 But then Leapfrog denies the rest: Given 7 that non-participation, TLG could easily have 8 told consumers, as it does on the 9 leapfroggroup.org, it lacks sufficient data to 10 provide safety grades for plaintiffs. Instead, 11 it imputed scores to plaintiffs and gave them 12 failing or near failing grades on the 13 hospitalsafetygrade.org website. 14 What's the basis for this denial? 15 A. Well, there's a lot of basis in this 16 particular paragraph, which is very recklessly 17 written given what we know about, and what we 18 have clearly stated on our website, about our 19 methodology. 20 So we don't -- instead, it imputed scores 21 to plaintiffs and gave -- the grades come from 22 all of the measures within the grade methodology, Page 384
1 BY MR. CHUNG: 2 Q. Exactly: The hospital safety grade 3 reflects how well a hospital does on safety, not 4 whether they complete the hospital survey. 5 Does Leapfrog stand by that statement? 6 A. I don't recall ever seeing that statement 7 made the way it's written here. Because -- but 8 that said, our focus is how well a hospital does 9 on safety, not whether they -- right? And 10 completing the survey is not what it's about. 11 It's doing well on the survey would be what we 12 would be looking at. 13 Q. Right. But this statement, the hospital 14 safety grade reflects how well a hospital does on 15 safety, not whether they complete the hospital -- 16 A. That -- 17 Q. -- survey, does -- is that -- does 18 Leapfrog stand by that statement? 19 A. Yes. 20 Q. Okay. Going to paragraph 57. Okay? 21 It's on page 29. 22 A. Okay. Page 383	1 which is 32 measures, not just the imputed 2 measures. 3 Q. But is it incorrect that they were given 4 failing or near failing grades? 5 MS. BLAIR: Objection to form. Misstates 6 the context of the next sentence. 7 THE WITNESS: They were -- right. 8 BY MR. CHUNG: 9 Q. Well, that's -- my question is, is it 10 incorrect that they were given failing or near 11 failing grades? 12 A. They were given Ds and Fs. 13 Q. Okay. Is it correct that, for at least 14 some of the metrics -- right? -- I'm not -- 15 again, I'm not reading from the answer here. 16 Is it correct that, at least for certain 17 of the metrics, they were -- the hospitals here 18 were given imputed scores? 19 A. That's not what this says. 20 Q. Yeah. But I'm -- 21 A. There were four metrics that are subject 22 to imputation in a well-described and Page 385

1 well-thought-through process, and it is not only 2 the reason why they get Ds and Fs. And that's 3 how this is recklessly written. It is not an 4 accurate characterization at all of what happened 5 with the hospital safety grade and why these 6 hospitals did poorly on it. 7 Q. Okay. So paragraph 59, just a couple 8 down, about Delray Medical Center. 9 You would -- I think -- Leapfrog admits 10 that Leapfrog assigned Delray Medical Center the 11 F grade, right? 12 A. Yes. 13 Q. But the denial is, under its flawed 14 technology [sic], TLG assigned Delray Medical 15 Center the lowest possible score on multiple 16 criteria for which TLG had no information, 17 including handwashing -- these are the imputed 18 metrics, right? 19 A. Right. 20 Q. All right. So what is -- is it incorrect 21 that TLG assigned Delray Medical Center the 22 lowest possible score on these four imputed Page 386	1 Q. All right. So you're calling the scores 2 themselves data; is that right? 3 A. It's information. This says we had no 4 information. Imputed scores are information, and 5 they're based on -- they're based on thoughtful 6 consideration. 7 Q. In other words, are you saying that the 8 scores, the imputed scores here, the lowest 9 available scores, are based on the scores? 10 MS. BLAIR: I'll object to form. 11 BY MR. CHUNG: 12 Q. Is that what you're saying? 13 A. They're -- no. Scores are -- well, that 14 would be sort of circular reasoning to say the 15 scores are based on scores. 16 Q. That's what I take you to mean. So what 17 do you mean? You said that -- 18 A. That imputed scores are information, and 19 that we came to those scores through a process 20 that is fundamentally thoughtful and informed. 21 Q. Okay. But are those scores based on any 22 data that TLG received from the hospital or from Page 388
1 metrics? 2 MS. BLAIR: Object to form. 3 THE WITNESS: The objection -- or the 4 denial would be around the line "to which TLG had 5 no information" and -- 6 BY MR. CHUNG: 7 Q. Well, isn't it true -- Ms. Binder, isn't 8 it true that, for those four metrics -- right? -- 9 the imputed metrics, TLG did not have data with 10 respect to those four imputed metrics? Isn't 11 that correct? 12 A. We have imputed data. And our imputed 13 data we stand behind. 14 Q. What is the imputed data? Is it the 15 score -- 16 A. The score. The imputed score is based on 17 our experience and knowledge and the expert panel 18 recommendation. So it's based on that. 19 And -- so we would say that it is not 20 based on nothing, which is what this -- 21 Q. Okay. But -- 22 A. -- is sort of claiming. Page 387	1 any secondary sources? 2 A. It's not based on data we got from the 3 hospital, but it's not based on no information, 4 which is what this states. 5 Q. Okay. Paragraph 88. It reads that this 6 has directly caused -- that Leapfrog's messaging 7 around the safety grades has directly caused 8 plaintiffs harm to their reputation and good 9 will. 10 Do you deny that the D and F grades that 11 were assigned to the plaintiff hospitals have 12 damaged the reputation of the hospitals? 13 A. Those hospitals performed so poorly in so 14 many ways that I could never isolate it to just 15 Leapfrog. 16 Q. So are you denying it? 17 MS. BLAIR: Objection. 18 THE WITNESS: We've denied it. 19 BY MR. CHUNG: 20 Q. Okay. And that's the basis for your 21 denial; is that correct? 22 A. That it's impossible to know whether it's Page 389

1 Leapfrog or just other elements of the poor 2 performance of these hospitals -- 3 Q. Okay. 4 A. -- that would cause them harm to their 5 reputation and good will which -- I haven't seen 6 evidence, but if there is evidence of that, which 7 there could be, that there's harm to their 8 reputation, it would be impossible -- or at least 9 I haven't seen any evidence or any way of 10 isolating that to Leapfrog. 11 Q. Okay. But would it be fair to say that, 12 just standing alone, that an F grade to a 13 hospital could negatively impact the reputation 14 of that hospital? 15 A. Yeah. It could, if it -- but it would 16 especially harm their reputation if they also had 17 one star or they had a bad press report -- 18 Q. I'm just talking about a Leapfrog 19 F grade. I'm not talking about other measures. 20 A. It -- yeah, it could. I guess it could. 21 Q. Okay. 22 A. But it would be very hard to point that Page 390	1 briefed on the lawsuit. 2 Q. Okay. Any -- and what's been the purpose 3 of those briefings? 4 A. To brief the board. As I said earlier, 5 I've briefed the board on -- well, with counsel 6 present, we have briefed the board on this 7 lawsuit. 8 Q. Okay. Has Leapfrog paid to lobby any 9 federal or state or local governments in relation 10 to this litigation? 11 A. No. 12 Q. No? Okay. Have you been involved in the 13 public relations aspect of Leapfrog's response to 14 this lawsuit? 15 A. Yes. 16 Q. All right. And in what capacity have you 17 been involved in the response? 18 A. I've been on the team within Leapfrog 19 that has worked with -- has worked on the 20 response to the lawsuit, starting when it was 21 filed. 22 Q. Okay. Page 392
1 out in a hospital that has other problems with 2 their safety performance and their quality. 3 Q. Let's go to -- has Leapfrog communicated 4 with any federal or state government agencies in 5 relation to this litigation? 6 A. We are in -- we are in communication with 7 CMS frequently on various topics. There is a 8 liaison to our board who is -- 9 Q. My question is -- 10 A. So -- 11 Q. So with CMS, any communications with CMS 12 relating to this litigation, is my question. 13 A. I was trying to answer it. 14 Q. Right. I'm trying to get to the point. 15 So any questions -- 16 A. I was right at that point, and then you 17 interrupted me. So -- 18 Q. Okay. 19 A. All right? We have a liaison to our 20 board. Her name is Michelle Schreiber. She is 21 the director of quality programs at CMS. And so 22 she's been to the board meetings and she's fully Page 391	1 MR. CHUNG: Let's go to tab 57. This 2 will be Exhibit 38. 3 (Binder Deposition Exhibit 38 marked for 4 identification and attached to the 5 transcript.) 6 BY MR. CHUNG: 7 Q. And you'll see here it's an e-mail thread 8 forwarded from Lauren Bailey to Karen Jupiter 9 sharing a thread she had with you. 10 Do you see that? 11 A. Yes. 12 Q. And you wrote, Let's make a goal to have 13 one story at a minimum every three days about 14 Tenet or one of the hospitals. 15 Do you see that? 16 A. Yes. 17 Q. All right. And why did you make that a 18 goal? 19 A. Because the plaintiff hospitals' 20 representative, who's one of your attorneys at 21 Gibson Dunn, had been all over the media in that 22 particular community telling falsehoods about Page 393

1 Leapfrog, and it was necessary for us to become 2 involved in having a voice in the media in that 3 local community, given that these falsehoods were 4 being thrown about in a very reckless way. 5 Q. And was part of that -- part of that 6 strategy of having one story at minimum every 7 three days about Tenet or one of the hospitals, 8 what were those stories going to be about? 9 A. Patient safety. 10 Q. Well, about Tenet or one of the 11 hospitals. Right? You specifically said that 12 you want to have one story at a minimum every 13 three days about Tenet or one of the plaintiff 14 hospitals. Right? 15 A. Uh-huh. 16 Q. So what about Tenet or the plaintiff 17 hospitals were you directing these stories to be 18 about? 19 A. Well, I wasn't saying what they 20 necessarily should be about, but with regard to 21 the hospitals, it would be about their 22 performance on different parts of their safety Page 394	1 Okay. So we are going to mark this 2 Exhibit 39. 3 (Binder Deposition Exhibit 39 marked for 4 identification and attached to the 5 transcript.) 6 BY MR. CHUNG: 7 Q. So Ms. Binder, this relatively thick 8 exhibit, I'm going to represent to you that this 9 is a Slack conversation that was produced by 10 CURA Strategies in response to a subpoena that 11 was sent to them. 12 And I want to direct your page -- direct 13 your attention to the page ending Bates 467. 14 Okay. 15 And do you see toward the middle of the 16 page -- Sarah Farinelli, is she at CURA 17 Strategies? 18 A. Yes. 19 Q. Okay. Someone that's working on the 20 public relations for you relating to this -- the 21 lawsuit; is that right? 22 A. She's working -- yes, but also public Page 396
1 grade or patient safety. 2 Q. Right. So the idea here was to have one 3 story at minimum every three days, a negative 4 story about Tenet or one of the plaintiff 5 hospitals; is that correct? 6 A. A story that would point out the record 7 on patient safety and/or respond to the 8 continuous series of lies, frankly, coming out 9 from the plaintiff hospitals and the 10 representative -- the lawyer representing them. 11 Q. But, here, it's specific to Tenet or -- 12 or the hospitals, correct? 13 MS. BLAIR: Objection to form. Asked and 14 answered. 15 THE WITNESS: Yeah. 16 BY MR. CHUNG: 17 Q. Okay. 18 A. I mean, that's who's telling the lies, so 19 yes. 20 Q. Okay. 21 MR. CHUNG: So let's turn to 22 Exhibit 84 -- or tab 4, I'm sorry. Page 395	1 relations in general for Leapfrog. 2 Q. Okay. And then she sends an article from 3 Bloomberg Law about Leapfrog's motion to dismiss 4 being denied. 5 Do you see that? 6 A. Yes. 7 Q. Okay. 8 MR. CHUNG: And just so you have it, 9 we're going to mark this Exhibit 36, I think. 10 MS. BLAIR: 40. 11 MR. CHUNG: 40, sorry. The article 12 itself. 13 (Binder Deposition Exhibit 40 marked for 14 identification and attached to the 15 transcript.) 16 BY MR. CHUNG: 17 Q. And do you recognize this article? Is 18 this the article that's linked by Ms. Farinelli 19 in the chat? 20 A. I believe so. 21 Q. Okay. 22 A. Looks a little different, but... Page 397

1 MS. BLAIR: And for the record, Daniel, 2 this doesn't have a Bates number, but it comes 3 from... 4 MR. CHUNG: It comes from Bloomberg Law. 5 MS. BLAIR: Oh. 6 MR. CHUNG: It's what we printed out. 7 BY MR. CHUNG: 8 Q. So on -- if we continue, Stephanie Wight 9 is another CURA Strategies member; is that right? 10 A. Yes. 11 Q. Okay. And at 7:50, she writes that -- On 12 Leah's e-mail, I agree about having talking 13 points ready, but I don't know about complaining 14 to Bloomberg. 15 Do you see that? 16 A. Yes. I -- I always say to the PR firm 17 that we will not complain or try to get 18 retractions unless it's an extremely serious 19 problem. 20 Q. So what e-mail is -- do you know what 21 e-mail that Stephanie Wight is referring to here? 22 A. No. Page 398	1 CURA Strategies about the public relations 2 strategy? 3 A. No. 4 Q. You didn't want to hurt Tenet? 5 A. I want to make sure that coverage of this 6 is aggressive in defending our integrity and our 7 reputation, but that's not necessarily hurting 8 Tenet. 9 And also -- 10 Q. Well, she's specifically calling out 11 Tenet here, right? 12 A. Right. Yeah. 13 Q. And she specifically says she wants to 14 hurt Tenet, and to do that, she has to hit them 15 financially. 16 Do you see that? 17 A. Right. Yeah. I don't -- 18 Q. And so do you -- does this reflect 19 discussions you had with CURA about a PR campaign 20 to hurt Tenet financially? 21 A. No. I don't even know how we would do 22 that. So... Page 400
1 Q. Okay. Did you want to complain to 2 Bloomberg Law about this article? 3 A. I very much doubt it. My usual statement 4 is only when it's a serious problem. 5 Q. Okay. But you don't remember this 6 specific instance whether you wanted to complain 7 to Bloomberg Law about this article? 8 A. I don't recall, but I don't believe I 9 wanted to. 10 Q. Okay. 11 A. Because it wouldn't be -- I almost never 12 want to. 13 Q. So moving to the next page ending in 14 Bates 468, at the top of the page, Ann writes, 15 The fact that it is Bloomberg, too, I think is 16 influencing her. She wants to hurt Tenet, and to 17 do that, she has to hit them financially. 18 Do you see that? 19 A. Yeah, but I don't know what she's talking 20 about. 21 Q. This doesn't reflect a conversation, any 22 sort of conversations, that you had with Page 399	1 Q. So where is this coming from? 2 MS. BLAIR: Objection to form. 3 BY MR. CHUNG: 4 Q. These are -- 5 A. I don't know where it's coming from. I 6 don't -- 7 Q. This -- 8 A. This is the first I've seen it. So... 9 Q. These are the public relations 10 professionals that you've hired, correct? 11 A. These are -- this is our PR firm that 12 works with us on variety of news items -- 13 Q. Okay. 14 A. -- including when this lawsuit became an 15 issue for us. 16 Q. Did you ask CURA to come up with a plan 17 to hurt Tenet financially as part of the public 18 relations campaign? 19 A. No, that's why I'm puzzled by that line. 20 We certainly did want coverage to be, especially 21 in the South Florida area, to highlight the 22 performance of these hospitals and to defend our Page 401

1 reputation against the very -- 2 Q. Okay. 3 A. -- very alarming lies that were being 4 told by counsel. 5 Q. Did the decision -- did the judge's 6 decision denying Leapfrog's motion to dismiss 7 somehow influence your public relations strategy 8 at this point? 9 A. No. I mean, other than it's news, so 10 that would influence it. 11 Q. Okay. 12 A. We would be responding to questions from 13 reporters, so we would be announcing it 14 ourselves. 15 Q. All right. How, if at all -- how, if at 16 all, did it change or impact the public relations 17 strategy? I'm talking about the denial of the 18 motion to dismiss. 19 A. We would respond -- I think we probably 20 had inquiries from reporters that we would 21 respond to. 22 Q. Okay. Let's go to tab 67. Page 402	1 to not have this ridiculous, frivolous lawsuit 2 and be more constructive. 3 Q. What did you want to write to him? 4 A. What I just said. 5 Q. That's what you were going -- did you 6 write that to him? 7 A. I believe I did, actually. 8 Q. Okay. What do you recall specifically? 9 I mean, I think you used the word "ridiculous" 10 and "frivolous lawsuit." But what do you recall 11 communicating to Mr. Sutaria? 12 A. I'd have to pull out -- it was a short 13 note that said, I've heard that you contacted 14 Johns Hopkins and -- I was glad to hear that he's 15 working on some patient safety programs at Tenet. 16 And that was it. 17 Q. Okay. So -- you can put that down. 18 I just wanted to ask some just questions 19 going back to -- kind of basic questions about 20 the methodology and the hospital safety grade. 21 So, earlier, when we were going through kind of 22 the chronology of expert panel meetings regarding Page 404
1 MR. CHUNG: This will be Exhibit 41. 2 (Binder Deposition Exhibit 41 marked for 3 identification and attached to the 4 transcript.) 5 BY MR. CHUNG: 6 Q. And this is an e-mail from April 29, 7 2025, from a Robert Galvin at Blackstone Group to 8 you, or an e-mail exchange. 9 And in the e-mail exchange you ask 10 Mr. Galvin for Saum Sutaria's e-mail address. 11 Who is -- is Saum Sutaria the CEO of 12 Tenet? 13 A. Yes. 14 Q. All right. And you ask him to provide 15 you with direct contact info for Mr. Sutaria; is 16 that right? 17 A. Yes. 18 Q. And why did you want his direct contact 19 information? 20 A. To reach out to him. 21 Q. About what? 22 A. About -- talking about what can be done Page 403	1 the methodology, there was discussion among the 2 expert panelists or notes about a bias in favor 3 of non-participating hospitals. 4 Do you recall that type of discussion? 5 MS. BLAIR: Objection to form. 6 THE WITNESS: No. 7 BY MR. CHUNG: 8 Q. Or from the previous -- from the previous 9 versions of the methodology. There was 10 discussion about how, under the previous versions 11 of the methodology, hospitals may be 12 disincentivized from responding to the survey. 13 Do you recall that? 14 A. I think there's discussion of that. 15 Yeah. 16 Q. Right. So would you say that -- so 17 that's -- would you say that another way of 18 putting that is that there was a bias in favor -- 19 in those previous methodologies, bias in favor of 20 hospitals that didn't respond to the survey? 21 A. I think that was some of the commentary 22 that we heard when we had -- Page 405

1 Q. Right. 2 A. -- it for public comment, we heard from 3 hospitals that felt that they were -- we were 4 inflating the score for those four measures for 5 hospitals that -- for no reason, for hospitals 6 that we -- that weren't reporting to the survey. 7 And reporting to the survey is a very high bar 8 and a very hard thing to do so that we should not 9 be inflating their scores. 10 Q. Okay. Doesn't the current methodology, 11 though, the current imputation methodology, raise 12 a bias against non-reporting hospitals? 13 MS. BLAIR: Objection to form. 14 THE WITNESS: I don't believe it does, 15 and neither does our expert panel. 16 BY MR. CHUNG: 17 Q. Okay. Why grade non-participating 18 hospitals at all? 19 A. Because those hospitals -- all hospitals, 20 but those hospitals are caring for thousands, 21 tens of thousands, hundreds of thousands of 22 Americans every day who are entrusting their Page 406	1 limited achievement score means? 2 MS. BLAIR: Objection to form. 3 THE WITNESS: Well, the -- I'm -- yeah, I 4 don't understand limited -- limited achievement 5 is not discussed on the hospital safety grade. 6 It is -- it's -- the hospitals are scored on each 7 one of the measures, including those four imputed 8 measures. 9 BY MR. CHUNG: 10 Q. Okay. Didn't -- 11 A. Limited achievement is from the survey. 12 Q. Didn't Leapfrog receive public comment in 13 connection with the change in methodology in 2024 14 that the public will not understand nor dig into 15 the methodology of the grades? Are you aware of 16 that public comment? 17 A. Some -- some commenters expressed that. 18 Yes. 19 Q. Okay. And Leapfrog doesn't provide the 20 information necessary to completely -- 21 comprehensively understand the methodology, 22 correct? Other than linking to the -- to the Page 408
1 lives every single -- 24/7 to these hospitals. 2 And people deserve to know how they're doing. So 3 we don't think that we should just exempt some 4 hospitals because they are not transparent. 5 Q. Okay. So transparency is the key here; 6 is that right? 7 MS. BLAIR: Objection to form. 8 THE WITNESS: Consumers having 9 information they need to protect their lives and 10 their families' lives when they are needing 11 hospital care, that's the foremost issue. And 12 transparency allows for that. 13 BY MR. CHUNG: 14 Q. Okay. But is -- just going back to 15 transparency, are Leapfrog's hospital safety 16 grades for these hospitals that didn't 17 participate, are they transparent? 18 A. Extremely so. 19 Q. All right. Well, is there any 20 information on Leapfrog's websites, other than 21 the link to the imputation -- other than the link 22 to the scoring methodology, about what the Page 407	1 scoring methodology; is that right? 2 A. We link -- 3 MS. BLAIR: Objection to form. 4 THE WITNESS: No. We link to the scoring 5 methodology in several different places on the 6 Hospital Safety Grade website and we explain in 7 layman's terms to anyone who is looking at any 8 particular hospital how they do on each measure, 9 and that we assign -- we assigned scores when we 10 don't have the data. 11 BY MR. CHUNG: 12 Q. Okay. Do you think the scoring 13 methodology is easy to understand for the layman? 14 A. I think the document on scoring 15 methodology is not that accessible to the average 16 layman, which is why we have translated it 17 into -- or translated the different measures and 18 explaining what they're about and why they matter 19 and how we scored hospitals -- we put that in 20 more layman's language throughout our website. 21 And we give consumers several different ways to 22 comprehend how each hospital did on each one of Page 409

1 the measures so the -- you know, the gas gauge, 2 the image, as well as the explanation, which is 3 written in layman's language, et cetera. 4 We have a number of techniques that we've 5 applied, which were originally developed in 6 consultation with a low literacy expert and 7 haven't changed much since then, actually. And 8 those are really aiming to give that high level 9 of transparency and comprehension by the lay -- 10 by laypeople. 11 Q. Okay. Is at least one of the reasons 12 Leapfrog grades non-participating hospitals 13 because it affects Leapfrog's revenue; is that 14 right? 15 MS. BLAIR: Objection to form. 16 THE WITNESS: No. The non-participant -- 17 non-participating hospitals come in, it costs us 18 money. It's very -- as I said, the survey is 19 expensive. And adding these five plaintiff 20 hospitals would just add to our expenses. 21 BY MR. CHUNG: 22 Q. Okay. Let me put it another way. Page 410	1 THE WITNESS: They get a grade. 2 BY MR. CHUNG: 3 Q. Well, if you do not give -- let's put it 4 another way. 5 If you do not give non-participating 6 hospitals a grade, aren't you concerned that 7 fewer hospitals will participate in the survey? 8 A. At -- that's not the primary concern. 9 The primary concern is we're not meeting our 10 mission, which is to give people information -- 11 Q. I -- 12 A. -- they deserve to know. 13 Q. But I'm asking, is it as -- let's say, is 14 it a concern that fewer hospitals will 15 participate in the survey if you do not give 16 non-participating hospitals a grade? 17 MS. BLAIR: Objection to form. 18 THE WITNESS: That's not the primary 19 concern. I don't even think that is a concern. 20 BY MR. CHUNG: 21 Q. You're testifying that it's not a concern 22 at all? Page 412
1 The accolades licensing program is 2 responsible for -- it is the most significant 3 source of revenue for Leapfrog. We've -- I've 4 asked it a bajillion times. Is that correct? 5 A. That is the highest -- 6 Q. Yes. 7 A. That is the highest source of revenue -- 8 Q. Okay. 9 A. -- for us right now. 10 Q. Okay. And are you worried that, if you 11 don't give -- if you do not give 12 non-participating hospitals a grade, if you allow 13 them to, say, opt out -- right? -- fewer 14 hospitals will participate in the survey; isn't 15 that correct? 16 MS. BLAIR: Objection to form. 17 THE WITNESS: Non-participating -- to opt 18 out of what? 19 BY MR. CHUNG: 20 Q. Opt out of the survey and therefore not 21 get a grade. 22 MS. BLAIR: Objection to form. Page 411	1 A. That non-participating hospitals, if we 2 didn't give them a grade, that would reduce -- 3 you're saying we're supposed to be worried that 4 would -- the -- 5 Q. Fewer hospitals will respond to the 6 survey; isn't that a concern? 7 MS. BLAIR: Objection to form. Asked and 8 answered. 9 THE WITNESS: I don't know. I hadn't 10 thought of it that way, so I don't know. 11 BY MR. CHUNG: 12 Q. Okay. Well, at the very least, are you 13 concerned that, if you do not give 14 non-participating hospitals a grade, the number 15 of hospitals that respond to the survey won't 16 increase? 17 A. This is not what keeps me up at night. 18 That's not what I'm -- 19 Q. I'm just asking you -- 20 A. -- worried about. 21 Q. If you could just answer the question. 22 I'm not asking you what keeps you up at night. Page 413

1 I'm asking -- 2 MS. BLAIR: Well, you're asking what 3 she's concerned about, so I think that's an 4 answer. 5 THE WITNESS: It's not a prevailing 6 concern. 7 BY MR. CHUNG: 8 Q. Is it a concern at all? 9 A. Anything that impacts full transparency 10 for every hospital in the country is a great 11 concern to me. 12 Q. All right. If there is -- Ms. Binder, if 13 there is a significant drop, a decrease in the 14 number of hospitals that participate in the 15 survey, would that negatively impact Leapfrog's 16 brand? 17 A. I don't know. We've -- before we had the 18 safety grade at all, we had 1300, 1400 hospitals 19 participating. So -- and we had a pretty 20 significant brand reputation then. 21 So that's not something I've worried 22 about. Page 414	1 the breadth and the brand of Leapfrog? 2 MS. BLAIR: Objection to form. 3 THE WITNESS: I don't know. It would 4 certainly impact patient safety and it would 5 undermine transparency. It would be a major step 6 backward for the country. 7 BY MR. CHUNG: 8 Q. If fewer hospitals were responding to the 9 survey, would that decrease or impair the 10 relevance of Leapfrog as an institution? 11 MS. BLAIR: Objection to form. Asked and 12 answered. 13 MR. CHUNG: That's a different question. 14 MS. BLAIR: Oh -- that is what reputation 15 is, isn't it? 16 MR. CHUNG: Please. 17 THE WITNESS: Leapfrog's relevance is 18 very, very high, and we are a high-profile 19 organization, extremely high profile. So I don't 20 see that participation in the survey, per se, is 21 the source of that. We are -- our influence is 22 broad and it's not just on the survey. Page 416
1 Q. But I think you testified earlier, and we 2 saw some of the -- kind of the self-evaluation 3 documents that, during your time as CEO, that 4 your -- through your efforts as CEO, that the 5 brand -- right? -- and the reputation of Leapfrog 6 has increased over time, correct? 7 A. I don't recall the precise wording I 8 used -- 9 Q. Right. 10 A. -- but the impact and influence of 11 Leapfrog to advance patient safety has shown -- 12 has grown significantly, and that has resulted in 13 some improvements in some national statistics on 14 patient safety incidents. 15 Q. Okay. So if you had much fewer -- let's 16 say that the number of hospitals that respond to 17 the survey went from -- right now I think it's 18 close to 3,000, right, or thereabouts? 19 A. No. 2400. 20 Q. 2400. Right. Let's say it went down to 21 1,000 hospitals. 22 Does that -- would that impact kind of Page 415	1 BY MR. CHUNG: 2 Q. If Leapfrog becomes less relevant because 3 of fewer hospitals responding to the survey, 4 would it be fair to say that fewer hospitals 5 would be willing to pay for accolade licensing? 6 MS. BLAIR: Objection to form. 7 THE WITNESS: I -- I don't know. 8 BY MR. CHUNG: 9 Q. Okay. If Leapfrog's brand goes down or 10 if it becomes less relevant, is it fair to say 11 that fewer hospitals would pay to -- pay to 12 license the survey data from Leapfrog? 13 MS. BLAIR: Objection to form. 14 THE WITNESS: We have not seen a -- 15 licensure revenues tied to the number of 16 hospitals reporting to the survey. 17 BY MR. CHUNG: 18 Q. Okay. Would you say that if fewer 19 hospitals -- if fewer hospitals responded to the 20 survey -- if there was a dramatic drop in the 21 number of hospitals that responded to the survey, 22 would you say that donations might go down? Page 417

1 Donations to Leapfrog. 2 A. No, no. Those could potentially go up 3 because people would be so outraged. 4 Q. If it becomes -- if Leapfrog becomes less 5 relevant if its brands go down, would you expect 6 donations to go down or up? 7 A. If Leapfrog becomes less relevant? 8 Q. Yeah. 9 A. I don't know how that would happen, so 10 it's hard for me to answer that question. 11 Q. Okay. Now, in terms of -- we read some 12 e-mails involving Dr. Romano where he was 13 discussing the -- kind of the aim or the 14 possibility of the new imputation methodology 15 penalizing hospitals. 16 Do you remember that discussion in the 17 e-mails? 18 A. Uh-huh. Yes. 19 Q. Are you -- it's -- would you say -- kind 20 of basic question: Is keeping -- is increasing 21 or at least maintaining Leapfrog's brand and 22 reputation an important part of your role as CEO? Page 418	1 tied to a lot more factors than just the number 2 of hospitals that participate in the survey. 3 Q. Okay. 4 A. Far beyond that. 5 Q. Is Leapfrog willing to penalize hospitals 6 in order to encourage them to participate in the 7 survey? 8 A. No. 9 Q. Okay. So your testimony is that that was 10 not at least one of the purposes of the change in 11 imputation methodology? 12 A. No, we don't set out to penalize 13 hospitals. Our goal is to get them to improve. 14 Q. Okay. And that's notwithstanding one -- 15 a member of your expert safety panel, Patrick 16 Romano, saying in an e-mail that a goal or a 17 purpose of the change in the imputation 18 methodology was to penalize non-participants, 19 correct? 20 MS. BLAIR: Objection to form. 21 THE WITNESS: I believe the wording was 22 something like, if you want to do this, blah, Page 420
1 A. It's very important that we maintain the 2 reputation and the trustworthiness of Leapfrog. 3 Q. Right. 4 A. Very, very critical. 5 Q. Okay. And part of that reputation and 6 the brand is having as many hospitals participate 7 in the survey as possible, correct? 8 MS. BLAIR: Objection to form. Asked and 9 answered. 10 THE WITNESS: That's really not the 11 centerpiece of our reputation. Our reputation is 12 wide -- has a wide breadth. 13 BY MR. CHUNG: 14 Q. But -- actually, I think one of the first 15 things that we discussed in the deposition is 16 that it's your wish, or the organization's wish, 17 to have as many, ideally all hospitals, 18 participate in the survey, correct? 19 A. Oh, sure. Yes, that would be great. But 20 that's -- you asked me if it's tied to our 21 reputation or our trustworthiness. And what I'm 22 saying is our reputation and trustworthiness are Page 419	1 blah, blah. And it's also his opinion, whatever 2 his opinion is. He said if you want to do that. 3 That is not our goal. 4 BY MR. CHUNG: 5 Q. Okay. So you disagree with what 6 Dr. Romano was writing in that e-mail? 7 A. I disagree with -- well, he said, if you 8 believe -- blah, blah, blah, so he didn't 9 actually express an opinion about what we do 10 believe. He just said, if you believe that. 11 We don't. 12 Q. Okay. 13 A. Our goal is not to penalize hospitals, 14 though. Our goal is to create a marketplace 15 where everybody can succeed and do better. 16 Q. Okay. And the -- let's go to -- in terms 17 of the methodology -- I wanted to go back to a 18 couple questions about the imputation 19 methodology. 20 MR. CHUNG: Let's go to 103. So this is 21 Exhibit 42. 22 Page 421

1 (Binder Deposition Exhibit 42 marked for 2 identification and attached to the 3 transcript.) 4 BY MR. CHUNG: 5 Q. Okay. So Ms. Binder, you're familiar 6 with -- and we've -- with step 1 and step 2 of 7 Leapfrog's current imputation methodology, 8 correct? 9 A. Yes. 10 Q. Okay. And let's take a look at kind of 11 an example here. 12 I'm showing you -- this doesn't have a 13 Bates stamp. We just took it directly, a 14 screenshot, from hospitalsafetygrade.org. 15 A. Uh-huh. 16 Q. And you'll see that the grade for Hilo 17 Benioff Medical Center here, it's a C grade, 18 right? 19 A. Yes. 20 Q. Okay. And if you look under the 21 practices to prevent errors tab, under notes and 22 definitions, it says, Declined to report. Page 422	1 Oh, so you're -- 2 Q. Yeah. Can you tell -- 3 A. Because -- 4 Q. -- from what's on the web -- 5 A. -- of the way this is Xeroxed, I'm trying 6 to understand what this -- which screenshot you 7 have. 8 You have the CPOE measure, it looks like, 9 doctors' order. And then we have -- they got a 10 score of 40, and a score was assigned. So that 11 must have been step 1. 12 Q. How do you tell that step 1 was assigned 13 here? 14 A. Because a 40 is a score that would be 15 associated with step 1. 16 Q. Okay. How is that? 17 A. Because it's not -- it wouldn't -- it's 18 not a 15, which would be the -- if we didn't have 19 any step 1 data from the past two cycles. 20 Q. Okay. How can a consumer tell, though, 21 from this webpage that it's 1, step 1? 22 A. They -- it doesn't matter. This is -- it Page 424
1 Do you see that? 2 A. Yes. 3 Q. Okay. So is it correct that we know, 4 based on that, that this was a hospital that did 5 not participate in the survey? 6 A. Prob- -- 7 MS. BLAIR: Objection to form. 8 THE WITNESS: Probably. But -- 9 BY MR. CHUNG: 10 Q. Okay. 11 A. Or it could have been that they just 12 didn't respond to that one question. 13 Q. Can you tell me whether the step 1 or 14 step 2 imputation was used for this particular 15 hospital? 16 A. I don't know that offhand. 17 Q. Okay. So there's no explanation here for 18 whether this particular hospital had the 19 historical data or the lowest achievement score 20 imputed to them, right? 21 A. Well, you've -- you didn't copy the 22 whole -- what parts did you copy? Page 423	1 says -- 2 Q. The question -- 3 A. -- the hospital declined to report their 4 performance on this measure, so a score was 5 assigned to reflect the lack of information 6 available. 7 Q. Okay. So -- Ms. Binder, my question is, 8 how can a consumer tell that Hilo Benioff was 9 assigned the score here based on step 1? 10 A. They don't -- there's no need for them to 11 know which step or whatever. It's -- they can 12 look it up on the methodology, which is linked to 13 in many places. But it -- 14 Q. Okay. So -- but you can't -- 15 A. We tell them that a score was assigned -- 16 Q. Okay. But a consumer -- 17 A. -- and it's in bold red. 18 Q. -- cannot tell from this page, again, 19 without linking to the -- looking at the 20 imputation methodology, whether it was step 1 or 21 step 2; is that correct? 22 A. They can tell that a score was assigned Page 425

1 to reflect the lack of information available -- 2 Q. Okay. 3 A. -- which is true. 4 Q. Let's go to the next exhibit. 5 MR. CHUNG: This is 43. 6 (Binder Deposition Exhibit 43 marked for 7 identification and attached to the 8 transcript.) 9 BY MR. CHUNG: 10 Q. Again, this is from the webpage for the 11 Hilo Benioff Medical Center, the survey measures. 12 So let's take a look at the breakdown of the 13 sources used to calculate Hilo's safety grade. 14 I'm showing you a screenshot from, again, 15 hospitalsafetygrade.org that shows the measures 16 used to calculate Hilo's safety grade. 17 And if you review this document, it says, 18 Imputation model applied for ceratin of the 19 measures. 20 Do you see that? 21 A. Yes. 22 Q. Okay. Is there any way here -- again, Page 426	1 were to link to and read the methodology document 2 that you might start to be able to parse how the 3 hospital is scored, right? 4 MS. BLAIR: Objection to form. 5 THE WITNESS: They're scored by 6 imputation. 7 BY MR. CHUNG: 8 Q. Right. 9 A. We make it quite clear that it was an 10 imputation model. 11 Q. Right. 12 A. The fact that this chart is not specific 13 about how that was applied, specifically step 1 14 or step 2, is one thing. But you don't need to 15 go into every detail on every single chart. 16 Q. But in order for the consumer to be 17 informed about whether step 1 or step 2 of the 18 imputation methodology was applied, they would 19 then have to go to the scoring methodology, 20 correct? 21 A. Yes. 22 Q. Right. And I think you testified earlier Page 428
1 for the consumer -- right? -- to know whether 2 step 1 or step 2 was used for those scores? 3 A. This chart is aimed at -- 4 Q. So Ms. Binder, I'm just going to bore you 5 to the question. 6 Can a consumer, looking at the webpage 7 here -- again, hospitalsafetygrade.org website, 8 which you testified is intended for consumers -- 9 correct? Low literacy consumers, correct? 10 MS. BLAIR: Objection to form. That's 11 not her testimony. 12 BY MR. CHUNG: 13 Q. Yes or no? 14 A. The website is intended to be accessible 15 to laypersons. 16 Q. Yes. Is there -- to that layperson, to 17 the consumer, is there any way, looking at this 18 page, for them to know whether this is -- whether 19 step 1 or step 2 was used for the scores for the 20 Hilo Medical Center? 21 A. I don't think so. 22 Q. Okay. And it's only if you -- if one Page 427	1 that the scoring methodology is -- and you can 2 correct me on the verbiage here -- is not -- is 3 not the easiest thing to understand, correct? 4 MS. BLAIR: Objection to form. 5 THE WITNESS: It's -- the scoring 6 methodology document is written in a way that is 7 aimed at somewhat knowledgeable hospital people. 8 BY MR. CHUNG: 9 Q. Not meant for kind of the consumers that 10 the hospitalsafetygrade.org website was designed 11 for, correct? 12 A. Right. The hospitalsafetygrade.org 13 was -- that website was designed to inform 14 consumers of when imputation -- well, of 15 everything we use to calculate grades, including 16 imputation, which is -- 17 Q. Okay. 18 A. -- plainly and transparently conveyed. 19 Q. Okay. 20 MR. CHUNG: Why don't we take a short 21 break. All right? 22 How much time do we have left? Page 429

1 VIDEO TECHNICIAN: The time is 6:19 p.m. 2 We're off the record. 3 (A recess was taken.) 4 VIDEO TECHNICIAN: The time is 6:28 p.m. 5 We're on the record. 6 BY MR. CHUNG: 7 Q. Ms. Binder, during your time as CEO of 8 Leapfrog, did at any point Leapfrog consider not 9 issuing hospital safety grades to hospitals that 10 did not respond to the survey? 11 A. No. 12 Q. So that was never an option that was ever 13 discussed? 14 A. No. 15 Q. All right. Was it ever an agenda item? 16 A. Not to my knowledge. 17 Q. All right. Is it an option or a proposal 18 that any member of the Leapfrog staff, executives 19 or otherwise, ever mentioned? 20 A. Not that I recall. The purpose of the 21 safety grade was specifically to expand 22 transparency. Page 430	1 Q. Okay. If the plaintiff -- the five 2 plaintiff hospitals in this lawsuit were to 3 prevail -- right? -- and Leapfrog had to take 4 down their grades, their hospital safety grades, 5 what would be the harm to Leapfrog? 6 MS. BLAIR: To Leapfrog? 7 MR. CHUNG: To Leapfrog. Yes. 8 THE WITNESS: We would undermine our 9 mission, which is full transparency for 10 hospitals. Other hospitals would also see that 11 we are willing to pull down grades for some 12 hospitals and they'd say, what about us too? 13 BY MR. CHUNG: 14 Q. And so that would be the harm to 15 Leapfrog, correct? 16 MS. BLAIR: Objection to form. 17 THE WITNESS: It's a harm to our mission. 18 BY MR. CHUNG: 19 Q. Right. And if other hospitals asked to 20 pull down their grades -- right? -- from -- their 21 hospital safety grades, that would -- that would 22 harm Leapfrog, correct? Page 432
1 Q. So your testimony is that no one at 2 Leapfrog ever even mentioned the possibility or 3 the option of not issuing hospital safety grades 4 to non-participating hospitals; is that your 5 testimony? 6 A. To my knowledge. That -- to my 7 knowledge, nobody discussed that. The purpose of 8 the grade was to -- was for full transparency. 9 Q. Okay. How about members of the expert 10 panel? Is there any -- anyone ever mention the 11 possibility of not issuing grades to 12 non-participating hospitals? 13 A. Again -- 14 MS. BLAIR: Objection to form. 15 THE WITNESS: -- not to my knowledge. 16 BY MR. CHUNG: 17 Q. Not to your knowledge. Okay. How about 18 members -- 19 A. I don't go to all their meetings, but -- 20 Q. Members of the board? 21 A. No. That was never discussed at the 22 board meetings either, that I can recall, anyway. Page 431	1 MS. BLAIR: Objection to form. 2 THE WITNESS: It would harm the public. 3 BY MR. CHUNG: 4 Q. I'm asking, would it harm Leapfrog? I'm 5 not asking about would it harm the public. 6 A. It would harm our mission. It would harm 7 our ability to achieve our mission. It would be 8 a setback. 9 Q. All right. And it would be a setback 10 because fewer hospitals, then, would be issued 11 hospital safety grades, correct? 12 A. It would be a setback because there would 13 be less transparency, and there would be whole 14 communities in this country that would not have 15 access to information about how their hospital is 16 doing on safety. 17 Q. I'm asking about the impact on 18 Leapfrog -- right? Not the public. All right? 19 So the harm -- the impact here would be 20 fewer hospitals would be participating in the 21 survey, correct? 22 MS. BLAIR: Objection to form. Page 433

1 THE WITNESS: I don't know about the 2 survey, per se. That would -- I would have to 3 think about what impact it would have on the 4 survey. 5 BY MR. CHUNG: 6 Q. Okay. 7 A. But in terms of pulling down these five 8 hospitals' grades, it would just be harmful to 9 that community that they serve. And then other 10 hospitals who felt that somehow it was a good 11 idea that Leapfrog would pull down -- would make 12 exceptions and pull down grades for hospitals 13 that don't like them, that would undermine the 14 whole cause of transparency and public reporting 15 and fairness, which we believe in for hospitals. 16 Q. Isn't the concern -- I mean, isn't the 17 concern here is that if -- just hypothetically, 18 if the plaintiff hospitals in this case 19 prevailed, that it would basically create a 20 domino effect where many, many hospitals, maybe 21 all hospitals, would ask to have their grade 22 taken down? Is that your concern? Page 434	1 mission, and that is the most important thing to 2 us. 3 Q. All right. Well, the accolades licensing 4 program, which is the most significant source of 5 revenue, would suffer, correct? 6 MS. BLAIR: Objection to form. 7 THE WITNESS: No. Unlikely to suffer. 8 The number of A-hospitals has remained fairly 9 steady because we score it on a C-score 10 methodology. And therefore, the sales to 11 A-hospitals could continue. 12 BY MR. CHUNG: 13 Q. Well, would you expect if a hospital, in 14 response to, again, a hypothetical result in this 15 lawsuit, would take their -- would no longer 16 participate in the survey and take their grades 17 down, are you concerned that even the A-grade 18 hospitals would follow suit and not devote 19 resources to completing the survey? Is that a 20 concern? 21 MS. BLAIR: Objection to form. 22 THE WITNESS: No, it's not a concern. Page 436
1 A. I guess so. Yeah, that would be a 2 problem. That would certainly be one concern. 3 Q. Right. And that would be a concern for 4 the mission, correct? Right? 5 A. Right -- 6 Q. And -- 7 A. -- for the mission of patient safety and 8 transparency. 9 Q. And that would be a problem for the 10 bottom line for Leapfrog, correct? 11 MS. BLAIR: Objection to form. 12 THE WITNESS: No. 13 BY MR. CHUNG: 14 Q. So you would be able to generate revenue? 15 Would you be able to generate revenue if there 16 was a domino effect of hospitals just choosing 17 not to participate in the -- in the survey and 18 taking down their grades? 19 A. From a revenue perspective, the survey is 20 a cost to us. So it would just be less cost if 21 fewer hospitals reported, from a purely financial 22 point of view. It would just be harmful to our Page 435	1 MR. CHUNG: Okay. No further questions. 2 Thank you. 3 MS. BLAIR: Excellent. Thank you. 4 THE WITNESS: Thank you. 5 VIDEO TECHNICIAN: The time is 6:34 p.m. 6 We're off the record. 7 (Whereupon at 6:34 p.m., the videotaped 8 deposition of LEAH F. BINDER was 9 concluded.) 10 11 12 13 14 15 16 17 18 19 20 21 22 Page 437

1 CERTIFICATE OF NOTARY PUBLIC 2 I, CHRISTINA S. HOTSKO, the officer before 3 whom the foregoing deposition was taken, do hereby 4 certify that the witness whose testimony appears in 5 the foregoing deposition was duly sworn by me; that 6 the testimony of said witness was taken by me in 7 stenotypy and thereafter reduced to typewriting under 8 my direction; that said statement is a true record of 9 the proceedings; that I am neither counsel for, 10 related to, nor employed by any of the parties to the 11 action in which this statement was taken; and, 12 further, that I am not a relative or employee of any 13 counsel or attorney employed by the parties hereto, 14 nor financially or otherwise interested in the 15 outcome of this action. 16 17 18  19 CHRISTINA S. HOTSKO 20 Notary Public in and for the 21 District of Columbia 22 My commission expires: 23 1 January 2027 Page 438	1 Good Samaritan Medical Center, Et Al v The Leapfrog Group 2 Leah Binder 7574666 3 ACKNOWLEDGEMENT OF DEPONENT 4 I, Leah Binder, do hereby declare that I 5 have read the foregoing transcript, I have made any 6 corrections, additions, or changes I deemed necessary as 7 noted above to be appended hereto, and that the same is 8 a true, correct and complete transcript of the testimony 9 given by me. 10 11 _____ 12 Leah Binder Date 13 *If notary is required 14 SUBSCRIBED AND SWORN TO BEFORE ME THIS 15 _____ DAY OF _____, 20____. 16 17 18 _____ 19 NOTARY PUBLIC 20 21 22 23 24 25 Page 440
1 Good Samaritan Medical Center, Et Al v The Leapfrog Group 2 Leah Binder Job No. 7574666 3 E R R A T A S H E E T 4 PAGE _____ LINE _____ CHANGE _____ 5 _____ 6 REASON _____ 7 PAGE _____ LINE _____ CHANGE _____ 8 _____ 9 REASON _____ 10 PAGE _____ LINE _____ CHANGE _____ 11 _____ 12 REASON _____ 13 PAGE _____ LINE _____ CHANGE _____ 14 _____ 15 REASON _____ 16 PAGE _____ LINE _____ CHANGE _____ 17 _____ 18 REASON _____ 19 PAGE _____ LINE _____ CHANGE _____ 20 _____ 21 REASON _____ 22 23 _____ 24 Leah Binder Date 25 Page 439	111 (Pages 438 - 440)

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Federal Rules of Civil Procedure

Rule 30

(e) Review By the Witness; Changes.

(1) Review; Statement of Changes. On request by the deponent or a party before the deposition is completed, the deponent must be allowed 30 days after being notified by the officer that the transcript or recording is available in which:

(A) to review the transcript or recording; and

(B) if there are changes in form or substance, to sign a statement listing the changes and the reasons for making them.

(2) Changes Indicated in the Officer's Certificate. The officer must note in the certificate prescribed by Rule 30(f)(1) whether a review was requested and, if so, must attach any changes the deponent makes during the 30-day period.

DISCLAIMER: THE FOREGOING FEDERAL PROCEDURE RULES ARE PROVIDED FOR INFORMATIONAL PURPOSES ONLY.

THE ABOVE RULES ARE CURRENT AS OF APRIL 1, 2019. PLEASE REFER TO THE APPLICABLE FEDERAL RULES OF CIVIL PROCEDURE FOR UP-TO-DATE INFORMATION.

VERITEXT LEGAL SOLUTIONS

COMPANY CERTIFICATE AND DISCLOSURE STATEMENT

Veritext Legal Solutions represents that the foregoing transcript is a true, correct and complete transcript of the colloquies, questions and answers as submitted by the court reporter. Veritext Legal Solutions further represents that the attached exhibits, if any, are true, correct and complete documents as submitted by the court reporter and/or attorneys in relation to this deposition and that the documents were processed in accordance with our litigation support and production standards.

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EXHIBIT 3

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

-----X
GOOD SAMARITAN MEDICAL)
CENTER, INC., et al.,)
)
Plaintiffs,) CASE NO.
)
v.) 9:25-CV-80526-DMM
)
THE LEAPFROG GROUP,)
)
Defendant.)
-----X

VIDEOTAPED 30(B)(6) DEPOSITION OF
THE LEAPFROG GROUP,
BY AND THROUGH ITS CORPORATE REPRESENTATIVE,
MELISSA AMEE DANFORTH,
AND IN HER PERSONAL CAPACITY
Thursday, September 18, 2025; 9:11 a.m. EST

Reported by: Cindy L. Sebo, RMR, CRR, CLR, RPR,
CCR, CSR, RSA, CA CSR 14409, NJ Certified CR
30XI0024460, NJ Certified RT 30XR00019500, NM CSR
589, NY Realtime Court Reporter, NY Association
Certified Reporter, OR CSR 230105, TN CSR 998, TX
CSR 12778, WA CSR 23005926, Remote Counsel
Reporter, LiveLitigation Authorized Reporter,
Notary Public
Job No. 7574666

1 Videotaped 30(b)(6) Deposition of THE LEAPFROG 2 GROUP, By and Through its Corporate Representative, 3 MELISSA AMEE DANFORTH, and in her personal 4 capacity, held at the law offices of Gibson, 5 Dunn & Crutcher LLP, 1700 M Street, Northwest, 6 Washington, D.C. 20036-4504, before Cindy L. Sebo, 7 Registered Merit Court Reporter, Certified 8 Real-Time Reporter, Certified LiveNote Reporter, 9 Registered Professional Reporter, Certified 10 Court Reporter, Certified Shorthand Reporter, 11 Real-Time Systems Administrator, California 12 Shorthand Reporter 14409, New Jersey Certified 13 Court Reporter 30XI00244600, New Jersey Certified 14 Realtime Reporter 30XR00019500, New Mexico 15 CSR 589, New York Realtime Certified Reporter, 16 New York Association Certified Reporter, 17 Oregon CSR 230105, Tennessee CSR 998, Texas CSR 18 12778, Washington CSR 23005926, Remote Counsel 19 Reporter, LiveLitigation Authorized Reporter 20 and Notary Public, beginning at approximately 21 9:11 a.m. EST, when were present on behalf of the 22 respective parties: Page 2	1 A P P E A R A N C E S (Continued): 2 Attorneys for Defendant: 3 WILSON ELSE 4 KIMBERLY E. BLAIR, ESQUIRE 5 COURTNEY L. WOOD, ESQUIRE 6 161 N. Clark, Suite 4500 7 Chicago, Illinois 60601 8 312.821.6139 9 kimberly.blair@wilsonelser.com 10 courtney.wood@wilsonelser.com 11 12 13 ALSO PRESENT: 14 15 GLEN FORTNER, Videographer 16 17 18 19 20 21 22 Page 4
1 A P P E A R A N C E S: 2 Attorneys for Plaintiffs: 3 GIBSON, DUNN & CRUTCHER LLP 4 LEE R. CRAIN, ESQUIRE 5 200 Park Avenue 6 New York, New York 10166-0193 7 212.351.2454 8 lcrain@gibsondunn.com 9 -and- 10 EMILY CARDONE, ESQUIRE 11 2001 Ross Avenue, Suite 2100 12 Dallas, Texas 75201-2923 13 214.698.3106 14 ecardone@gibsondunn.com 15 16 17 18 19 20 21 22 Page 3	1 --oOo-- 2 INDEX OF EXAMINATION 3 MELISSA AMEE DANFORTH 4 Good Samaritan, et al. v. The Leapfrog Group 5 Thursday, September 18, 2025 6 --oOo-- 7 8 EXAMINATION BY PAGE 9 Attorney Crain 16, 233 10 11 12 13 14 15 16 AFTERNOON SESSION 233 17 CERTIFICATE OF REPORTER 598 18 INSTRUCTIONS TO WITNESS 599 19 ERRATA 600 20 ACKNOWLEDGMENT OF WITNESS 602 21 22 Page 5

1	--oOo--	1	--oOo--
2	INDEX TO EXHIBITS (Continued)	2	INDEX TO EXHIBITS (Continued)
3	MELISSA AMEE DANFORTH	3	MELISSA AMEE DANFORTH
4	Good Samaritan, et al. v. The Leapfrog Group	4	Good Samaritan, et al. v. The Leapfrog Group
5	Thursday, September 18, 2025	5	Thursday, September 18, 2025
6	--oOo--	6	--oOo--
7	DANFORTH	7	DANFORTH
8	DEPOSITION	8	DEPOSITION
9	EXHIBIT NUMBER DESCRIPTION PAGE	9	EXHIBIT NUMBER DESCRIPTION PAGE
10	Exhibit 13 Calendar invite with attachment,	10	Exhibit 20 Expert Panel's Guiding
11	Austin to multiple recipients,	11	Principles on the Development
12	April 12, 2024, Bates stamped	12	of the Composite Leapfrog
13	LEAPFROG00437361 through	13	Hospital Safety Grade for U.S.
14	LEAPFROG00437379 350	14	Hospitals 486
15	Exhibit 14 Article, Patients deserve to be	15	Exhibit 21 E-mail string, Bates stamped
16	able to trust Delray Medical	16	LEAPFROG00244555 through
17	Center with their healthcare	17	LEAPFROG00244558 535
18	Opinion, by Binder, The Palm	18	
19	Beach Post, June 30, 2025 368	19	
20	Exhibit 15 E-mail string, Bates stamped	20	
21	LEAPFROG00205986 through	21	
22	LEAPFROG00205990 389	22	
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1	--oOo--	1	--oOo--
2	INDEX TO EXHIBITS (Continued)	2	P R O C E E D I N G S
3	MELISSA AMEE DANFORTH	3	--oOo--
4	Good Samaritan, et al. v. The Leapfrog Group	4	--oOo--
5	Thursday, September 18, 2025	5	Washington, D.C.
6	--oOo--	6	Thursday, September 18, 2025; 9:11 a.m. EST
7	DANFORTH	7	--oOo--
8	DEPOSITION	8	--oOo--
9	EXHIBIT NUMBER DESCRIPTION PAGE	9	(Danforth Deposition Exhibit Number
10	Exhibit 16 Text string, Bates stamped	10	1, Notice of 30(b)(6) Deposition
11	LEAPFROG00139558 through	11	of The Leapfrog Group, marked for
12	LEAPFROG00139561 400	12	identification, as of this date.)
13	Exhibit 17 E-mail string, Bates stamped	13	--oOo--
14	LEAPFROG00220682 through	14	--oOo--
15	LEAPFROG00220686 417	15	(Danforth Deposition Exhibit Number
16	Exhibit 18 E-mail string, Bates stamped	16	2, Leapfrog's Designations and
17	LEAPFROG01081490 through	17	Objections to Plaintiffs' Notice
18	LEAPFROG01081491 438	18	of 30(B)(6) Deposition of The
19	Exhibit 19 E-mail string with attachments 470	19	Leapfrog Group, marked for
20		20	identification, as of this date.)
21		21	--oOo--
22		22	THE VIDEOGRAPHER: Good
	Page 11		Page 13

1 morning. We are going on the record 2 at 9:11 on September 18th, 2025. 3 Please note the microphones 4 are sensitive and may pick up 5 whispering and private conversations. 6 Please mute your phones at 7 this time. 8 Audio and video recording 9 will continue to take place unless 10 all parties agree to go off the 11 record. 12 This is Media Unit 1 of the 13 videorecorded deposition of 14 Melissa Danforth, both in her 15 personal capacity and as a 30(b)(6) 16 representative for Leapfrog, taken by 17 counsel for Plaintiff in the matter 18 of Good Samaritan Medical Center, 19 Inc., et al. v. The Leapfrog Group 20 filed in the United States District 21 Court for the Southern District of 22 Florida, Number 9:25-CV-80526. Page 14	1 CERTIFIED STENOGRAPHER: 2 Thank you. 3 The witness is sworn, 4 Counsel. 5 --oOo-- 6 EXAMINATION BY COUNSEL FOR PLAINTIFFS 7 --oOo-- 8 BY ATTORNEY CRAIN: 9 Q. Good morning, Ms. Damforth. 10 A. Good morning. Danforth. 11 Q. Danforth. I'm sorry. 12 A. Yes. I'm sorry. I know. 13 As soon as he said it, I was like, 14 it's going to last all day. 15 Danforth. 16 Q. Like go forth? 17 A. Yeah. 18 Q. Got it. 19 Well, welcome to Gibson Dunn. 20 A. Thank you. 21 Q. My name is Lee Crain. I am counsel 22 for the Plaintiffs in this lawsuit. Page 16
1 The location of the 2 deposition is Gibson Dunn. 3 My name is Glen Fortner, 4 representing Veritext, and I'm the 5 videographer. The court reporter is 6 Cindy Sebo from the firm Veritext. 7 I'm not related to any party 8 in this action nor am I financially 9 interested in the outcome. 10 Counsel will be noted on the 11 stenographic record. 12 Will the court reporter 13 please swear in the witness? And 14 then counsel may proceed. 15 --oOo-- 16 MELISSA AMEE DANFORTH, 17 after having been first duly sworn under 18 penalty of perjury by the certified 19 stenographer to tell the truth, the whole 20 truth and nothing but the truth, testified 21 herein as follows: 22 --oOo-- Page 15	1 Can you please state your full 2 name for the record? 3 A. Melissa Danforth. 4 Q. And have you ever gone by any other 5 names? 6 A. Everyone calls me Missy. 7 Q. Great. 8 Have you ever been deposed 9 before? 10 A. No. 11 Q. Okay. So I want to go through some 12 just ground rules so we're on the same page. 13 A. Okay. 14 Q. You understand that the court 15 reporter is taking a transcription? 16 A. Yes. 17 Q. And you understand that all our 18 questions and answers need to be oral? 19 A. Yes. 20 Q. So no nodding heads, that sort of 21 thing. Just make sure when you're responding to 22 a question, it's all oral. Page 17

1 A. Understood. 2 Q. We're going to need to make sure we 3 slow down our conversation, a little bit 4 differently from normal talk. Try not to talk 5 over me. I will try not to talk over you to 6 make sure she has a clean record. 7 Sound fair? 8 A. Yes. 9 Q. If you have any need for a break -- 10 I understand you may need to stand up at certain 11 times because of a medical condition -- don't 12 hesitate to say if you need a break. 13 The only thing I will ask is I 14 -- we -- we will not be taking a break while a 15 question is pending. 16 A. Understood. 17 Q. Okay. You understand today you're 18 under oath -- 19 A. Yes. 20 Q. -- as if you were testifying in a 21 court? 22 A. Yes. Page 18	1 A. Yes. 2 Q. Do you recognize those documents? 3 A. Yes, I do. 4 Q. Have you seen them before? 5 A. I have. 6 Q. And Exhibit 1 is the Notice of 7 Deposition -- 30(b)(6) Deposition of The 8 Leapfrog Group. 9 Do you see that? 10 A. Yes. 11 Q. And then Exhibit 2 is Leapfrog's 12 Designations and Objections to Plaintiffs' 13 Notice of 30(b)(6) Deposition. 14 Do you see that? 15 A. Yes. 16 Q. You understand today you are 17 testifying both in your personal capacity and on 18 behalf of The Leapfrog Group, the Defendant in 19 this case? 20 A. That's correct. 21 ATTORNEY BLAIR: Objection to 22 form. Page 20
1 Q. Great. 2 And are you taking any 3 medication or under the influence of anything 4 that might impair your ability to give truthful 5 testimony today? 6 A. No. 7 Q. You understand that you have the 8 obligation to testify truthfully today? 9 A. Yes. 10 Q. Okay. You understand from time to 11 time, your attorney may object? 12 A. Yes. 13 Q. And if she objects, unless she 14 instructs you not to answer, you're -- you still 15 are required to answer the question. 16 Do you understand that? 17 A. Yes. 18 Q. Great. 19 Okay. So let's jump in. I 20 want to start -- first, you have two documents 21 in front of you that we have premarked as 22 Exhibits 1 and 2. Page 19	1 BY ATTORNEY CRAIN: 2 Q. Do you understand that you're 3 testifying today on behalf of The 4 Leapfrog Group? 5 A. Yes. 6 Q. Do you understand that you're also 7 here to testify in your personal capacity? 8 A. I do. 9 Q. Great. 10 And Leapfrog has designated you 11 as its corporate representative for certain of 12 the designated topics. 13 Do you see that? 14 A. I do. 15 Q. Are you -- have you reviewed these 16 topics before? 17 A. I have. 18 Q. Great. 19 Okay. So I won't go through 20 all of them now. We'll go through all of them 21 throughout the day. 22 You can set those aside for Page 21

1 now. 2 So you said you were never -- 3 you have never been deposed, correct? 4 A. Correct. 5 Q. Have you ever testified in court? 6 A. No. 7 Q. Testified in any other context? 8 A. No. 9 Q. Okay. And did you prepare for your 10 deposition today? 11 A. I did. 12 Q. What generally did you do to 13 prepare? 14 A. I met with Ms. Blair and Ms. Wood 15 three to four times -- 16 Q. Okay. 17 A. -- I believe. 18 Q. Approximately when? 19 A. I would say over the past several 20 weeks since the notice of deposition. I know -- 21 I apologize. 22 Can I look at the timing? Page 22	1 BY ATTORNEY CRAIN: 2 Q. Okay. And approximately how long 3 were your meetings? 4 A. I would say between a few hours and 5 a full day. 6 Q. Did you review any documents to 7 prepare for this deposition? 8 A. I did. 9 Q. Can you tell me generally what you 10 looked at? 11 A. I looked at PowerPoints, e-mails, 12 financial documents -- a lot of documents. 13 Q. Any -- any ballpark estimate? 14 A. Probably a couple dozen. 15 Q. Did you watch any videos in 16 preparation for this deposition? 17 A. No. 18 Q. Listen to any audio recordings? 19 A. No. 20 Q. Did you review any deposition 21 transcripts from this case? 22 A. I reviewed the drafts of those Page 24
1 Q. Of course. 2 A. This was since -- three or four 3 times since the notice of deposition -- 4 Q. All right. 5 A. -- yeah. 6 Q. And did you meet with other Leapfrog 7 employees? 8 A. The first time we prepared for 9 depositions, which none of us had taken before, 10 we initially met as a small group of those on 11 the deposition list briefly probably for three 12 or four hours just to have Ms. Blair explain 13 what a deposition is. 14 And then -- 15 Q. I just -- I do not want you to share 16 anything that your counsel conveyed to you. And 17 I assume Ms. Blair agrees. 18 ATTORNEY BLAIR: Yes, I 19 agree, but -- 20 THE WITNESS: But then after 21 that, I did all of my preparation just 22 with Ms. Blair and Ms. Wood alone. Page 23	1 deposed prior to me. 2 Q. The rough transcripts? 3 A. Yes. 4 Q. Okay. That includes Ms. Campion? 5 A. Yes. 6 Q. Mr. Banerjee? 7 A. Yes. 8 Q. Ms. Jupiter? 9 A. Yes. 10 Q. And I forget the last one. 11 A. Bailey. 12 Q. Ms. Bailey? 13 A. Yes. 14 Q. Okay. You remember better than I 15 do. 16 Okay. And approximately when 17 did you review those? Like, in the last week or 18 so? 19 A. Yes -- 20 Q. Okay. 21 A. -- last two weeks. 22 Q. And did you read them top to -- Page 25

1 like, cover to cover? 2 A. No. 3 Q. Okay. Scanned them. Got it. 4 A. A scan. 5 Q. Okay. Did you speak to anybody at 6 The Leapfrog Group about your deposition? 7 A. Besides my attorneys? 8 Q. Correct. 9 A. No, I did not. 10 Q. Okay. Did you speak to anybody else 11 about it? 12 A. No, I did not. 13 Q. Okay. Let's talk -- these are the 14 easy questions. 15 A. Sure. 16 Q. Can you tell me a little bit about 17 your employment history, starting with where you 18 went to college and -- and sort of subsequently? 19 So where did you go to college? 20 A. Sure. I went to the University of 21 Maine in Farmington, Maine. And following 22 graduation, I was a stay-at-home mom for five Page 26	1 was a hospital and trying to grow into an 2 integrated health network that included Healthy 3 Community Coalition. 4 And so I became a special projects 5 manager there. And then when Leah Binder came 6 to Leapfrog in 2008, she recruited me in 2009. 7 And I've been at Leapfrog ever since. 8 Q. Okay. Just breaking down some of 9 that -- 10 A. Sure. 11 Q. -- what did you study at Farmington? 12 A. English and women's studies. 13 Q. And women's studies. 14 Okay. And how did you decide 15 to get into healthcare? 16 A. I didn't. I decided to get into 17 service work. And so I had been a stay-at-home 18 mom for five years. I was trying to decide what 19 to do. Had a very close friend that was working 20 for the child abuse and neglect agency. She was 21 talking to me about her work. It sounded 22 amazing. Page 28
1 years. 2 My first job was at the Franklin 3 County -- oh, I'm sorry -- yes, Franklin County 4 Children's Task Force, which is the child abuse 5 and neglect agency for Franklin County, Maine. 6 I did grant writing there. I taught parenting 7 classes for parents who had been 8 court-mandated, and I also led a bullying 9 prevention program in local elementary and 10 middle schools. 11 My next job was with a community 12 health organization called Healthy Community 13 Coalition. At the time, Leah Binder, the 14 president and CEO of The Leapfrog Group, was 15 the executive director of that community 16 organization. 17 There, I did a lot of grant writing 18 for things like bringing breast cancer 19 screenings to our area, smoking cessation 20 programs. 21 I then moved on to Franklin 22 Community Health Network, which, at the time, Page 27	1 I had just had two small children, 2 so the idea of working at an agency that 3 protects children really appealed to me. 4 Once I started at that first 5 non-profit, I found it incredibly engaging and 6 rewarding and basically made the decision at 7 that point that I would have my whole career in 8 a place where I could do public good and help 9 take care of people. 10 Q. And -- and can you tell me -- remind 11 me, when did you first meet Ms. Binder? 12 A. So I went back to work when my son 13 went to kindergarten. So that would have 14 been -- '97 plus five -- 2002 -- maybe 2004 -- 15 '5 -- 2005. 16 Q. Okay. And what was her position at 17 the time? 18 A. She was executive director of 19 Healthy Community Coalition, which was that 20 community-based -- so they had a mobile health 21 van, for example, and they did community health, 22 not acute care. Page 29

1 Q. Did you report to her there, 2 or . . . 3 A. I did. So I started as a 4 consultant, actually just -- just doing grants. 5 And when I moved to Franklin Community Health 6 Network as a special projects manager, I also 7 reported to her there as well. 8 Q. Okay. And talk to me about -- how 9 did she join The Leapfrog Group? 10 A. When we were working together at 11 Franklin Community Health Network, we just heard 12 one day that Leah was moving to Washington, D.C. 13 I'm not exactly sure. I know that the board at 14 The Leapfrog Group did a national search, and 15 she was one of the candidates interviewed and 16 then ultimately selected, but I don't have much 17 more detail than that. 18 Q. Okay. What were your initial 19 impressions of her in those early days? 20 A. Exceptional grant writer. I had 21 been writing to that point mostly smaller 22 grants, focused on things like domestic violence Page 30	1 which is, like, good and bad. They were 2 getting older. And we thought maybe it would 3 be a good change for our family and just give 4 them a little bit more opportunity but also 5 access to slightly better education. 6 Q. And then before we get to Leapfrog 7 Group -- 8 A. Sure. 9 Q. -- I saw in your LinkedIn you are -- 10 you have -- you own a jujitsu studio? 11 A. My husband and I own and operate a 12 Brazilian jujitsu gym in Mont -- 13 Montgomery County, Maryland. 14 Q. So we've got to watch out on this 15 side of the table? 16 A. I -- I've had this back injury for 17 two years, so if I can -- 18 Q. So we're safe? 19 A. -- get back and forth to the 20 restroom today, we'll be -- we'll be happy -- 21 Q. Okay -- 22 A. -- but -- Page 32
1 prevention. 2 She really taught me a great deal 3 about the process of writing Federal grants. 4 And with that mentorship, I was able to 5 actually bring hundreds of thousands of dollars 6 into that rural community from SAMHSA, from the 7 Kellogg Foundation. 8 And so it was actually, like, a 9 very good working experience. 10 Q. And then can you talk to me a little 11 bit about how you got the Leapfrog job? 12 A. Like I said, Leah Binder came to 13 Leapfrog in 2008. After about a year, I would 14 say, she gave me a call and said, you know, I 15 miss working with you. I think we worked really 16 well together. I think there is a position here 17 that could work out for you -- similar kinds of 18 special projects like I was doing at the health 19 network. 20 It was a big move for me and my 21 family. My husband is from Farmington, Maine. 22 Our children had the same teachers that he had, Page 31	1 Q. -- if you need any breaks -- 2 A. Yeah. But, again, like, I've -- 3 I've been really committed, like I said, to 4 trying to do service things. And so, like, 5 there, I had been teaching just one class, which 6 is a women's-only class, that had a lot of 7 mothers and daughters, young women, older women. 8 So it was more fun than career. 9 Q. Okay. Can you tell me -- we saw you 10 had multiple positions at Leapfrog -- 11 A. Yes. 12 Q. -- can you tell me about your 13 gradual, it seems like, ascendance? 14 A. Yes. So when I first came to 15 Leapfrog in 2009, I was the director of 16 communications and membership. The work I had 17 been doing at Franklin Community Health Network 18 was really focused on things like putting out an 19 annual report. I was working with some 20 practices. I was doing some EHR-based projects. 21 It really was special projects. 22 When I came to Leapfrog, Page 33

1 originally, it was more focused, specifically 2 on working with some of our employer and 3 purchaser groups. When I say "purchaser 4 groups," I'm talking about people who purchase 5 healthcare, sort of a term of art. 6 It confused me at first, but 7 employers and purchasers can be thought of in 8 the same way. They're people that purchase 9 employee benefits. 10 It was, at that time, a really 11 small organization. There was only of a 12 handful of us. I was doing a number of things 13 because of that, as I had done previously in my 14 non-profit work. 15 After a couple of years -- we had 16 been working with a team at the University of 17 Wisconsin in Madison, and they were providing 18 the scientific oversight over our Leapfrog 19 Hospital Survey. 20 Q. Can I ask you, is that, like, the 21 role that Armstrong ultimately -- 22 A. Yes. I was going to describe that. Page 34	1 quality of hospitals. 2 And so immediately after we were 3 founded, we built this relationship with the 4 University of Wisconsin in Madison to help us 5 ultimately design what would become the 6 Leapfrog Hospital Survey. 7 I say that as background because 8 after I had been at Leapfrog for a couple of 9 years -- and tell me if I'm going too fast -- 10 Q. Yeah. 11 A. -- I know you said to speak 12 slowly -- after I had been at Leapfrog for a 13 couple of years, those scientists that were 14 working with us at the University of Madison in 15 Wisconsin [sic] both, within a couple of months 16 of each other, took other jobs. 17 One was our senior scientist. Her 18 name was Dr. Barbara Rudolph. She was the 19 first senior scientist ever involved in the 20 survey. And so that had been, you know, up to 21 that point, Leapfrog's history. She had worked 22 with them. Page 36
1 So just by way of background so 2 it's not confusing, we were founded in -- in 3 2000 immediately after this very famous report 4 came out from the Institute of Medicine, Call 5 to Earth Human. It was the first time that 6 anyone had ever quantified, put a number on, 7 the number of people that die every year in 8 hospitals from preventable medical errors. 9 And employers, purchasers -- and 10 these are large, self-insured employers: GM, 11 GE, Marriott, FedEx -- got their hands on this 12 report through the Business Roundtable, which 13 is a association of Fortune 100 CEOs, and they 14 were really shocked that they had been spending 15 millions if not billions of dollars to provide 16 these benefits and there were all of these 17 preventable harms occurring in hospitals. 18 And they said, We need more 19 information. Like, we should not have been 20 blindsided by this report. And they literally 21 founded our organization to go out and get that 22 information for them about the safety and Page 35	1 Q. Approximately what time period? 2 A. That would be 2000- -- probably 3 around 2011, 2010, maybe. 4 Her Ph.D. candidate research 5 assistant at that time was Dr. Matt Austin -- 6 or who had become Dr. Matt Austin. So 7 Ms. Rudolph was recruited by the Robert Wood 8 Johnson Foundation to lead the largest 9 community health survey in the country. Hard 10 to say no to that job. 11 I always refer to it as her 12 Devil-Wears-Prada moment. It was a dream job 13 that every girl wanted. And so she took it. I 14 don't blame her. 15 But at that same time, Matt Austin 16 was recruited to Johns Hopkins to Armstrong 17 Institute for Patient Safety and Quality by 18 Dr. Peter Pronovost, who had been working with 19 us in an expert capacity on the survey. 20 To your point, we were able to 21 basically -- almost have continuous scientific 22 leadership over the content of the survey by Page 37

1 ending that agreement with the University of 2 Wisconsin and starting an agreement with the 3 Armstrong Institute for Patient Safety. 4 Q. Can I ask you a question? So you -- 5 you mentioned the employers that -- that helped, 6 I guess, start Leapfrog. 7 A. Yeah. 8 Q. Are they still involved? 9 A. Yes -- not necessarily the same 10 exact ones, but yes. We continue to be governed 11 by employers and purchasers. Our governing 12 board has grown to also include some patient 13 safety advocates, but we have no healthcare 14 represented on our board or governance 15 whatsoever. 16 Q. Which employers are represented? 17 A. We -- I'm going to give you a 18 handful. This will not be an exhaustive list. 19 And to be clear, Leah Binder, I think, is 20 assigned that particular topic. 21 But, for example, Sally Welborn 22 serves on our board of directors. She was head Page 38	1 your first title was senior -- was it vice 2 president of communications? 3 A. Yes. Should I go back and talk to 4 you about my trajectory at Leapfrog? 5 Q. What's your second title? It was, I 6 think -- 7 A. My second title was probably 8 director of the Leapfrog Hospital Survey. 9 Q. I have vice president of hospital 10 ratings. 11 Does that sound right? 12 A. There would have been one in 13 between. 14 Q. Okay. Got it. 15 A. Sorry. 16 Q. Okay. So just tell me a little bit 17 about the -- 18 (Simultaneous unreportable crosstalk.) 19 THE WITNESS: My LinkedIn 20 probably is not the most up-to-date. 21 So -- so when 22 Barbara Rudolph and Matt Austin -- Page 40
1 of benefits for Walmart for many, many years. 2 She now has a private consulting firm where she 3 basically consults on the same topics. 4 Linda Schwimmer, who is our current 5 chair of our board -- she is the president or 6 executive director of the New Jersey healthcare 7 Quality Institute that represents purchasers, 8 employers in the State of New Jersey. 9 Previously, Michelle Martin -- 10 Martin, A- -- M-A-R-T-I-N -- was on our board 11 for many years, and she was a head of benefits 12 for Paramount, which is, like, a television -- 13 the television station, not the movie station, 14 and others. 15 And, again, Leah would be the -- 16 have the full complete list. 17 Q. Understood -- 18 A. Yeah. 19 Q. -- I understand. 20 Let's shift gears a little bit. 21 A. Okay. 22 Q. So you -- you started -- I think Page 39	1 they sort of took these separate 2 jobs, Leah and I had a long 3 conversation about how that could 4 have been more disruptive to our 5 operations than it ended up being 6 because we were so reliant on 7 external resources to do the 8 administration of our Hospital 9 Survey. 10 We were using a company 11 first called Thomson and then 12 Thomson Reuters, and -- and they 13 became something else. They were 14 primarily responsible for 15 administering the survey via an 16 online data collection tool, scoring 17 the survey responses, preparing the 18 scored survey results files. 19 So just -- I don't know how 20 familiar you are with our survey 21 operations, but we collect individual 22 responses. Those individual Page 41

1 responses get processed through 2 scoring algorithms, and the result is 3 a result that we publicly report. 4 And so in the simplest 5 terms -- for C-sections, we may be -- 6 get a numerator and denominator, we 7 calculate a rate, it's the rate 8 that's published -- it's the rate 9 that Thomson Reuters was putting into 10 these files for us. 11 They were also doing all of 12 the technical assistance. The 13 hospitals participating in the survey 14 said they had questions about the 15 measure of specifications of the 16 reporting period. Thomson Reuters 17 did all of that. 18 And then -- 19 BY ATTORNEY CRAIN: 20 Q. So -- 21 A. -- with -- 22 Q. -- a lot of -- Page 42	1 had more expertise in-house and 2 weren't so reliant. It's very common 3 at small nonprofits that you have a 4 small staff and you rely on external 5 expertise to do a lot so you're not 6 carrying those costs yourself. 7 But we had been around at 8 that point for a decade, and we 9 thought it was time to really bring 10 some of that work in-house. So I 11 became the director of the Leapfrog 12 Hospital Survey and then eventually 13 the vice president for healthcare 14 ratings, as we've expanded beyond 15 hospitals to include ambulatory 16 surgery centers. 17 BY ATTORNEY CRAIN: 18 Q. Got it. 19 And what's your position today? 20 A. Senior vice president for healthcare 21 ratings. 22 Q. And -- and what feeds into that? Page 44
1 A. Okay. 2 Q. -- what Leapfrog does today is -- 3 was outsourced back then? 4 A. Was outsource -- 5 (Whereupon, as the certified 6 stenographer seeks clarification, 7 colloquy will not be captured on 8 the written record.) 9 BY ATTORNEY CRAIN: 10 Q. Outsourced back then? 11 CERTIFIED STENOGRAPHER: Just 12 let him finish the question. 13 THE WITNESS: Oh, I was 14 trying to finish my answer, but I 15 understand. 16 CERTIFIED STENOGRAPHER: 17 Well, then finish your answer. 18 (Laughter.) 19 THE WITNESS: So with that 20 big transition of our scientific team, 21 we decided we would move some 22 functions in-house, mostly just so we Page 43	1 What -- how many people report 2 to you? 3 A. Ten. 4 Q. And can you -- does that include 5 Ms. Campion? 6 A. I -- I can list them. 7 Q. Sure. 8 A. Okay. 9 So I have a director of healthcare 10 ratings, Kathryn Stewart. 11 I have a director of the Leapfrog 12 Ambulatory Surgery Center Survey, 13 Jean-Luc Tilly, J-E-A-N-L-U-C Tilly. 14 I have a director of licensure 15 programs, Kush Banerjee. 16 I have a program manager for the 17 Hospital Safety Grade, Alex Campion. 18 I have a program manager for data, 19 Dylan Eller, and two data analysts: Leo Rule 20 and Austin Edwards. He has, like, two first 21 names -- 22 Q. Yeah? Page 45

1 A. -- Austin Edwards. 2 And then I have a senior program 3 coordinator, Robyn Nabi. 4 Another senior program coordinator, 5 Leah Kaufman. 6 A program coordinator Heather Scott 7 and a program associate, Mallory Fries. 8 Q. And who do you report to? 9 A. I report directly to Leah Binder. 10 Q. And what are the topics that you're 11 responsible for? 12 A. Many. 13 Q. Just give me a sense. 14 A. Stop me if I'm going on. 15 I mean, first and foremost, 16 responsible for working with the rest of our 17 senior executive team to provide overall input 18 on the general strategic direction of the 19 organization and making sure we're being 20 responsive to the board and the goals that they 21 set out for us. 22 Specifically, I oversee all of our Page 46	1 performance measurement, healthcare equity and 2 diagnostic excellence. 3 So I participate on several 4 different CMS, the Centers for Medicaid & 5 Medicare Services -- CMS technical expert 6 panels, and I currently serve on Patel's 7 partnership for quality governing board and 8 other of their committees. 9 Q. You said you're an expert, I think, 10 in patient safety and performance measurement 11 and healthcare equity. 12 Did you develop that over time, 13 or was there education that you -- that went 14 into that? 15 A. I developed it over time. As I 16 said, we have a long-standing relationship at 17 this point with Johns Hopkins. They are the 18 scientific experts. But I'm able to advise more 19 on things like feasibility, mostly because of 20 the work that I do directly with hospitals at 21 Leapfrog. 22 So I might not be able to be the Page 48
1 healthcare ratings programs, including the 2 Leapfrog Hospital Survey, Hospital Grade, 3 Ambulatory Surgery Center Survey and our 4 value-based purchasing program, and that 5 includes managing our contract with the John -- 6 Johns Hopkins Armstrong Institute for patient 7 safety and quality. 8 I also recently, since about 9 halfway through 2023, have responsibility over 10 data licensure and Accolade sales. I also 11 actually do quite a bit around education. 12 Leapfrog offers a number of free and some paid 13 educational opportunities for various 14 stakeholders. I develop and deliver, I would 15 say, three-quarters of that content. 16 Q. Got it. Okay. 17 A. Oh -- I'm sorry. 18 Q. No, please. 19 A. I also in my capacity -- I serve on 20 several different national technical expert 21 panels, and so I am, myself, a subject-matter 22 expert in the areas of patient safety, Page 47	1 expert on if we're developing every admissions 2 measure or should heart attack or pneumonia 3 patients be included or excluded, but in terms 4 of feasibility of data collection, I can be 5 helpful in that way. 6 Q. Got it. Okay. 7 And then one other -- I just 8 want to make sure you -- the -- the Safety Grade 9 itself is under your supervision; is that right? 10 A. The Hospital Safety Grade is one of 11 our programs, correct, that I oversee. 12 Q. Great. Okay. 13 Stepping back just a little 14 bit, can you tell me, like, generally what is 15 Leapfrog's mission? 16 A. I can tell you specifically what is 17 Leapfrog's mission. 18 Q. Wherever you want to go. 19 A. Sure. So our mission is to reduce 20 preventable harm and specifically death from 21 medical errors. 22 Q. Does Leapfrog advise hospitals how Page 49

1 to improve their quality? 2 A. We do not -- 3 Q. Okay. 4 A. -- in any capacity, and we never 5 have. 6 Q. Okay. And what is Leapfrog sort of 7 an expert in? 8 A. So we are an expert in -- what I 9 would say is elevating topics within patient 10 safety. 11 Could I give two examples -- 12 Q. Sure. 13 A. -- in case that's not clear? 14 So patient safety, thankfully, is 15 an area within health services research that 16 has got -- health services research which has 17 gotten, thankfully, a lot of attention 18 recently. And so through our work with about 19 13 different independent voluntary technical 20 expert panels -- 21 (Whereupon, as the certified 22 stenographer seeks clarification, Page 50	1 you're really sick. We have to admit 2 you. 3 Unfortunately, for a lot of 4 different reasons, sometimes once 5 that order has been sent in, you can 6 wait in that emergency department or 7 in a hallway or a -- back in the 8 waiting room for hours, for days, for 9 over a week. 10 When that happens, what we 11 know, because of published literature 12 that comes from that health 13 science -- health services research 14 community, is you're less likely to 15 get medications, so your condition 16 can be exasperated. You're less 17 likely to be taken for the tests or 18 treatments that have been ordered for 19 you, sometimes literally because 20 people can't find you. 21 So when that becomes 22 identified as this is a critical Page 52
1 colloquy will not be captured on 2 the written record.) 3 ATTORNEY CRAIN: Voluntary. 4 THE WITNESS: -- voluntary 5 technical expert panels and our 6 relationships with other aligned 7 national organizations, like the 8 Agency for Healthcare Research and 9 Quality -- AHRQ -- the Centers for 10 Disease Control and Prevention, CMS, 11 the Institute for healthcare 12 Improvement. We're able to take some 13 of that evidence-based research and 14 sort of bring it to the public. 15 And what I mean by that is 16 there's been a particular issue that 17 we've been focused on in the past 18 couple of years called "hospital 19 boarding" in the emergency 20 department. It's basically when you 21 go to the emergency department, the 22 doctor sees you and they say, Man, Page 51	1 patient safety issue that has 2 reasonable interventions that could 3 make it better for patients, we have 4 the opportunity at Leapfrog, through 5 our annual Hospital Survey, to pull 6 together a national expert panel to 7 help us develop a series of questions 8 or to implement measures that have 9 already been developed by others. 10 So we can collect 11 information on hospital performance, 12 score that and ultimately publicly 13 report performance on that measure. 14 And if any of that is 15 confusing, let me know and I can give 16 a different example. 17 BY ATTORNEY CRAIN: 18 Q. No, that's helpful. 19 A. Okay. 20 Q. Thank you. 21 Can we talk a little bit about 22 the Safety Grade, going back to that issue? Page 53

1 A. Yes. 2 Q. So just starting at a benchmark -- 3 A. Sure. 4 Q. -- what is Leapfrog's Hospital 5 Safety Grade? 6 A. So the Hospital Safety Grade is a 7 composite, so it's a letter grade of an A, B, C, 8 D or F that represents their performance on 22 9 national measures of patient safety, and I'm 10 sure at some point today this will come up. So 11 when we talk about patient safety, we're talking 12 about, again, that preventable harm. Other 13 aspects of hospital performance that we measure 14 on our Leapfrog Hospital Survey are more 15 comprehensive to include things like quality. 16 And quality might be a readmission measure where 17 it's best if you're not being readmitted too 18 often, but sometimes it's necessary. 19 The preventable errors that we 20 focus on in the Hospital Safety Grade are 21 things that largely the scientific community -- 22 including doctors, nurses, et cetera -- have Page 54	1 purchasers and employers, and they were 2 somewhat frustrated that since the IOM report 3 had come out, there didn't actually seem to be 4 this drastic reduction in preventable harm to 5 patients in hospitals. I think everyone 6 thought, you know, this will be the match that 7 lights the fuse that ignites this change, and 8 we'll make sure that people aren't harmed as 9 much. And actually, the opposite was happening 10 because of advances in medical coding and 11 research science. It was basically suggested 12 that actually the IOM report was like a gross 13 underestimate of the number of people that was 14 actually being harmed and dying in hospitals 15 from medical errors, and that number was much 16 higher. 17 So the discussion as I remember it 18 was really focused around how can we at 19 Leapfrog, who have been focused on a lot of 20 important things, like I said, maternity care, 21 so C-section rates, readmissions, surgical 22 volume; but, again, largely quality measures, Page 56
1 said, There are known evidence-based 2 interventions in place to make sure that these 3 things either rarely happen or never happen. 4 Q. And then can you tell me when was 5 the Safety Grade developed originally? 6 A. So the Safety Grade was developed -- 7 started being developed around 2012. I think we 8 launched it for the first time in 2013. 9 Q. And who came up with the idea? 10 A. It -- I couldn't identify a single 11 individual. It was a number of things happening 12 at the same time, or my recollection is that it 13 was a number of things happening at the same 14 time. 15 So first and foremost, Leapfrog had 16 been around at that point about 10 years. I 17 think we were sort of getting ready to 18 celebrate or just celebrated our 10-year 19 anniversary, and we had some board members and 20 others who worked with us at that time who had 21 been working with us since our founding or 22 almost since our founding, and the -- again, Page 55	1 where you don't want to see too much of it or 2 not enough of it, but sometimes it's necessary, 3 how can we get back to really focusing on these 4 deaths from preventable harm, this -- this 5 really narrow concept of patient safety. 6 About that same time, two things 7 happened: One is in New York, and one is in 8 Los Angeles, I believe. The state health 9 departments or local health departments started 10 having restaurants put the sanitation grades on 11 their windows, and I -- I think I remember 12 someone saying, No one's going to go to a C 13 restaurant in New York. You know, like, I've 14 been to New York. No one's going to go to a C 15 restaurant in New York. 16 And there was something about that 17 level of transparency driving that C sushi 18 restaurant to be in a -- you know, to -- to get 19 better, to get cleaner, whatever it was. 20 Additionally, what was happening is 21 that these letter grades didn't only include 22 you're an A, you're a B, you know, God forbid, Page 57

1 you're a C sushi restaurant, but it sort of, 2 like, listed, like, why they were an A or a B 3 or a C. And there was this education happening 4 to -- like, the general public about, like, 5 what New York cares about when they're looking 6 at the sanitation or the hygiene of 7 restaurants. And we thought that's what we 8 have the opportunity to do around patient 9 safety. What is patient safety? Who is 10 involved in patient safety? And frankly, it 11 includes patients themselves. We all have a 12 role in keeping ourselves safe. If we're in a 13 hospital or a doctor's office, or an ambulatory 14 surgery center. 15 And so it was just really, I think, 16 some things happening at the same time, 17 frustration over the slow pace of change. 18 These novel restaurant grades and this idea 19 that we could and should do more, specifically 20 to educate patients -- so to be clear, when 21 Leapfrog was founded, and I say we were founded 22 by employers and purchasers, and we were Page 58	1 Hospital; Dr. Peter Pronovost from John -- at 2 the time, Johns Hopkins -- now he's in Ohio -- 3 Lucian Leape who was considered literally the 4 father of patient safety and just passed this 5 year. 6 And they also, I think, had a lot 7 of energy around bringing the focus to patient 8 safety, and they, themselves, as researchers, I 9 think, were frustrated with how many people 10 were still getting hurt from things that 11 shouldn't happen. 12 Q. And -- and the grade you mentioned 13 was designed to be consumer focused? 14 A. It was designed to be consumer 15 friendly, so the idea that, like, these 16 restaurant grades -- people understand a -- a C 17 sushi restaurant is not where you probably want 18 to eat. It was designed just to be something 19 more commonplace than maybe what we had been 20 using for the Hospital Survey results. 21 Q. Okay. So just going back to the 22 hospital analo- -- sorry -- the restaurant Page 60
1 working directly with purchasers -- employers 2 and purchasers, I mean that quite literally. 3 Over time, however, they expressed 4 to us, you know, This is great, but maybe it 5 would be great if we can make something a 6 little bit more consumer friendly. They didn't 7 use that term. They're talking about, like, 8 more understandable, easier to consume for our 9 covered lives. 10 And so the idea of a composite, I 11 think, is one that appealed to us in sort of 12 meeting the requests we were getting from 13 employers and purchasers to be more 14 understandable, if we could, to their covered 15 lives. So it would be hard to say whose idea 16 was it. It really felt, to me, at the time 17 just a lot of different things sort of 18 coalescing around a single concept. 19 We also had been working at that 20 point with some extremely prominent globally 21 known subject-matter experts, including folks 22 like Dr. David Bates from Brigham and Women's Page 59	1 analogy. 2 A. Yes. 3 Q. Fair to say we're talking about 4 market forces, like putting out letter grades 5 that SV effect change in the marketplace? 6 A. So these were regulatory in nature 7 in New York and -- and Los Angeles, and I 8 couldn't say if they effected change. I would 9 often hear people bragging, My pizza -- my 10 favorite pizza place in New York has a C, and 11 I'll never stop going, and they'll never change. 12 And that just might be, like, the 13 New York/L.A., like, rebel attitude, but I -- I 14 couldn't speak to whether or not it did or 15 didn't. 16 I think that whether or not it did, 17 it at least increased transparency around those 18 things, and then people could make a decision. 19 It's just pizza; I don't care. I'll go if 20 they're a C. 21 Q. Yeah. For -- for hospitals, 22 though -- Page 61

1 A. Yes. 2 Q. -- was it designed to -- to 3 encourage change and improvement through those 4 market forces? 5 A. It was designed to help us meet our 6 mission in reducing preventable harm and death 7 to patients, correct. 8 Q. Okay. 9 So I want to take a look at a 10 document. So let's step back for a second. 11 A. Sure. 12 Q. I want to talk a little bit about 13 the excerpt -- the Safety Grade expert panel. 14 A. Okay. 15 Q. When was that established? Was it 16 around the same time? 17 A. It would have been almost 18 immediately. Like, as we started at the board 19 level to talk about this idea of doing something 20 around patient safety, we would have -- I can't 21 honestly remember those conversations exactly, 22 but just knowing how we work at Leapfrog, we Page 62	1 patient safety and quality, they're responsible 2 for convening our technical expert panels. And 3 so Matt Austin, as I've talked about, was -- 4 would have been with us at this time, so we 5 would have asked him to help us convene this 6 panel. 7 And probably -- because, again, 8 we -- we're already working with folks like 9 Peter Pronovost and David Bates, we would have 10 asked them out of courtesy -- they are 11 literally giants in the field of patient 12 safety, not just in the United States but 13 around the world -- if they would like to be 14 included. Lucian -- Lucian Leape had had an 15 association with Leapfrog. I'm sure we would 16 have asked him if -- Matt would have asked him 17 if he wanted to be included, and then I'm not 18 exactly sure how Matt identified the others. 19 Q. Okay. 20 A. Probably -- to be frank, probably 21 going to David and Peter saying, Who else is 22 giant in this space that you think would bring Page 64
1 would probably almost immediately start 2 consulting with subject-matter experts in the 3 field, correct. And we had existing ongoing 4 relationships with many of them. 5 Q. Like Dr. Pronovost? 6 A. Like -- Pronovost. 7 Q. Pronovost? 8 A. Yes. 9 Q. Sorry. I read that wrong. 10 A. That's okay. 11 Q. So tell me a little bit about the 12 expert panel, how it developed. 13 How often do they meet? 14 A. So I -- at Leapfrog, one of my roles 15 is not convening technical expert panels, so 16 just if I could talk about that for a second -- 17 Q. Please. 18 A. -- is that okay? 19 So I do -- like I said, I do 20 oversee these programs but not every aspect of 21 those programs. And so part of the contract 22 that we have with Armstrong Institute for Page 63	1 some value? And Matt independently reviews 2 their published literature, their CVs, 3 et cetera. 4 Q. So Dr. Austin makes the decision of 5 who to invite to join the panel? 6 A. He helps recognize and identify 7 them. For this particular panel, again, in my 8 memory, Peter and David Bates were probably 9 involved early on, would also have had some 10 input, like, Yes, like, he or she is really an 11 expert in that area. We should definitely bring 12 them on. 13 Q. So, like, just to put a concrete 14 example -- 15 A. Sure. 16 Q. -- do you know how Dr. Romano joined 17 the panel? 18 A. I don't. 19 Q. Okay. Dr. Austin presumably would 20 know? 21 A. Yes. 22 Q. Okay. And then just going back to Page 65

1 my question -- 2 A. I don't know how he was -- 3 Q. Yeah. 4 A. -- identified or joined the panel or 5 when; however, I do know at that time we were 6 interested in the specific patient safety 7 measures called Patient Safety Indicators. The 8 acronym is PSIs. They were developed by the 9 Agency for Healthcare Quality and Research 10 [sic], AHRQ, and they're an interesting type of 11 measure. 12 So basically they're a 13 software-based measurement tool, where you can 14 read in hospital claims, and it picks up 15 procedure and diagnosis codes from those claims 16 to identify a pool of patients that are 17 eligible to be measured and then the things 18 that we're looking for that shouldn't have 19 happened to them; maybe it's postoperative 20 sepsis or postoperative wound adhesions, 21 meaning the wound came out, right. 22 So all of these things that Page 66	1 patient safety. And then over time, we 2 typically meet once or twice a year. 3 Q. And do you typically join those 4 meetings? 5 A. I do. I attend most all of our 6 technical expert panel meetings for the Survey 7 and the Safety Grade. 8 Q. And does the -- the expert panel -- 9 does it have a chair? 10 A. No, it does not. 11 Q. Dr. Austin plays the role of sort of 12 a facilitator; is that right? 13 A. Correct. So his -- it's his actual 14 contractual responsibility to develop an agenda, 15 meeting materials, meeting notes. 16 Q. Got it. 17 And then how does the -- does 18 the expert panel make decisions, or does it just 19 make recommendations? 20 A. They provide guidance. 21 Q. Okay. 22 A. So they are, as I've described, Page 68
1 happened also happened to be recorded and 2 documented on claims, and so these are called 3 claims-based measures. And Patrick Romano was 4 leading the team that was developing and 5 refining these patient safety indicator 6 measures that we were very interested. And so 7 my sense is that's how he was identified and 8 then invited. 9 Q. And Dr. Romano would have -- or 10 sorry -- Dr. Austin would have invited him? 11 A. Correct. 12 And Dr. Romano continues to be 13 involved in that project through AHRQ as they 14 continue to refine those measures. 15 Q. And then just going back to my 16 question, how often, generally, does the -- does 17 the Safety Grade expert panel meet? 18 A. My recollection is that in the 19 beginning, we met more frequently because we're 20 trying to work everything out and identify 21 measures and make decisions about the 22 methodology and how narrowly we were defining Page 67	1 whether it's our maternity care expert panel or 2 the Safety Grade, across the board, the foremost 3 experts in these areas. And so the criteria 4 that we look for is that you've been widely 5 published, not that you've published a handful 6 of articles, you've published decades of 7 articles on these particular topics. Many of 8 them also serve on other technical expert panels 9 or otherwise subject-matter experts outside of 10 Leapfrog in a number of different capacities. 11 I also, I think I described, serve 12 on several technical expert panels, and my role 13 as an expert panelist and their role as an 14 expert panelist for Leapfrog really mirror each 15 other, and that I'm often asked to provide 16 guidance based on my personal expertise. 17 They're asked to provide guidance based on 18 their research and their own personal 19 expertise. 20 Q. Who makes the ultimate decision if 21 there's a disagreement? 22 A. To be quite frank, I can't think of Page 69

1 a disagreement among expert panelists. The 2 panels are quite collegial, as are the ones I've 3 been on. If there's -- if someone voices a 4 concern during a discussion, which is often 5 quite open and frank -- again, these individuals 6 haven't met for the first time on our panel. 7 They've likely known each other longer than 8 we've known them, and no one is afraid to speak 9 up. There are no shrinking violets on any of -- 10 any of our panels, and so there's always a 11 lively discussion; sometimes, I'm sure, debate. 12 But they ultimately themselves will 13 typically come to guidance at the -- like, This 14 is -- you know, this is what we think. That 15 sounds right. That sounds good to me. David, 16 does that sound right to you? You know, that 17 kind of thing. 18 Ultimately, though, if they did 19 have a disagreement, Matt would let us know 20 that the panel couldn't come to consen- -- and 21 this is theoretical, the panel couldn't come to 22 consensus. I would let Leah know if it was Page 70	1 telephone.) 2 (Sotto voce discussion between the 3 witness and counsel.) 4 BY ATTORNEY CRAIN: 5 Q. So there's no, like, vote, right? 6 A. No. I've never taken a vote as an 7 expert panelist. And we don't ask our panelists 8 to vote either. 9 Q. And then -- so there -- there's -- 10 at these meetings, there's a topic of 11 discussion -- 12 A. An agenda, yes. 13 Q. -- an agenda. There's a dec- -- a 14 decision point, for instance, whether to 15 include -- 16 A. Not necessarily. Sometimes -- 17 Q. If I can finish my question. 18 A. Oh, sorry. 19 Q. -- for instance, whether to include 20 something on the Hospital Survey or in the 21 Safety Grade. 22 Like, there's a do we want to Page 72
1 something very serious. Leah would go to the 2 board of directors. 3 But, again, I -- I really can't 4 think of a single instance across any of our 5 technical expert panels where that's occurred, 6 and we operate about 13 of them. 7 Q. Who -- who decides sort of what the 8 consensus is? Is that Dr. Austin? 9 A. I don't understand the question. 10 I'm sorry. 11 Q. Like, who -- who -- who speaks for 12 the panel at the end of the day and says, This 13 is the group's consensus? 14 A. So I guess, technically, it would be 15 Dr. Austin, but it's not really necessary to 16 have that specific function. I'm on the calls. 17 I'm part of the conversation. So there's not 18 really a necessary formality for Matt to be, 19 like, this is what the panel decided. I heard 20 the conversation. 21 Does that makes sense and -- 22 (Interruption by cellular Page 71	1 include this metric, for instance, right? That 2 could come up, yes? 3 A. It could. 4 Can I give one caveat? And 5 apologize for -- 6 Q. Sure -- 7 A. -- interrupting you -- 8 Q. -- no. 9 A. -- so across all of our programs -- 10 you know, the Hospital Survey, as I described, 11 has been around for -- this is our 25-year 12 anniversary. We have over 2,400 hospitals a 13 year voluntarily participating in that survey. 14 And many of them have been doing it for many 15 years even for our newer program, the Ambulatory 16 Surgery Center Survey. It's been around for -- 17 just since 2019, but we still have ASCs that are 18 doing it every year. 19 And so it's often our 20 responsibility to actually bring topics to 21 these panels sometimes years ahead of when the 22 change might actually go into place. So I just Page 73

1 want to be clear. 2 So it's not like I'm taking to 3 them -- or we're taking to them can you please 4 make a decision about this measure because 5 we're going to include it in six months. It's 6 really on us, myself and Dr. Austin, to make 7 sure that we are staying ahead of things. You 8 know, this measure is going to be publicly 9 reported by CMS in 2027. We would like to talk 10 to the panel about it now so we can give 11 hospitals one-year notice, two-year notice, 12 three years. 13 So it's oftentimes for discussion. 14 It may not be for immediate decision or 15 implementation. I -- if that -- 16 Q. That's helpful -- 17 A. -- makes sense. Okay. 18 Q. -- it does. 19 And I guess my follow-up 20 question is -- you said "immediate decision." 21 Who's making the decision? 22 A. If it's to add or remove a mother -- Page 74	1 And when I say "controversial," for 2 example, following the decision on Roe versus 3 Wade, we had a lot of employers and purchasers 4 very concerned about the impact that would have 5 on the safety of women and really said, This is 6 a patient safety issue. Why isn't Leapfrog 7 speaking out about this? Why isn't Leapfrog 8 doing something about this? 9 Given the political nature of that 10 particular topic, if one of our expert panels 11 had theoretically said, I -- if our maternity 12 care expert panel had said, I think we need to 13 do something around this from a measurement and 14 public reporting perspective, that likely would 15 have gone to our board of directors, if that's 16 a helpful example. 17 Q. It is. 18 So when you say 19 "controversial" -- 20 A. Yes. 21 Q. -- that's helpful -- 22 A. Yeah. Page 76
1 measure, it's the Panel saying, I think this is 2 a good measure to add. And usually people will 3 say, I agree, I agree, I agree. 4 But, again, it's not a verbal vote; 5 it's -- it's a verbal consensus. 6 Q. So the -- the expert panel makes the 7 decision or Leapfrog makes the decision? 8 A. The expert panel provides us with 9 some guidance that this would be a good measure 10 to add. Ultimately, it's our decision whether 11 or not we add it, but we tend to always follow 12 the expert panel's guidance. 13 Q. And when you say "our," just so it's 14 clear, that's Leapfrog, correct? 15 A. Correct. 16 Q. And anybody particular internally at 17 Leapfrog? 18 A. Anything related to any of the 19 measures on any of our ratings programs would be 20 Matt Austin, myself, Leah Binder. And like I 21 said, if it was something controversial, it 22 would go to our board. Page 75	1 Q. -- and -- and I remember that 2 decision well. 3 A. Yeah. 4 Q. Going back to the Safety Grade, 5 are -- are -- what are the types of hospitals 6 that are not assigned a Safety Grade? 7 A. So for the Hospital Safety Grade -- 8 is it okay if I start a little bit at the 9 beginning so it's not confusing -- 10 Q. Sure. 11 A. -- and if it -- if you're like, oh, 12 I already know this, then just tell me, because 13 I'm not, you know -- 14 Q. Go ahead. Yeah. 15 A. -- so for the Hospital Safety Grade, 16 again, we're just using these measures of 17 patient safety as our expert panel has defined 18 "patient safety," which is freedom from harm, 19 right. 20 And so the Safety Grade includes 21 two domains of measures. You can sort of think 22 of them as, like, two buckets. Okay. And I'm Page 77

1 going to use my hands, but I'm going to use my 2 words, too. 3 Two buckets. One of the buckets 4 includes what we call "process and structural 5 measures." So these are processes and 6 structures that researchers, scientists have 7 said and have evidence -- so they actually are 8 things that would prevent harm to patients. 9 An example would be the use of 10 computerized prescriber order entry to order 11 inpatient medication orders can prevent adverse 12 drug events, which is basically someone giving 13 you a medication that they shouldn't for any 14 number of reasons and it kills you. Right. So 15 that's an adverse drug event. 16 So that's a structural measure. 17 It's, in this case, a piece of technology 18 including some systematic implementation. 19 The other bucket of measures are 20 called "outcome measures." And this is 21 actually rates or incidences of harm occurring. 22 So catheter-associated urinary tract Page 78	1 harm, right. 2 There were some concerns 3 early on that if we just looked at 4 outcomes, that could be frustrating 5 to hospitals because it can take a 6 long time to change some of those 7 rates, or maybe -- there are just 8 various complexities related. 9 So they really just wanted 10 to basically say try really hard, and 11 we'll consider that. And also, like, 12 we're going to look at how that 13 worked out and -- and we're going to 14 consider -- we're going to consider 15 that. 16 Does that make sense? 17 BY ATTORNEY CRAIN: 18 Q. Yes -- 19 A. Okay. 20 Q. -- no; it does. 21 A. Okay. So -- so in thinking about 22 the types of hospitals that don't get graded, Page 80
1 infections -- no one wants one of those, right? 2 Q. Pass. 3 A. Yeah. One of those -- 4 (Laughter.) 5 THE WITNESS: We all pass. 6 Pass around the table. 7 ATTORNEY CRAIN: See, Kim. 8 You like -- you like coming to a 9 deposition with me. 10 ATTORNEY BLAIR: You got me. 11 THE WITNESS: We -- one of 12 the founding principles that our 13 technical expert panel came up with at 14 the very beginning and has since 15 affirmed continuously is that 16 hospitals should basically get equal 17 credit or equal consideration -- let's 18 say equal consideration for the 19 processes and structures they're 20 having in place. You can kind of 21 think of it as, like, their effort to 22 reduce harm and then, like, the actual Page 79	1 it's related to the fact that in that outcomes 2 bucket, that outcomes domain I talked about, 3 virtually all of the measures come from the 4 Centers for Medicare & Medicaid Services, or 5 CMS. 6 And those measures are only 7 available for hospitals that participate in 8 something called the IPPS program. It's the 9 Introspective [sic] Payment -- there's another 10 P. But, basically, it's the agreement that CMS 11 enters into with hospitals in order to get 12 reimbursed for the care and services provided 13 to traditional Medicare patients, right, so 14 Medicare fee-for-service patients. 15 Because of that, critical access 16 hospitals, for example -- they'll participate 17 in the traditional Medicare payment structure, 18 so they wouldn't be required by Medicare to 19 report on those measures, and we wouldn't have 20 data. 21 Pediatric hospitals only care for 22 pediatric patients. They would typically have Page 81

1 Medicaid, not Medicare, so they're not included 2 in that IPPS program -- Veterans Administration 3 hospitals, Indian Health Services hospitals, 4 et cetera. 5 Additionally, though, there's other 6 general acute care hospitals that otherwise are 7 participating in the program, but because they 8 may be specialized -- like, we mostly or always 9 care for cancer patients, or we mostly or 10 always care for surgical patients -- because of 11 the nature of the patients who are included in 12 these measures, they would never have 13 information available, right. And this is, 14 like, oncology hospitals, certain types of 15 orthopedic surgery hospitals where, like, 16 the -- their scope of service is quite narrow. 17 So that generally describes the 18 type of hospitals that aren't assigned Safety 19 Grades, and it's due specifically to CMS' 20 policy on who they mandate to report on these 21 measures. 22 Does -- Page 82	1 Q. There are other minimum data 2 requirements, too, right? 3 A. Correct. 4 Q. Can you walk us through that? 5 A. Sure. 6 One of the measures that we use to 7 calculate the Safety Grade in that outcome 8 measures bucket is called PSI 90. It's a 9 patient safety composite also developed by 10 AHRQ, however, calculated by CMS. It, in and 11 of itself, includes 10 individual PSIs. 12 So we call them -- there's 10 child 13 PSIs. Each of those 10 child PSIs has a rate 14 calculated. There's a weight -- 15 (Sotto voce discussion between the 16 certified stenographer and the 17 witness.) 18 (As the certified stenographer 19 seeks clarification, colloquy will 20 not be captured on the written 21 record.) 22 THE WITNESS: This is a Page 84
1 Q. Got it. 2 A. -- that make sense? 3 Q. No; it's helpful. 4 I -- 5 A. Okay. 6 Q. -- so is it -- am I understanding 7 this right that those buckets of hospitals -- 8 there just isn't enough data to reliably -- 9 reliably grade? 10 A. There isn't outcomes data -- so 11 there isn't outcomes data. Again -- so going 12 back to the two buckets, because each bucket is 13 worth 50 percent of the overall grade, the panel 14 would not -- would not be supportive of not 15 having any outcomes measures, right. 16 Not to say the processes and 17 structures aren't important, but, really, 18 they -- they really want those outcomes. And 19 those outcome measures would not be available. 20 Q. So you're missing half, essentially, 21 of the equation? 22 A. Yeah. Yes. Page 83	1 Dr. Seuss. 2 For each of those individual 3 child PSIs, a rate, R-A-T-E, is 4 calculated, then a weight, 5 W-E-I-G-H-T, is assigned for an 6 overall composite. 7 Because that one CMS measure 8 includes these 10 component measures, 9 in the Hospital Safety Grade 10 weighting formula, it receives about 11 15 percent as the standard weight. 12 So hospitals that are missing a score 13 for PSI 90 don't receive a Hospital 14 Safety Grade. 15 Do you want me to keep 16 going, or did you have a question? 17 BY ATTORNEY CRAIN: 18 Q. There -- there are two more, right? 19 A. Yes. I was going to keep going, but 20 it looks like you had a question -- okay. 21 Q. Yeah. I was going to go to those 22 next, so feel free. Page 85

1 A. Okay. I'm good at reading nonverbal 2 cues. 3 Q. I'm good at making them. 4 (Laughter.) 5 THE WITNESS: In addition to 6 that, hospitals missing measure scores 7 for more than six process and 8 structural measures, hospitals missing 9 measure scores for more than five 10 outcome measures are also not graded. 11 And this typically will 12 include, like, very small, rural 13 hospitals that aren't critical access 14 hospitals but could be a critical 15 access hospital where their volumes 16 are so low they typically are missing 17 too many outcome measures in order to 18 receive a Hospital Safety Grade. 19 BY ATTORNEY CRAIN: 20 Q. And what about the process measures? 21 A. There are not many hospitals in the 22 U.S., frankly, who are missing too many process Page 86	1 measures, are they? 2 A. The five -- 3 Q. HCAHPS. 4 A. -- HCAHPS patient experience 5 measures are included in the process and 6 structural measure domain -- 7 Q. Okay -- 8 A. -- in that bucket -- 9 Q. -- got it. 10 Okay. 11 A. -- yes, correct. They're five of 12 the 12 measures included in that bucket. 13 Q. So there are 12 process and 14 structural measures, correct? 15 A. Correct. And 10 outcome measures. 16 Q. And 10 outcome measures? 17 A. Yes. 18 Q. If a hospital does not respond to 19 Leapfrog's survey -- 20 A. Yes. 21 Q. -- how many process and structure 22 measures does Leapfrog not have survey data for? Page 88
1 measures, I will say, with one exception. In 2 that process and structural measure bucket, 3 right, we include five patient experience 4 measures that come from CMS. It comes from a 5 survey instrument for patients called HCAHPS. 6 It's, like, the healthcare Consumer Attitudes 7 [sic] -- don't ask me the rest of it, but it's 8 basically why you were at the hospital. You get 9 discharged. When you get home, they send you a 10 survey. 11 There are some hospitals, due to 12 small volume, where enough patients don't 13 return the survey. You can't make patients do 14 the survey. Enough patients don't do the 15 survey. 16 So in those instances, if they're 17 missing patient experience scores for those 18 five measures and then, say, they don't operate 19 an ICU and maybe they're missing data for one 20 other measure -- but it's very rare. Very 21 rare. 22 Q. Those aren't, though, the process Page 87	1 A. Measures or measure scores? 2 Q. Process -- tell me the difference. 3 A. Sure. 4 So for -- for determining the 5 Hospital Safety Grades, since its inception 6 back in 2013, we've always used the term 7 "measure scores." And the reason is because 8 when we first started doing the Hospital Safety 9 Grade and the expert panel were setting out 10 some guidelines for us to follow, they wanted 11 to be able to include -- again, because we're a 12 national not-for-profit, we're trying to do a 13 public service -- as many hospitals as 14 possible. And so they urged us to identify as 15 often as we could both primary and secondary 16 data sources that may be available. 17 And so while the primary and 18 secondary data sources have varied over the 19 years, we look for scores among -- or across 20 those things. 21 Q. So to that point -- 22 A. Sure. Page 89

1 Q. -- can we talk generally about what 2 that means? 3 A. Yes. 4 Q. So can you give us just a clean -- 5 like, you -- what is your view of what "primary 6 data source" means? 7 A. So the primary data source is 8 actually not a view I have; it's something that 9 we define. 10 So I don't want to be presumptuous, 11 but I assume you have the Safety Grade 12 methodology document in your pile. 13 Q. Is that helpful to you? 14 A. Could pull out a table? 15 Q. Absolutely. 16 A. I'm sorry. 17 Q. No, no, no. Please. 18 ATTORNEY CRAIN: You know 19 what -- 20 THE WITNESS: I just think it 21 will -- 22 ATTORNEY CRAIN: -- we've Page 90	1 take a break. We'll tee that up and 2 come back -- 3 THE WITNESS: Okay. 4 ATTORNEY CRAIN: -- after the 5 break. Yeah. 6 THE VIDEOGRAPHER: Going off 7 the record. The time is 10:10. 8 --oOo-- 9 (Whereupon, a recess was taken from 10 10:10 a.m. EDT to 10:30 a.m. EDT.) 11 --oOo-- 12 --oOo-- 13 (Danforth Deposition Exhibit Number 14 3, Leapfrog Hospital Safety 15 Grade, Scoring Methodology, Spring 16 2025, Bates stamped 17 LEAPFROG00217511 through 18 LEAPFROG00217537, marked for 19 identification, as of this date.) 20 --oOo-- 21 THE VIDEOGRAPHER: Going back 22 on the record. The time is 10:30. Page 92
1 been going an hour. 2 Should we take a break -- 3 (Simultaneous unreportable 4 crosstalk.) 5 (Whereupon, as the certified 6 stenographer seeks clarification, 7 colloquy will not be captured on 8 the written record.) 9 THE WITNESS: If I'm not 10 allowed to ask for documents, just 11 tell me, and -- 12 ATTORNEY CRAIN: You are 13 absolutely allowed to ask. Whether I 14 give it is a different question. 15 (Laughter.) 16 ATTORNEY CRAIN: But we will 17 give you that one -- 18 THE WITNESS: Okay. 19 ATTORNEY CRAIN: -- let's -- 20 we've been going about an hour -- 21 THE WITNESS: Yes. 22 ATTORNEY CRAIN: -- let's Page 91	1 BY ATTORNEY CRAIN: 2 Q. Good? 3 Okay. Great. 4 Ms. Danforth, welcome back. 5 Before the break, we were 6 starting to talk about the methodology of the 7 Safety Grade -- 8 A. Yes. 9 Q. -- correct? 10 And just, again, wait for me to 11 finish the question before you say yes or no. 12 Just to -- to start -- so we 13 premarked this Exhibit 3. And on the front 14 page, you'll see it says, Leapfrog Hospital 15 Safety Grade, Scoring Methodology, Spring 2025 16 Safety Grade. 17 Do you see that? 18 A. Yes. 19 Q. Was this the document you were 20 asking to see before the break? 21 A. Yes. 22 Q. Okay. And I had asked you for your Page 93

1 view of what primary data is, and I think you 2 were going to tell me the definition from this 3 document, right? 4 A. Yes. I just thought it would be 5 helpful. 6 Q. Absolutely. 7 So tell me -- which page would 8 you like to go to? 9 A. We're going to go to Page 4 -- 10 Q. Okay. 11 A. -- of this document. And it looks 12 like this is printed front to back -- 13 Q. Yep. 14 A. -- so just going back one step, I 15 described those two buckets -- 16 Q. Yes. 17 A. -- those six process and structural 18 measures. That's the table that you see on 19 Page 4 and 5. 20 And then I described that there are 21 10 outcome measures, and that's the table you 22 see on Pages 6 and 7. Page 94	1 for my question. 2 A. Sure. 3 Q. My question is -- I just want a 4 definition so we're on the same page -- 5 A. Sure. 6 Q. -- what is primary data? 7 A. So a primary data would indicate if 8 this is available, we'll use it; otherwise, 9 we'll go to the next column -- 10 Q. Okay. 11 A. -- labeled Secondary Data -- 12 Q. So I -- 13 A. -- chronologically. 14 Q. -- I had understood that primary 15 data, as defined at least scientifically, as the 16 data that a researcher collects themselves for a 17 specific purpose. 18 Is that a fair definition? 19 A. I am not myself a researcher. I 20 honestly couldn't speak to whether or not that's 21 the case or not. The way I'm using it and 22 describing it in this context doesn't Page 96
1 And then I described that one of 2 the measures we use in the outcome measures 3 bucket is called that CMS PSI 90 and that it 4 included those 10 child measures. And that -- 5 those 10 child measures are listed on Page 8. 6 Q. Um-hum -- 7 A. Okay. 8 Q. -- yep. 9 So where's the definition of 10 what primary data is? 11 A. Sure. 12 Q. Just to focus on my question. 13 A. There is no definition. These 14 primary and secondary data sources in this 15 table -- so moving left to right, the second 16 column, Primary, the third -- fourth column 17 labeled Secondary Data Sources -- this is how 18 the data has always been represented. 19 I couldn't speak exactly to when 20 this table first got created -- 21 Q. So I -- I want to just cut you off 22 there just before we go to a different direction Page 95	1 necessarily come from how someone doing a random 2 control trial study might describe it. 3 I believe these original terms, 4 again, came from our original expert panel, 5 indicating that if this was available, we'd use 6 it; otherwise, we'd move on to see if a 7 secondary data source was available. 8 Theoretically, there could be a 9 third, or a tertiary, data source. 10 Q. So -- then let's -- do you have a 11 definition of what a secondary source is? 12 ATTORNEY BLAIR: Objection -- 13 THE WITNESS: In the context 14 -- I'm sorry. 15 ATTORNEY BLAIR: -- objection 16 to form. 17 THE WITNESS: I can speak to 18 it in the context of my programs. 19 Again, I'm not a researcher. 20 BY ATTORNEY CRAIN: 21 Q. What does it mean to you -- what 22 does secondary data mean to you? Page 97

1 A. Yeah. Specifically in this context, 2 it means if what's in the primary data source 3 column is not available, we would move to the 4 second column, that literally. 5 Q. So Leapfrog, over the 13 years since 6 it started issuing the Hospital Safety Grades, 7 has used different types of secondary data 8 sources; is that correct? 9 A. Yes. 10 Q. And I just want to go through a 11 couple of them to see if we're on the same page 12 about what -- what they are. 13 A. Okay. 14 Q. Is CMS data a secondary data source? 15 A. Not always. Oftentimes -- then 16 that's why I thought it would be helpful to 17 look -- 18 Q. Yeah. 19 A. -- at the chart. It's a primary 20 data source. And in some cases, like with these 21 HCAHPS measures, it's the sole data source. 22 Q. But CMS data is not collected by Page 98	1 A. Yes. 2 Q. -- the American Hospital Association 3 data that Leapfrog used to use, right? 4 A. Correct. 5 Q. And tell me just a little bit -- so 6 that's AHA, right? The 7 American Hospital Association? 8 A. Yes. 9 (Laughter.) 10 BY ATTORNEY CRAIN: 11 Q. Yeah. Sorry. We're going to have a 12 lot of aha moments today. 13 A. I was like, the '80s band? 14 (Laughter.) 15 BY ATTORNEY CRAIN: 16 Q. So Leapfrog, for a time, used 17 American Hospital Association data to inform its 18 methodology, correct? 19 A. We did. 20 Q. And that was a form of secondary 21 data, right? 22 A. Correct. Page 100
1 Leapfrog, right? 2 A. Correct. 3 Q. Okay. It's collected by CMS, 4 correct? 5 A. Correct. 6 Q. And it's not collected to inform 7 Leapfrog's grading process, correct? 8 A. Can you repeat the question? 9 Q. I'm asking about the purpose of why 10 CMS collects its data. 11 CMS does not collect its data 12 to help Leapfrog grade hospitals, correct? 13 A. Correct. 14 Q. It -- it collects its data for a 15 different purpose, right? 16 A. Correct. It makes it publicly 17 available -- 18 Q. Yes. 19 A. -- yeah. 20 Q. Then other forms of secondary data 21 that Leapfrog has used in the past -- and, 22 again, I just want to get on the same page -- Page 99	1 Q. Leapfrog also used certain averages 2 or means to -- to inform its methodology at 3 times, right? 4 ATTORNEY BLAIR: Objection to 5 form. 6 THE WITNESS: At times, our 7 imputation methodology has included 8 the use of averages or means, correct. 9 BY ATTORNEY CRAIN: 10 Q. And that's the secondary data in 11 that context, right? 12 A. Correct. 13 Q. Okay. Leapfrog has also used 14 historical scores as secondary data, right? 15 A. As part of our imputation 16 methodology -- 17 Q. Yes. 18 A. -- only, correct. 19 Q. And I just want to make sure we're 20 not crossing wires here. 21 Is it fair to say that -- the 22 imputation methodology is the process by which Page 101

1 secondary data is imputed into the score, 2 correct? 3 ATTORNEY BLAIR: Objection to 4 form. 5 BY ATTORNEY CRAIN: 6 Q. If you don't understand, I can 7 clarify that. 8 A. If you can ask the question again. 9 I -- 10 Q. Yeah. 11 A. -- I apologize. It's not that I 12 don't necessarily understand what you're asking, 13 but you're describing something in terms that 14 I've never heard it described before. Using 15 words that I know, I just want to make sure I 16 answer you correctly. 17 Q. For sure. 18 A. Okay. 19 Q. I'm trying to figure out the 20 relationship between the imputation 21 methodology -- 22 A. Yes. Page 102	1 not available. I'm not clear enough 2 on your question to know if we're 3 saying the same thing or not, but 4 what I just described is accurate. 5 BY ATTORNEY CRAIN: 6 Q. Fair enough. Okay. 7 I'm just trying to think if 8 we're on the same page or not. 9 A. Can I give an example? 10 Q. A short one. A slow one to Cindy's 11 point. 12 ATTORNEY BLAIR: Slow and 13 short. 14 THE WITNESS: Okay. 15 If we're missing a measure 16 score for one of these measures that 17 has a -- in this -- in the column 18 saying Secondary Data Source 19 Imputation Model Applied, then we are 20 imputing a measure score for that 21 measure. 22 Is that what you're saying? Page 104
1 Q. -- or model -- 2 A. Yeah. 3 Q. -- and secondary data. 4 A. Sure. 5 Q. The imputation model is like a 6 structure, right? 7 A. Yes. 8 Q. And it's a structure by which 9 Leapfrog takes secondary data and imputes it 10 into the Safety Grade -- 11 ATTORNEY BLAIR: Object -- 12 BY ATTORNEY CRAIN: 13 Q. -- methodology; is that right? 14 ATTORNEY BLAIR: -- objection 15 to form. 16 THE WITNESS: It's a 17 structure by which Leapfrog imputes it 18 into the Safety Grade . . . 19 I would say that we use our 20 imputation model developed by our 21 national expert panel to assign 22 measure scores when primary data is Page 103	1 BY ATTORNEY CRAIN: 2 Q. I think that's right. 3 A. Okay. 4 Q. I guess what I'm saying is it -- 5 this column has confused me, candidly -- 6 A. Understood. 7 Q. -- because it says "secondary data 8 source" -- 9 A. Yes. 10 Q. -- and -- and really what, like, the 11 source would be is the mean or the AHA or the 12 historical data, right? 13 ATTORNEY BLAIR: Objection to 14 form. 15 THE WITNESS: No, that's not 16 correct. 17 BY ATTORNEY CRAIN: 18 Q. Okay. So tell me why that's not 19 right. 20 A. The source has historically been 21 since the inception of the Safety Grade -- or I 22 guess I would call it a source for the second Page 105

1 score. So it can include American Hospital 2 Association and data. It can include imputed 3 data. It does include data from the CMS Cost 4 Report. It's really any source where a 5 secondary -- where a measure score can be 6 determined, located, made available. 7 So it's not limited to those 8 examples you gave but definitely does include 9 those examples you gave as well as others. The 10 methodology for this program has been evolving 11 constantly. That's why we have a technical 12 expert panel -- 13 Q. Sure. 14 A. -- so it may include other things in 15 the future that they deem necessary and 16 appropriate, but it certainly would also include 17 what you just described. 18 Q. Yeah. 19 A. Okay. 20 Q. So over the history -- so I guess 21 let me ask this question, just a year. 22 A. Yes. Page 106	1 A. That's what I'm trying to remember. 2 Q. Yeah. 3 A. So, again, not to overexplain, but 4 the American Hospital Association actually 5 administers a handful of different surveys at 6 different times of the year. We weren't using 7 data points from a single American Hospital 8 Association -- 9 Q. Okay. 10 A. -- survey. We were using data 11 points across various American Hospital 12 Association surveys, including a HIT, or health 13 information technology, supplement that they 14 administer -- administered to hospitals as well. 15 I believe we stopped using all 16 American Hospital Association data. The last 17 time we got it, I think, was 2021. I was just 18 trying to remember. 19 Q. Yeah, and I -- 20 A. It -- it would be accurate it's 21 around that time, yes. 22 Q. We'll come to documents. So I Page 108
1 Q. Approximately when did Leapfrog 2 start using an imputation methodology for at 3 least certain measures? 4 A. Years ago, I would estimate, but we 5 need to look through the detailed methodology -- 6 Q. Yeah. 7 A. -- document. 8 Q. Just your best understanding. 9 Let me -- let me triangulate 10 you -- 11 A. I think -- oh. 12 Q. -- if this might help, let me 13 triangulate you. 14 In, I think, approximately -- 15 we'll get to documents, but 2020 or 2021, the 16 AHA stopped licensing data; is that right? 17 A. Yes. 18 And that's what I was trying to 19 remember, that date. 20 Q. Was that the first time that an 21 imputation methodology was used, or was one 22 before? Page 107	1 wanna -- 2 A. Yeah. 3 Q. -- it's either 2020 or 2021? 4 A. Yes. 5 Q. Just to triangulate with that 6 marker -- 7 A. Yes. 8 Q. -- was there an imputed -- was there 9 an imputation model prior to that date that you 10 recall? 11 A. Not that I can remember -- 12 Q. Okay. 13 A. -- no. 14 Q. Since 2021 -- 15 A. Yes. 16 Q. -- can you identify any other 17 secondary data sources that we have not 18 discussed that Leapfrog had used in its scoring 19 methodology? 20 A. Since 2021, are there any additional 21 data sources . . . 22 We have used in the past something Page 109

1 called the CMS IMPACT, all caps, I-M-P-A-C-T, 2 file, which is different than what we use now, 3 called the CMS cost report. That would be the 4 only other source I can remember right now. 5 Q. Can I ask this question? 6 A. Um-hum. 7 Q. So on the chart, you saw down -- it 8 lists CMS in Primary. 9 A. Yes. 10 Q. And I know CMS, you just mentioned, 11 has been used as a secondary data source. 12 A. Correct. 13 Q. Why the -- why both? 14 A. Sure. 15 Can I refer to a page number? 16 Q. Of course. 17 A. So if you turn to Page 6. 18 So this is the table that includes 19 those 10 outcome measures: The only instance 20 where CMS is used as a secondary data source 21 are for these five -- what we call -- 22 "healthcare-associated infections," so it's Page 110	1 hospitals that participate in that IPPS program 2 are required to report their infections into 3 NHSN, so you can't choose to do it or not. And 4 CMS gets the data directly from NHSN and 5 publicly reports it on its Care Compare 6 website. 7 As we were learning about this at 8 Leapfrog, we learned that we as a national not 9 for-profit could also administer an NHSN 10 hospital group similar to CMS, where instead of 11 waiting for CMS to publish the data on their 12 Care Compare website, hospitals would give us 13 rights to the same reports that CMS publishes, 14 which include no patient data, no patient 15 identifiers, thereby allowing us to report 16 those data alongside our other Leapfrog 17 Hospital Survey results. 18 Q. So I want to go back to my 19 definition of primary data, which -- which you 20 said was not yours, so I -- I take that, but -- 21 A. Yes. 22 Q. -- recall that my definition was Page 112
1 CLABSI, or central line-associated bloodstream 2 infections, CAUTI, catheter-associated 3 bloodstream infections, surgical site 4 infections following colon surgery, MRSA, which 5 is -- 6 Q. Don't want that? 7 A. -- an antibiotic resistant, and a 8 C. difficile, which is antibiotic -- and, 9 actually, that's the one you don't want. 10 Q. I don't want any. 11 A. Yes. 12 Through its annual Hospital Survey, 13 Leapfrog administers one of the largest 14 national NHSN groups in the country -- so NHSN 15 stands for the National Healthcare Safety 16 Network. It's currently administered through 17 the CDC, and it is a place where CDC does 18 national infection surveillance for these 19 healthcare infections healthcare things like 20 pneumonia, previously COVID. 21 Through participation in CMS' IPPS 22 program, which we talked about earlier, Page 111	1 data that a researcher seeks for a specific -- 2 collects for specific purpose -- 3 A. Okay. 4 Q. -- right? 5 In -- in these two columns, the 6 2024 Leapfor- -- Leapfrog Hospital Survey for 7 C. diff fits that definition, right? 8 ATTORNEY BLAIR: Objection to 9 form. 10 THE WITNESS: I'm sorry. Can 11 you repeat that? 12 BY ATTORNEY CRAIN: 13 Q. Yeah. 14 So Leapfrog collects this 15 information on -- itself, right? 16 A. No, and I'm not trying to be too 17 too -- 18 Q. Okay. 19 A. -- technical -- 20 Q. Yeah. 21 A. -- but, again, hospitals submit this 22 information to NHSN. They choose or choose not Page 113

1 to give us the right to access this data through 2 NHSN. We don't go out and collect it directly 3 from hospitals. 4 It literally is a downloadable 5 report from -- directly from NHSN that only 6 includes those hospitals that have completed 7 NHSN's data rights template. 8 Q. So why does this say 2024 Leapfrog 9 Hospital Survey, then? 10 A. Because for the purposes of the 11 Hospital Safety Grade, an important component of 12 the measures that we use in calculating the 13 grade is whether or not it's publicly available. 14 Leapfrog Hospital Survey results are publicly 15 available, and that's important because we like 16 to have hospitals be able to see their 17 performance on these measures prior to them 18 being used to calculate the Hospital Safety 19 Grade. 20 So hospitals have an opportunity 21 through the Leapfrog Hospital Survey to preview 22 their scored survey results before we publicly Page 114	1 only from hospitals who have completed our rates 2 template and said, We give NHSN permission to 3 give this data to Leapfrog. 4 Q. So then why does this say 2024 5 Leapfrog Hospital Survey? That's what I -- 6 that's the disconnect. I'm still not 7 understanding. 8 A. Because the mechanism that we have 9 to go through the process of administering the 10 group and obtaining the -- the rights from 11 hospitals is described in the Leapfrog Hospital 12 Survey -- 13 Q. Okay. 14 A. -- I believe it's Section 7B of the 15 hard copy of the Survey -- 16 Q. Yeah. 17 A. -- and it includes step-by-step 18 instructions of exactly how that process is 19 done. 20 Q. Okay. But just -- just to make 21 sure, again, that I'm understanding it right, on 22 CAUTI -- Page 116
1 report them on leapfroggroup.org. Hospitals 2 have an opportunity -- actually, an obligation 3 through CMS to review their CMS performance 4 measures 30 days before CMS makes it available 5 on their Care Compare website. 6 So the technical, I guess, place 7 where hospitals would know, Hey, where did 8 Leapfrog get this -- is through the Leapfrog 9 Hospital Survey and the corresponding website, 10 which is leapfroggroup.org. 11 Q. Okay. So I -- I guess I'm a little 12 confused. 13 The -- the data for CAUTI -- 14 A. Um-hum. 15 Q. -- that's collected not by Leapfrog? 16 A. No; it's directly collected into 17 NHSN. We have a heavily password-protected 18 website that we log into following a very 19 arduous, called SAMS, S-A-M-S, process for the 20 Federal Government -- 21 Q. Yeah. 22 A. -- we get a report four times a year Page 115	1 A. Yes. 2 Q. -- the -- the source of data that 3 Leapfrog uses is not the Leapfrog -- the 4 Hospital Survey? 5 ATTORNEY BLAIR: Objection to 6 form. 7 THE WITNESS: Technically for 8 both Leapfrog and CMS for these five 9 healthcare infection measures, the 10 source of data could be considered 11 NHSN. 12 BY ATTORNEY CRAIN: 13 Q. Okay. 14 A. It's the identical report for both. 15 Q. Got it. Okay. 16 A. And I'm not trying to be confusing. 17 I'm just trying to understand the question. 18 Sorry. 19 Q. No, no, I -- I'm learning live on 20 this question -- 21 A. Yeah. 22 Q. -- so that's what I'm trying to Page 117

1 understand. 2 So why doesn't Leapfrog put 3 "NHSN" here? 4 A. We could put "NHSN," and CMS could 5 also put "NHSN" -- 6 Q. Okay. 7 A. -- yeah. 8 Q. Okay. Okay. 9 A. That would -- that would be accurate 10 and correct as well. 11 Q. Is this inaccurate? 12 A. No. 13 Again, maybe 4,000 hospitals submit 14 data to NHSN. We don't have access to all 15 4,000 hospitals. So this is really meant to 16 convey that for those hospitals that have given 17 us permission -- and, again, the hospitals know 18 they have because they've gone through our 19 survey. That is how we're going to be getting 20 that data from them -- 21 Q. Okay. 22 A. -- we can't just get data from NHSN Page 118	1 A. So through the Hospital Safety 2 Grade -- we have a process that's described in 3 painful details on the Hospital Safety Grade 4 website, where we first announce years in 5 advance what we call data snapshot dates so 6 hospitals know, These are the days we're going 7 to pull down your Leapfrog Hospital Survey 8 results, your CMS data, whatever the -- data is 9 available. 10 We then take that data inside, 11 Alex Campion -- who you met, my Safety Grade 12 program manager -- processes the data, runs it 13 through our scoring algorithm, we do a round of 14 QA and then we hold what we call a courtesy 15 data review period. It's usually a two- to 16 three-week period twice a year where we provide 17 a version of this document that includes some 18 extra pages I'm not seeing here called data 19 review instructions. And it basically tells 20 hospitals, You will go to this 21 password-protected website using a username and 22 password. You get to review all of the data, Page 120
1 from every -- any hospital in the country. 2 It's -- that's just not how it works. 3 Q. Can I -- can we just go back to the 4 top of this document for a second? 5 A. Yes. 6 Q. And I have some questions about it. 7 Who crafted this originally, if 8 you know? 9 A. I don't know -- 10 Q. Okay. 11 A. -- it's not been redesigned, only 12 updated over the years. 13 Q. No worries. 14 Did you have a role in the 15 revisions? 16 A. I review it every round. 17 Q. Every round. 18 And how often is it updated? 19 A. Twice a year -- 20 Q. Okay. 21 A. -- I'm sorry. Four times a year. 22 Q. Why four times? Page 119	1 so the measure scores for each of the measures 2 used to calculate your Hospital Safety Grade. 3 We provide hyperlinks directly back to the 4 source. 5 So in the case of these infection 6 measures where it says "Leapfrog Hospital 7 Survey," it would actually go back to 8 leapfroggroup.org -- 9 Q. Got it. 10 A. -- so they could verify, I see a 11 standardized infection ratio for CLABSI of 12 0.118. Yes, that's correct. Leapfrog made 13 that. 14 So they have three weeks to 15 basically review the data, click the links. We 16 make an Excel-based calculator available so 17 they can re-create our calculations. And they 18 get what's called a preliminary numerical 19 score, a preliminary numerical score. But 20 there's no letter grade associated with that. 21 During the review period -- and 22 that is described in this document in the Page 121

1 latter pages -- if hospitals have closed, we 2 have to remove them from our data set. If 3 hospitals have what's called a CMS, 4 certification number change, or CCN, which is 5 how we match hospitals to that data that CMS 6 publishes, we would have to record that change, 7 and that may mean updating their measure scores 8 for those CMS measures. 9 Therefore, the data means, standard 10 deviations, et cetera, used for the overall 11 calculation are not finalized until after the 12 two- to three-week data review period. So this 13 document -- may I take you to a different page? 14 Q. I -- well, I -- I kind of want to go 15 just back to my question, if I could. 16 A. Right. 17 But that's why I'm saying I do this 18 four times a year -- 19 Q. Four times -- 20 A. -- not twice. 21 Q. -- a year. Okay. 22 A. Yeah. Page 122	1 referencing the Leapfrog Hospital Safety Grades. 2 Q. Is there any other place publicly 3 available that describes Leapfrog scoring 4 methodology? 5 A. I would not know the answer to that 6 question. There very -- there very well may be. 7 I -- I'm not sure. 8 Q. You're -- you're not the corporate 9 rep for websites, so I take that. 10 A. Okay. 11 Q. Are you aware of any -- 12 A. No, I'm not. 13 Q. Okay. Let -- let me finish the 14 question -- 15 A. Okay. 16 Q. -- if I could. 17 Are you aware of any other 18 location on Leapfrog's website -- strike that. 19 Let me -- let me start back. 20 This document, I'll represent 21 to you, we pulled off Leapfrog's website -- 22 A. Yes. Page 124
1 So there's a preliminary version -- 2 Q. Yeah. 3 A. -- and then a final version -- 4 Q. Okay. 5 A. -- okay. 6 Q. Great. 7 A. Do you want me to show what changed? 8 Q. No -- 9 A. Okay. 10 Q. -- I'm -- I'm good now. 11 A. Okay. 12 Q. A couple other questions on this. 13 A. Yes. 14 Q. So who is this written for? 15 A. Hospitals who are receiving a 16 Hospital Safety Grade -- 17 Q. Okay. 18 A. -- as well as people, like the 19 public, who have questions about the Hospital 20 Safety Grade methodology as well as researchers 21 who use the Hospital Safety Grade data in 22 research, and others who are using or Page 123	1 Q. -- okay? 2 You're aware that it's 3 available on the website? 4 A. Yes. 5 Q. Are you aware of any other document 6 or website where the scoring methodology is laid 7 out for the public? 8 ATTORNEY BLAIR: Objection to 9 form. 10 THE WITNESS: On the Hospital 11 Safety Grade Web site, there's one to 12 two places where the methodology is 13 described in more of a summary 14 format -- 15 BY ATTORNEY CRAIN: 16 Q. Okay. 17 A. -- and is not a PDF. So I don't 18 know if there are other PDF documents available, 19 but there are two Web pages that generally 20 describe -- and the process of describing the 21 Safety Grade to the public in a more summary 22 way, and then we linked the more detailed Page 125

1 document. 2 So if that's what your question is, 3 then the answer is yes. 4 Q. The answer is yes. Okay. So let -- 5 let me just -- because it was a long question. 6 When you -- do you -- when you 7 say there are other websites that summarize at a 8 high level, what are those websites? 9 A. Other Web pages -- 10 Q. Web pages, yeah. 11 Which ones? 12 A. -- on the Hospital Safety Grade 13 website. 14 Q. Do you remember their title at all? 15 A. If you showed me a screenshot of the 16 home page, I would be able to immediately locate 17 it. I can't verbatim recite it off the top of 18 my head. 19 Q. Okay. Do you recall whether it 20 describes how the imputation methodology works? 21 A. It describes that we use imputation. 22 Probably not in the detail we have here -- Page 126	1 both numerically as well as using gas gauge 2 icons. Anytime a score has been imputed, it's 3 marked by an asterisk using the exact same size 4 font as the score itself. 5 And there's a note, I believe, in 6 red font; but, again, please -- without it in 7 front of me -- 8 Q. Let me -- let me stop you there. I 9 don't mean to cut you off, but we have a 10 document that I think will help you. 11 A. Okay. 12 ATTORNEY CRAIN: So let's 13 mark this as Exhibit 4. 14 Thank you. 15 --oOo-- 16 (Danforth Deposition Exhibit Number 17 4, Leapfrog Web page, Delray 18 Medical Center, marked for 19 identification, as of this date.) 20 --oOo-- 21 THE WITNESS: Thank you. 22 Page 128
1 Q. Okay. 2 A. -- correct. 3 Q. So is it fair to say that for a 4 patient to understand how a hospital imputes -- 5 how Leapfrog -- strike that. Let me fix that. 6 Boy, just all over the place. 7 Is it fair to say that for a 8 patient to understand how Leapfrog imputes 9 scores to non-participating hospitals, they need 10 to read this document, Exhibit 3? 11 ATTORNEY BLAIR: Objection to 12 form. 13 THE WITNESS: No. 14 BY ATTORNEY CRAIN: 15 Q. Where else can they get that 16 information? 17 A. I'm going to describe the Web 18 page -- again, please -- this is not verbatim. 19 Q. Okay. Fine. 20 A. -- whenever you are looking at a 21 Hospital Safety Grade, you will see their 22 performance on each of the measures represented Page 127	1 BY ATTORNEY CRAIN: 2 Q. It's not a memory test. Kim and I 3 have discussed. 4 A. Yes. 5 ATTORNEY CRAIN: So this is 6 Exhibit 4. 7 CERTIFIED STENOGRAPHER: Let 8 me mark it. 9 ATTORNEY CRAIN: No worries. 10 Thank you. 11 (Sotto voce discussion.) 12 BY ATTORNEY CRAIN: 13 Q. So I've given you Exhibit 4. 14 I assume you recognize this 15 document? 16 A. Yes. Thank you. 17 Q. Yeah. So let me just go back to my 18 question, and I wanted to understand -- is there 19 another website where a patient can understand 20 how the imputation model imputes a grade? 21 ATTORNEY BLAIR: I'm just 22 going to -- you keep saying "website," Page 129

1 and -- are you asking her if there are 2 other people somewhere in the world 3 that put their scoring methodology on 4 it and not Leapfrog -- 5 ATTORNEY CRAIN: No, I -- 6 ATTORNEY BLAIR: -- or you 7 mean a Web page? That's what I'm 8 getting confused at. 9 ATTORNEY CRAIN: Fair enough. 10 ATTORNEY BLAIR: Sorry. And 11 I -- I would have just objected to 12 form, but I just wanted to make -- 13 ATTORNEY CRAIN: No, no, no. 14 It's -- I -- 15 ATTORNEY BLAIR: Okay. 16 ATTORNEY CRAIN: -- I 17 appreciate it. I very much appreciate 18 it. 19 BY ATTORNEY CRAIN: 20 Q. Let me -- let me establish some 21 ground rules on this discussion so we're on the 22 same page. Page 130	1 falls underneath that. 2 We're all on the same page? 3 A. Yeah. 4 Q. Okay. So my question is, With that 5 as our universe -- 6 A. Yes. 7 Q. -- is there any other page besides 8 Exhibit 3, the scoring methodology document -- 9 A. Yes. 10 Q. -- that describes how Leapfrog 11 imputes a score for nonparticipating hospitals? 12 Do you understand my question? 13 A. I did -- 14 Q. Okay. 15 A. -- and I was desc- -- I was 16 describing -- 17 Q. Yeah. Let me -- let me take you 18 there. Just -- we'll get there. 19 A. Yes. 20 Okay. 21 Q. You were describing what I think is 22 Exhibit 4; is that right? Page 132
1 A. Okay. 2 Q. When I'm talking about the Web page 3 here -- 4 A. Okay. 5 Q. -- or the website, interchangeably, 6 I'm referring to hospitalsafetygrades.org 7 [sic] -- 8 Do you know what that website 9 is? 10 A. Yes. 11 Q. -- and any of its subpages. 12 A. Perfect. 13 Q. I'm also referring to hospital -- 14 to -- leapfroggroup.org, I think, is Leapfrog's 15 other website? 16 A. Yes. 17 Q. And is there a third? 18 A. No. 19 Q. Okay. So those are the two websites 20 I'm talking about -- 21 A. Okay. 22 Q. -- as the top and any page that Page 131	1 A. Yes. 2 Q. And Exhibit 4 is the 3 Delray Medical Center's Safety Grade page. 4 Is that fair to say? 5 A. Yes. 6 Q. Okay. And on the Safety Grade page, 7 I think you were going to Page 2, where it talks 8 about the hospital score. 9 Do you see that? It's 15. 10 A. Yes. 11 Q. And there's a little asterisk, 12 correct? 13 A. Yes. 14 Q. And the asterisk says, The hospital 15 declined to report their performance on this 16 measure, so a score was assigned to reflect the 17 lack of information available. 18 A. Correct. 19 Q. Was that what you were referring to? 20 A. Yes. 21 Q. So now we're on the same page? 22 A. Yes. Page 133

1 Q. So my follow-up question -- 2 A. Yes. 3 Q. -- is, How will a patient know how a 4 score was assigned? 5 A. I'm not following your question. 6 Q. So this page says a score was 7 assigned, correct? 8 A. Yes. 9 Q. If a patient wants to understand how 10 Leapfrog assigned that score -- 11 A. Right. 12 Q. -- where do you get that 13 information? 14 A. Sure. 15 Let me answer the question and also 16 just reframe the page, if I could. 17 So -- 18 Q. Well, can you start with answering 19 the question? And then we can reframe. 20 A. If a patient wants to know how we 21 assigned this specific score, that information 22 is available in the PDF that you have produced Page 134	1 --oOo-- 2 (Danforth Deposition Exhibit Number 3 5, Leapfrog Web page, Hospital 4 Details, Delray Medical Center, 5 marked for identification, as of 6 this date.) 7 --oOo-- 8 ATTORNEY CRAIN: And I'm 9 going to ask -- 10 ATTORNEY BLAIR: This is 5? 11 ATTORNEY CRAIN: This is 5. 12 ATTORNEY BLAIR: Okay. Thank 13 you. 14 BY ATTORNEY CRAIN: 15 Q. We'll get there. 16 So Exhibit 5 -- 17 A. Yes. 18 Q. -- you were -- going back to 19 Exhibit 4, you were referencing For details on 20 sources, click here -- 21 A. Yes. 22 Q. -- right? Page 136
1 for me, which is hyperlinked immediately in the 2 measure description. You can see the -- I think 3 it's a green -- 4 Q. So I'll -- so I'll tell you that is 5 -- 6 A. -- hyperlink. 7 Q. -- that is not correct. The -- that 8 -- that link goes to -- I can give you 9 Exhibit -- we can do Exhibit 5 -- goes to the 10 longer table, right? 11 A. Where the methodology lives, 12 correct. 13 Q. So let's do Exhibit 5. I just want 14 to be on the same page. I don't -- 15 A. Sure -- 16 Q. -- want to confuse you. 17 A. -- and I'll come back to my 18 response, if I could -- 19 Q. Sure. 20 A. -- because I wasn't able to finish 21 it. 22 Page 135	1 I will represent to you, 2 because I'm not showing it to you on a 3 computer -- 4 A. Okay. 5 Q. -- that Exhibit -- that link goes 6 here (indicating), to -- 7 A. Yes -- 8 Q. -- Exhibit 5? 9 Okay -- 10 A. -- that's correct. 11 Q. -- are you saying that this page, 12 Exhibit 5, says how a score was imputed? 13 A. No. I'm saying that's where the 14 link to the full PDF document that you showed me 15 is located. 16 Q. Okay. So the link to Exhibit 3, 17 the -- the longer scoring methodology -- 18 A. Yes. 19 Q. -- is on Exhibit 5? 20 A. Yes, and other pages as well, but 21 yes. 22 Q. Okay. On Exhibit 5 and Exhibit 4 -- Page 137

1 A. Yes. 2 Q. -- does it say anywhere how the 3 score was imputed? 4 ATTORNEY BLAIR: I'm going to 5 object to form. We had this before, 6 but for -- 7 ATTORNEY CRAIN: Yeah. 8 ATTORNEY BLAIR: -- whatever 9 reason, the link is not showing. 10 ATTORNEY CRAIN: So -- so I 11 will -- I will represent to counsel 12 this is how it prints to us every 13 time -- 14 ATTORNEY BLAIR: Okay. 15 ATTORNEY CRAIN: -- but I 16 agree with you; there -- 17 ATTORNEY BLAIR: Thank you -- 18 ATTORNEY CRAIN: -- is a link 19 to the survey. 20 ATTORNEY BLAIR: -- so we can 21 say for the record there is -- 22 ATTORNEY CRAIN: Yes -- Page 138	1 P, we tried to say down. 2 It doesn't print that way, 3 but we agree with you; it's on the 4 website -- 5 ATTORNEY BLAIR: Excellent. 6 Thank you. 7 ATTORNEY CRAIN: -- so no 8 dispute there. 9 ATTORNEY BLAIR: Okay. 10 BY ATTORNEY CRAIN: 11 Q. My question, though, is, On the -- 12 In the -- 13 A. Yes -- 14 Q. -- four corners of this page -- 15 A. -- I understand your question. 16 Q. -- where does it say how a score was 17 imputed? 18 A. We don't on that page -- 19 Q. Okay. That's my question. 20 I just want to answer my -- we 21 have limited time -- 22 A. Absolutely. Page 140
1 ATTORNEY BLAIR: -- a link -- 2 there is -- 3 ATTORNEY CRAIN: -- for -- 4 for -- 5 ATTORNEY BLAIR: -- she is 6 not wrong? 7 ATTORNEY CRAIN: -- for the 8 record -- yeah, I'm agreeing -- 9 ATTORNEY BLAIR: Okay. 10 ATTORNEY CRAIN: -- for the 11 record, on Exhibit 5, when you look 12 under a website, under Communication 13 about discharge -- you see that came 14 at the bottom on Page 3? 15 ATTORNEY BLAIR: Yeah. 16 ATTORNEY CRAIN: There's a 17 link to the survey methodology, the 18 28-pager. 19 For some reason -- we've 20 tried -- 21 ATTORNEY BLAIR: It's fine. 22 ATTORNEY CRAIN: -- Control Page 139	1 Q. -- today, so I want to focus you. 2 A. Sure. 3 Q. On Exhibit 4 -- is your back okay? 4 A. Yeah -- 5 Q. Okay. 6 A. -- I'm going to stand for a little 7 while. 8 Q. If you need a break, any time. 9 A. I'm okay. 10 Q. Okay. On Exhibit 4 -- 11 A. Yeah. 12 Q. -- same question -- 13 A. Yeah. 14 Q. -- on Exhibit 4, does it say how a 15 score was imputed? 16 A. No. 17 Q. Okay. On Exhibit 3 -- 18 A. Yes. 19 Q. -- the 28-page methodology -- 20 A. Yeah. 21 Q. -- it does say how a score was 22 imputed, correct? Page 141

1 A. Correct. On the website, we only 2 represent that it's the worst possible score. 3 Q. Correct. 4 Now -- now -- now I'm answering 5 correct. 6 Is there any other Web page in 7 our universe -- Leapfrog's .org, 8 hospitalsafetygrade.org -- that says how a score 9 imputed? 10 A. There very well may be. I would not 11 be responsible for those other Web pages. 12 Q. I understand you're not the 13 corporate rep for that. I get that. And it's 14 not a memory test, but I'm asking for your best 15 memory today. And if the answer is I don't 16 know, I don't have -- that's fine. 17 But my question is, Are you 18 presently aware of any other page, besides the 19 28-page PDF that's Exhibit 3, where it explains 20 how a score is imputed? 21 (Whereupon, the witness reviews the 22 material provided.) Page 142	1 A. -- I'm just trying to be as thorough 2 as possible. 3 Q. And I appreciate that -- 4 A. Okay. 5 Q. -- it's helpful to know the 6 universe. 7 My other question is, On 8 Exhibit 4 and 5, the Delray F page -- 9 A. Yes. 10 Q. -- and the more detailed Delray F 11 page -- 12 A. Yes. 13 Q. -- are any of those other materials 14 linked to those pages? 15 A. They're not. 16 Q. Okay. 17 If I'm -- strike that. 18 Okay. Let's see. 19 ATTORNEY CRAIN: Sorry. Give 20 me one second. 21 BY ATTORNEY CRAIN: 22 Q. Okay. So are you doing okay? Page 144
1 THE WITNESS: If I'm being 2 very technical, yes. 3 BY ATTORNEY CRAIN: 4 Q. What page? 5 A. So Leapfrog -- I think I described 6 earlier today we hold several -- what we call 7 "town hall calls," so basically free webinars. 8 We actually explain the scoring methodology for 9 the Safety Grade in detail. 10 Any webinar that we hold, we 11 record. So both an audio description as well 12 as the slides would have all of those details. 13 Those would live probably on both 14 leapfroggroup.org as well as 15 hospitalsafetygrade.org. 16 Additionally, I do presentations 17 for employer groups, consumer groups all the 18 time. And any time I talk about the Safety 19 Grade, I talk about imputation to a level of 20 detail. And all of those materials would also, 21 theoretically, be public on our website -- 22 Q. Okay. Page 143	1 A. Yes. 2 Q. Okay. I'm mindful of your back. 3 A. That's okay. 4 Q. Okay. Let's talk a little bit about 5 the methodology. And you're more than welcome 6 to refer to Exhibit 3, if it's helpful. 7 A. Yes. 8 Q. So just to get the nomenclature 9 on -- and, again, I just want to just focus you 10 on my questions because we have limited time. 11 A. Yes. 12 Q. Can you tell me what "achieve the 13 standard" means? 14 A. Yes. For the purposes of the 15 Leapfrog Hospital Survey, we publicly report 16 hospitals' performance on those measures that 17 come from the survey in four performance 18 categories where achieve the standard is 19 represented as four cell phone bars; 20 considerable achievement is represented as 21 three; some achievement is two; limited 22 achievement is one. Page 145

1 Additionally, we use scoring terms, 2 such as "unable to calculate score," "does not 3 apply," "did not measure." 4 Q. And -- and just in lay terms, like, 5 what are they supposed to mean? 6 A. They're meant to denote progress 7 towards achieving Leapfrog's overall standard 8 for that measure, which is established by one of 9 those 12 independent technical expert panels. 10 So, for example, for C-sections, if 11 a hospital's C-section score on the Leapfrog 12 Hospital Survey website is represented as four 13 filled bars, or achieve the standard, it 14 literally means that their C-section rate was 15 23.6 percent or less. 16 So it's a way to visually and 17 descriptively denote progress towards achieving 18 our standard in a way that we hoped would be 19 motivating for hospitals to improve over time. 20 And that's why we have, like, some achievement 21 and then considerable achievement. 22 So it's a way to try to describe a Page 146	1 Court, what is BCMA? 2 A. Barcode medication administration is 3 both a technology and a process by which people 4 in hospitals, usually nurses, are supposed to 5 make sure they're scanning both your patient ID 6 band as well as a barcode on the medication that 7 you're about to receive to make sure they're 8 giving the right medication to the right patient 9 in the right dose at the right time. 10 It's a way to try to avoid the 11 wrong patient getting the wrong medicine or at 12 the wrong time or the wrong dose. 13 Q. The prover- -- tell me if this is 14 fair. The proverbial example I have is, like, 15 the patient with the penicillin allergy, not 16 giving them that. 17 Is that right? 18 A. No. 19 Q. No. Okay. 20 A. So for barcode medication 21 administration, it may catch that, but ideally, 22 it's computerized prescriber [sic]/add [sic] on Page 148
1 performance scale. 2 Q. And -- and what does limited 3 achievement convey? 4 A. It means that they did not achieve 5 the standard. So it's almost like a -- it can 6 be used as a catchall to mean they're working on 7 it; they're starting, but they're not there yet. 8 Q. Anything else? 9 A. It's basically, in a four-point 10 scale, I guess, the lowest performance. 11 Q. Okay. 12 A. Um-hum. 13 Q. I want to talk through -- I'm not 14 going to go through every one of the 22 because 15 we have limited time but a couple just to get us 16 on the same page. 17 A. Sure. 18 Q. Let's start with BCMA. 19 A. Yes, barcode medication 20 administration. 21 Q. You got it. 22 Just in lay terms for the Page 147	1 p. 48 order entry, which is an electronic system 2 that physicians can use to prescribe medications 3 where, hopefully, their clinical decision 4 support is advanced enough to actually stop that 5 medication even from being ordered. 6 BCMA can be seen as a second line 7 of defense if it gets through, but frankly, if 8 the CPOE isn't catching it, it's not likely the 9 BCMA would -- 10 Q. Okay. 11 A. -- catch it either. 12 Q. So they work together -- 13 A. They do -- 14 Q. -- okay. 15 A. -- one is ordering medications and 16 one is administering medications, like, 17 literally before they put the -- the IV in your 18 arm. 19 Q. That's very helpful -- 20 A. Yes. 21 Q. -- and just to -- so it's clear -- 22 A. Yeah. Page 149

1 Q. -- the ordering is CPOE -- 2 A. Correct. 3 Q. -- and the administration is BCMA? 4 A. Yes. 5 Q. That's very helpful. 6 So almost two sides of the same 7 coin? 8 A. Yes. 9 Q. Okay. Great. 10 You must have been a great 11 teacher. 12 So a couple questions about 13 BCMA -- 14 A. Yes. 15 Q. -- does CMS register -- does CMS 16 measure BCMA? 17 A. Not today. 18 Q. Okay. Has it ever? 19 A. So CMS has what is called "safer 20 guides," S-A-F-E-R guides. They have some 21 requirements through the IPPS program that 22 hospitals attest to their use of the safer Page 150	1 Cindy. 2 ATTORNEY CRAIN: Sorry, 3 Cindy. 4 BY ATTORNEY CRAIN: 5 Q. Is it -- 6 ATTORNEY CRAIN: You all 7 right? 8 CERTIFIED STENOGRAPHER: Yes. 9 ATTORNEY CRAIN: We'll get 10 there. 11 CERTIFIED STENOGRAPHER: Okay 12 . 13 BY ATTORNEY CRAIN: 14 Q. Is it accurate to say that for 15 nonparticipating hospitals, as we just defined 16 it, Leapfrog has no data on their actual BCMA 17 performance? 18 A. Correct. 19 Q. Okay. I want to go back to CPOE. 20 A. Yes. 21 Q. Does CMS register CPOE beyond the 22 safer guidelines that you mentioned? Page 152
1 guides. 2 The safer guides include guidelines 3 for the safe use of technology, quite 4 literally. It may include things like the use 5 of CPOE or the use of BCMA or the use of 6 infusion pumps. I would not be the 7 subject-matter expert on that, so I couldn't 8 say definitively. 9 Q. Okay. No. Fair enough. 10 And then we're going to talk a 11 little bit in a bit about nonparticipating 12 hospitals. 13 Do you understand what I 14 mean -- 15 A. Yeah -- 16 Q. -- when I say -- okay. 17 A. -- you mean that they're not 18 participating in a Leapfrog Hospital Survey -- 19 Q. Exactly -- 20 A. -- I'm with you. 21 Q. -- and just let -- let me finish, 22 and I'll let you finish for the -- for poor Page 151	1 A. Not that I'm aware of. 2 Q. Okay. Same question -- 3 A. When you say "register," do you mean 4 measure? 5 Q. I do mean measure -- 6 A. Okay. 7 Q. -- thank you. That's fair enough. 8 And if -- if you have questions anytime, ask. 9 A. Okay. 10 Q. So same question for CPOE: For a 11 nonparticipating hospital, does Leapfrog have 12 any data measuring the actual performance of a 13 hospital's CPOE? 14 A. No. 15 Q. Okay. IPS -- tell me what IPS is. 16 A. ICU physician staffing. So, 17 basically, it measures how hospitals are 18 staffing their adult medical-surgical ICUs and 19 pediatric medical-surgical ICUs, specifically 20 whether or not they're using board-certified 21 intensivists to care for those patients, because 22 it can reduce mortality in those units by Page 153

1 40 percent. It's really significant. 2 Q. Yeah. 3 And ICU -- I just -- I just -- 4 I told Kim last week I just watched The Pitt. 5 So IC- -- 6 A. Oh. 7 Q. -- that's the IC- -- ICU? 8 A. Yes -- 9 Q. Yeah. Okay. 10 A. -- no, no; that's the emergency 11 department. 12 Q. I always confuse -- the -- the ICU 13 is where The Pitt sends folks? 14 A. Yes, yes. 15 ATTORNEY BLAIR: Several. 16 ATTORNEY CRAIN: Kim says 17 yes. 18 ATTORNEY BLAIR: Several 19 folks get sent there, I think. 20 ATTORNEY CRAIN: Fair. Not 21 all. 22 THE WITNESS: I think the Page 154	1 have any data for the IPS measure? 2 A. We do. 3 ATTORNEY BLAIR: Objection -- 4 objection: form. 5 BY ATTORNEY CRAIN: 6 Q. Okay. What is the data? 7 A. The CMS cost report, which is the 8 data source I referred to earlier, includes some 9 information that hospitals are required to 10 provide regarding operating adult and/or 11 pediatric intensive care units and charges from 12 those units. 13 Q. Is it -- are the CMS cost reports 14 one-to-one with what Leapfrog collects in the 15 survey? 16 A. They are not. 17 Q. Okay. How do they differ, just 18 generally? 19 A. We get more information on our 20 survey. 21 Q. Okay. So there are at least some 22 pieces of information that you -- that Leapfrog Page 156
1 emergency department would send 2 patients to the ICU -- 3 BY ATTORNEY CRAIN: 4 Q. Okay. 5 A. -- it actually can't work the other 6 way. 7 ATTORNEY BLAIR: No. That's 8 what I think, too. 9 ATTORNEY CRAIN: Yeah. Okay. 10 Great. We're on the same page. 11 BY ATTORNEY CRAIN: 12 Q. So back to IPS -- 13 A. Yes. 14 Q. -- and we should -- we should kibitz 15 about The -- The Pitt afterwards, fabulous show 16 -- 17 ATTORNEY BLAIR: Agreed. 18 BY ATTORNEY CRAIN: 19 Q. -- same question for IPS -- 20 A. Yes. 21 Q. -- for a nonparticipating hospital 22 in the Leapfrog Hospital Survey, does Leapfrog Page 155	1 is missing for nonparticipating hospitals for 2 IPS. 3 Is there -- 4 A. Correct. 5 Q. Okay. Hand hygiene -- everyone's 6 favorite. 7 Tell me about what "hand 8 hygiene" means. 9 A. On the survey? 10 Q. On the survey. 11 A. Leapfrog's hand hygiene standards 12 include several different elements. Again, this 13 is a structural measure, so assessing whether or 14 not have these things in place. 15 There are two core components of 16 the standard focused on what we call 17 "monitoring," so whether or not hospitals are 18 observing whether clinicians and others who 19 touch patients or touch things that will touch 20 patients, like surgical instruments, are 21 appropriately sanitizing their hands -- it's 22 not always washing. That's why I say Page 157

1 "sanitizing" -- based on World Health 2 Organization guidelines. 3 Additionally, the other core 4 component of five is something called 5 "feedback." And so not only are you actually 6 making sure people are doing the right thing at 7 the right time using the right substance, 8 whether it's soap and water or alcohol-based 9 hand sanitizer, but are you then taking those 10 data and getting them back to the right people 11 so they can see if improvement -- quality 12 improvement activities are needed or any kind 13 of training or remediation are needed. 14 The standard includes three other 15 elements focused on things like infrastructure 16 as well as culture and -- feedback, culture -- 17 and there's another one -- 18 Q. That's all right. Not a memory 19 test. 20 A. There are five. Oh, my gosh. I'm 21 so disappointed in myself. 22 Q. You studied up, I can tell. Page 158	1 Q. Okay. I want to talk -- talk about 2 a couple more, safe -- the safe practices. 3 Do you know what I refer to 4 when I say "Safe Practice 1"? 5 A. Yes. 6 Q. Safe Practice 1, I have, is Culture 7 of leadership structures and systems measure -- 8 A. Correct. 9 Q. -- does that sound right? 10 Okay. And if you need help, we 11 can go to document, but you got it. 12 Tell me again for the Court, 13 who is a layperson -- or a -- a lawyer -- an 14 imminent lawyer but not a doctor, I think, what 15 is Safe Practice Number 1, Culture of leadership 16 structures and systems. 17 A. There is an organization called the 18 National Quality Forum, and it is a organization 19 that, in the past, has convened subject-matter 20 experts. And in this case, they convened a very 21 large group to publish a report called Safe 22 Practices for Better Healthcare. Page 160
1 A. Demote me -- no. I look at it every 2 day. 3 Q. You live this, yeah. 4 When you say "infrastructure," 5 does that mean, like, sanitizers? 6 A. It means several things. It means, 7 like, are people making sure there's batteries 8 when they -- when they run out. It also means 9 sanitizers, yes. It's a number of things. 10 Q. And then same question: With 11 respect to hand hygiene -- 12 A. Yes. 13 Q. -- for nonparticipating hospitals -- 14 A. Yes. 15 Q. -- let me finish. 16 A. Oh. 17 Q. It's just hard for Cindy. 18 For -- for nonparticipating 19 hospital, for hand hygiene, does Leapfrog have 20 any data measuring their performance for hand 21 sanitizer? 22 A. No. Page 159	1 It includes 30 or 33 evidence-based 2 practices that not only hospitals but other 3 healthcare facilities should use specifically 4 to prevent adverse events, so without 5 preventable harm to patients. 6 Of those 30, 33 safe practices -- 7 and that report has been updated with the 8 latest science at least two or three times -- 9 long ago, Leapfrog included all of them, I 10 think, on the Leapfrog Hospital Survey at one 11 point. 12 Over time, because of advancements 13 in measurement, changes in evidence, we now, in 14 2025, only include two of the original National 15 Quality Forum-endorsed safe practices: Safe 16 Practice 1, which you just read: And another 17 called Safe Practice 2, which is culture, 18 measurement, feedback and intervention. 19 Q. Okay. And what do those two 20 measure? 21 A. Sure. The first one measures 22 whether or not hospitals have their leadership Page 161

1 engaged, specifically in patient safety 2 practices. So it's things like making sure 3 patient safety gets on the board agenda, making 4 sure that the board has resourced a patient 5 safety officer, someone whose job it is to 6 monitor patient safety. 7 Culture of safety refers to 8 something fairly specific in the healthcare 9 industry. It measures, in essence, whether or 10 not staff feel safe to speak up if they see 11 something going on. And it's most often talked 12 about -- if you're a nurse in the operating 13 room and you see the surgeon skip a step, do 14 you feel safe to speak up or if you basically 15 told leave him alone, let him do his job. 16 So it requires the hospitals every 17 two years, they're administering an 18 evidence-based culture of safety survey. 19 HRQ -- we've talked about them a lot today. 20 They put out one. And there are other tested 21 evidence-based tools specifically to measure 22 this. Page 162	1 Yes, that's actually very good, 2 yeah. 3 Q. I take the subway a lot. 4 A. Oh, okay. I take -- go by a lot of 5 airports. 6 Q. So when you say "AHRQ measure," does 7 it measure everything that's in this practice or 8 just certain parts of it? 9 A. HRQ has developed a survey tool that 10 measures culture of safety -- 11 Q. Okay. 12 A. -- so earlier we talked about that 13 HCAHPS survey -- 14 Q. Yeah. 15 A. -- I think I confused people -- that 16 patient experience survey. 17 HRQ has developed a culture of 18 safety survey. So a hospital would give it to 19 their staff -- 20 Q. Yeah. 21 A. -- and they anonymously report. 22 Press Ganey does this, for example, on behalf of Page 164
1 The safe practice assesses whether 2 or not hospitals are doing this every two 3 years, presenting the results back to units and 4 different levels of leadership throughout the 5 organization, investing and making sure that 6 the survey can be done every two years and then 7 using the results to try to improve safety. 8 And sometimes that can be done in a 9 number of different ways, again, using -- 10 Q. Yeah. 11 A. -- tool kits from ARC. 12 Q. So I'm going to boil it down. Just 13 tell me if this is fair. 14 A. Yes. 15 Q. Is this the -- like, the "see 16 something, say something" metric? 17 Fair? 18 A. It measures the -- the extent to 19 which -- yes -- 20 Q. Yeah. 21 A. -- you feel safe if you see 22 something to say something. Page 163	1 hospitals, and then they give the results back. 2 Like, the nurses in the maternity care say that 3 teamwork is high and communication is great, but 4 in the emergency department, like on The Pitt, 5 maybe teamwork is bad and communication is poor. 6 Q. Yeah. Depends on the -- you know, 7 where in The Pitt. 8 So on -- so for this one -- 9 A. Yes. 10 Q. -- Leapfrog does not use the AHRQ 11 Survey for its measures, right? 12 A. I don't think I explained this well. 13 Q. Okay. So, yeah, tell -- 14 A. So -- 15 Q. -- me where -- how I'm not 16 understanding. 17 A. -- in the hard copy of the survey, 18 this particular safe practice has maybe six 19 questions associated with it. The first 20 question is, Has your hospital in the last 21 24 months administered a standardized 22 evidence-based culture of safety survey to at Page 165

1 least 50 percent of its staff? 2 Q. I see. 3 A. HRQ has developed a survey that can 4 be used to say yes to Question 1. 5 Q. Got it -- 6 A. Okay. 7 Q. -- that's my confusion. 8 A. I'm sorry. 9 Q. Okay. So the HRQ survey can be used 10 to inform a hospital's answers to the Leapfrog 11 survey? 12 A. To the first question -- exactly. 13 And then they get results back, and then -- yes. 14 Q. Got it. Okay. That's helpful. 15 Okay. 16 And then does Leapfrog -- is 17 Leapfrog able to get access to the HRQ surveys 18 or no? 19 A. So HRQ has developed a survey you 20 can download free on its website. It does not 21 administer the survey. 22 Q. Got it. Page 166	1 Q. Okay. And then the last one I want 2 to talk about is the Total Nursing Care Per -- 3 Per Patient Day Measure. 4 A. Yes. 5 Q. Sound familiar? 6 Can you tell me again just at a 7 30,000-foot level what that measures? 8 A. It was developed by the American 9 Nurses Association, or the ANA. It includes a 10 set of specifications to allow hospitals to 11 report in a standard way on the total number of 12 patient days in specific units, not 13 hospital-wide -- a medical unit, a surgical 14 unit, a med-surg unit -- as well as specific 15 instructions to allow hospitals to report in a 16 standardized way the total number of nursing 17 hours in those units. It defines nursing hours, 18 inclusions and exclusions, direct patient care, 19 inconclusions and exclusions in the different 20 roles that are included in the measure. 21 So it's not just registered nurses. 22 It can also include nursing assistants and Page 168
1 A. Other organizations like 2 Press Ganey -- 3 Q. I see. 4 A. -- because it's basically a free 5 public recourse, Press Ganey can administer the 6 survey if the hospital asks them to do so. 7 Q. I see. 8 So there's no, like, central 9 repository where Leap- -- 10 A. No, unfortunately. 11 Q. Just -- just -- I know it's 12 unnatural because of the deposition format, but 13 just make sure we're helping Cindy out. Sorry. 14 So there's no central 15 repository where Leapfrog can go to get this 16 type of AHRQ information? 17 A. No. 18 Q. Okay. Now, for Safe Practice 1 and 19 Safe Practice 2, the same question I've asked 20 before: For a nonparticipating hospital, does 21 Leapfrog have any data informing those measures? 22 A. No. Page 167	1 something called LPNs, which are licensed 2 practical nurses. 3 Q. That was not quite the 30,000-foot, 4 but I appreciate the effort. 5 So -- so in terms of -- this is 6 measuring, essentially, how -- how -- nursing 7 staffing, more or less, right? 8 A. Yes. 9 Q. Okay. That's my 30,000-foot. 10 A. Sorry. 11 Q. That's okay. I just want us all to 12 be on the same page. 13 A. Yes. 14 Q. Then I'll ask again just for -- 15 for -- 16 A. Yes. 17 Q. -- completion. 18 For this measure, for the Total 19 Nursing Care Hours Per Patient Day Measure, if a 20 hospital does not participate in the survey, 21 does Leapfrog have any data to inform that 22 measure? Page 169

1 A. No. 2 Q. Okay. So we've gone through seven, 3 right? They -- they're the four im- -- what we 4 will ultimately call, I think, the "imputed 5 measures." 6 Does that mean -- we're on the 7 same page about that? 8 A. I understand that to -- 9 Q. That -- 10 A. -- mean CPOE, BCMA, hand hygiene and 11 ICU physician staffing. 12 Q. We're definitely on the same page. 13 And then the other three are 14 measures for which Leapfrog ultimately excludes 15 from the calculation of the Safety Grade for 16 nonparticipating hospitals? 17 A. Correct. There's no imputation. 18 Q. What's the difference? Why is that? 19 A. Thirty-foot level? 20 Q. Well, start at 30,000, and I'll -- 21 I'll direct you down. 22 A. Oh, 30,000? Page 170	1 country -- and, actually, we know this from 2 getting the data previously from AHA -- would 3 at least say yes to the first question: Yes, 4 we have CPOE. Yes, we have BCMA. Yes, we're 5 doing something related to hand -- you know, 6 hand hygiene. Yes -- or, No, we have an ICU. 7 We don't need to infer that. 8 Again, we get that from the CMS cost report. 9 So I just want to make that separate from the 10 other three for a minute. But still, it's a 11 structural measure, either you have an ICU or 12 you don't. Either you have barcode medication 13 technology or you don't. 14 The other three measures, which we 15 don't have imputation method for -- Safe 16 Practice 1, Safe Practice 2 and Total Nursing 17 Hours Per Patient Day -- hopefully, the way I 18 described them to you implied they're not 19 structures. They're processes. One is 20 culture, right. 21 So to try to infer culture or Total 22 Nursing Hours Per Patient Day -- hospital unit Page 172
1 ATTORNEY BLAIR: Not 30. 2 BY ATTORNEY CRAIN: 3 Q. Not 30, no. 4 A. No. Now I'm paranoid. I'm, like, 5 Aah. Usually hospitals want, like, more 6 information, more detail, and that's who I'm 7 always talking to -- 8 Q. Yeah. 9 A. -- so no one ever says -- 10 Q. Give me the 30,000-foot level. 11 Yeah. 12 A. -- give me less. 13 A little while ago, I described the 14 Safety Grade of having those two buckets, 15 processes and structures, plainly, I hope. 16 Structures are things like do you 17 have a CPOE system? Do you have a barcode 18 medication system? And those are things where 19 because of the structure of the questions and 20 our hard copy of the survey, we can generally 21 assume today, and actually probably for the 22 past decade, that most hospitals in the Page 171	1 types vary so dramatically -- for example, the 2 Kaiser hospitals in California, all of their 3 patient care units are what's called mixed 4 acuity, so it's a mix of some general medical 5 patients, maybe some ICU patients. And there's 6 no way for us to know that in advance, right. 7 And, again, for the first three 8 measures I just described, we do have some 9 indication at least whether or not they were in 10 place because we used to get that information 11 from the American Hospital Association. 12 For the other three measures, I 13 don't feel that the expert panel ever felt like 14 there was a good other source or that those 15 would be measures that could reasonably be 16 imputed because they're not structures. 17 They're processes or culture. 18 Q. Couldn't you, though, for 19 nonparticipating hospitals just impose limited 20 achievement for those three? 21 A. If our expert panel gave us that 22 guidance, it's certainly something theoretically Page 173

1 we could do. They've just not given us that 2 guidance. 3 Q. And -- and why? 4 ATTORNEY BLAIR: Objection to 5 form. 6 THE WITNESS: For the reasons 7 I just described. I think in their 8 discussions, they've said that 9 structures are different than 10 processes. 11 BY ATTORNEY CRAIN: 12 Q. Do you recall a specific discussion 13 in any of those expert panel meetings where the 14 three measures -- Safety Practice 1, Safe 15 Practice 2 and Total Nursing Care -- were 16 discussed in assessing whether to include them 17 in an imputation model? 18 A. Only Safe Practice 2. Many, many 19 years ago, one of the experts on our Safety 20 Grade expert panel -- her name is Sara Singer. 21 She used to be at Harvard. She's now at 22 Stanford. She is a culture of safety Page 174	1 scoring methodology, it's a topic that was 2 always discussed. 3 Q. Yeah. 4 A. Do you want me to repeat that? 5 Q. Let me take one look-see. 6 Yeah. So it was -- your 7 recollection is it was discussed over several 8 years? 9 A. It can be discussed before it's 10 used. I've been talking -- 11 Q. Yeah. 12 A. -- to my husband about taking a 13 vacation for years. We have yet to go. 14 Q. We have the same discussion. I -- I 15 hear you. 16 Okay. So let's -- let's take a 17 look -- just before we leave the methodology -- 18 A. Yes. 19 Q. -- can you describe, let's say 20 15,000-foot, how are the different measures that 21 inform the Safety Grade weighted? 22 And you have the document if Page 176
1 subject-matter expert. That's her area of 2 expertise. 3 In the very beginning of the 4 development of the Hospital Safety Grade, at 5 that time, I believe, to my recollection, she 6 had indicated culture of safety is not 7 something that could be inferred or imputed. 8 Q. At the very beginning? 9 A. Yes. 10 Q. So 2012ish? 11 A. I could -- I could not say exactly 12 when. 13 Q. Do you see where I'm -- that I'm a 14 little confused about? Because imputation, I 15 thought we had discussed, came into being after 16 the AHA decided not to license data in around 17 2021. 18 Are you saying Sara Singer 19 brought up this topic before? 20 A. Imputation is a common technique in 21 scoring methodologies and healthcare ratings. 22 Though it may not have been used in the actual Page 175	1 you need it. Feel free. 2 A. The trick is keeping it at 3 15,000 feet. 4 There's a weighting calculation 5 also developed by the national expert panel 6 that includes four components. The first 7 component, I believe, is severity of harm, 8 so -- 9 Q. Yeah. I -- 10 A. -- some of these things could kill 11 you; some of them could just hurt you. The 12 second component -- and at this point, I am 13 actually going to -- 14 Q. Page 18? 15 A. -- just to keep it short -- yes, 16 exactly. 17 The second -- so that's impact, 18 which includes the number of patients affected 19 and the severity of harm. 20 The other criteria is evidence, and 21 so either it's supported by suggestive or 22 clinical experience or experimental. It's Page 177

1 meant to differentiate between, like, maybe 2 measures that -- like a -- a -- like a closed 3 control group was used, which is hard in 4 medicine. 5 Opportunity is actually a 6 calculation, so it's like the actual -- it's 7 called standard deviation, but it basically 8 means across all hospitals' performance on, 9 say, central line-associated bloodstream 10 infections. Are the scores relatively in a 11 tight range or actually are they spread out in 12 a large range? If they're in a small range, 13 there's not that much room for movement, or, in 14 this case, we're calling it "improvement" 15 because they're already grouped or clustered 16 around a particular area. That would have a 17 low opportunity rating. 18 If it's a big range, then that 19 suggests that there is more opportunity for 20 improvement. 21 So like PSI 90, which we've talked 22 about a lot today, that measure is so heavily Page 178	1 BY ATTORNEY CRAIN: 2 Q. Okay. This has changed over time; 3 is that right? 4 A. So because of the nature of that 5 opportunity score I just described, which is 6 calculated, it changes between the preliminary 7 -- or it can change between the preliminary -- 8 that courtesy Safety Grade review period I 9 described -- and then the final, and that's why 10 every round we do two versions of this. These 11 opportunity scores change even if we remove one 12 hospital because they closed -- 13 Q. Got it. 14 A. -- two hospitals because they 15 closed. 16 And so that can impact very, very 17 slight changes in the overall weight, so, 18 again, that's why we produced the two 19 documents. 20 Q. Okay. And -- and going back to the 21 seven measures we've talked about. 22 A. Yes. Page 180
1 risk adjusted for patient characteristics that 2 the range of scores are typically between just 3 under 1.0 and maybe 3.0. There's not that much 4 opportunity, right, within that very tight 5 range of scores, so that -- I'm just trying to 6 convey that concept. 7 The final criteria is what's called 8 the number of component measures. That fourth 9 criteria was only adopted when we added PSI 90 10 because the panel did not think that a measure 11 that included 10 separately endorsefully 12 specified measure should be treated as a single 13 measure. 14 Q. Got it. Okay. Yeah. 15 So then if you go to the next 16 page, 20 -- 17 A. Yes. 18 Q. -- it has -- the standard measure 19 weights are the different percentages that each 20 of these measures are weighed at the last -- 21 (Simultaneous unreportable crosstalk.) 22 THE WITNESS: That's correct. Page 179	1 Q. So you see SP 1, SP 2 and Total 2 Nursing Care? 3 A. Yeah. 4 Q. For nonparticipating hospitals, am 5 I -- am I right in understanding that the weight 6 -- those weights are effectively redistributed? 7 A. They're reapportioned across other 8 measures within that specific domain for which 9 there is a measured score available, and that's 10 described in here. 11 Should I go to the page reference? 12 Q. Yeah. Let's go to that page. 13 Where -- where are you looking? 14 A. Page -- bottom of Page 23, top of 15 Page 24. 16 So, basically, how I described -- 17 the expert panel really thought it was 18 important that the process and structural 19 measure domain stay at 50 percent, the outcome 20 measure domain stay at 50 percent. So if 21 you're missing a measure score on a process and 22 structural measure, none of that weight can Page 181

1 flow to the outcome measures. 2 Q. Got it. 3 A. It's constrained to that process and 4 structural domain bucket. 5 Q. Can -- can I just rearticulate to 6 make sure I understand? 7 A. Yes. 8 Q. You're saying that if you pull 9 something out of one bucket, the weight can't go 10 to the other? 11 A. Correct. 12 Q. Got it. That's helpful. Okay. 13 So -- so for -- now, but can it 14 go -- so SP 1 is a structural or process, right? 15 A. Process and structural measure, 16 correct. 17 Q. Its weight could then be 18 redistributed to handwashing? 19 A. Anything within that domain. 20 Q. Okay. 21 A. And we can go back to that table, if 22 that's helpful, but anything within that domain. Page 182	1 the missing score to other measures with the 2 same domain. 3 For example, a hospital missing a 4 measure score for ICU physician staffing 5 because the hospital does not operate in adult 6 or pediatric IC- -- 7 (Whereupon, as the certified 8 stenographer seeks clarification, 9 colloquy will not be captured on 10 the written record.) 11 THE WITNESS: ICU. 12 CERTIFIED STENOGRAPHER: Or 13 pediatric? 14 THE WITNESS: Yeah. 15 ATTORNEY CRAIN: In adult or 16 pediatric, yeah. 17 THE WITNESS: -- the standard 18 weight of 6.9 percent will be 19 reapportioned to the remaining 11 20 measures within the process and 21 structural measure domain -- 22 Page 184
1 Q. Yeah. Okay. And do you know -- is 2 it in here what it's distributed -- 3 redistributed to for nonparticipating hospitals? 4 A. Yes. That's what's described on 5 Page 23 and 24. 6 Can I -- can I read from the 7 document or not? 8 Q. Please, yeah, tell me where. 9 A. If you go to the bottom of Page 23, 10 you should see a subheader called Dealing with 11 Missing Data: Due to a variety of reasons, a 12 hospital may not have a measure score for all 22 13 measures. If a hospital is missing a measure 14 score for any measure (except for PSI 90; 15 hospitals missing PSI 90 are not graded), the 16 standard weight for that measure is 17 redistributed to the other measures in the same 18 measure domain. 19 The new measures -- I'm sorry -- 20 the new weight for each measure within the 21 domain is calculated by reapportioning the 22 standard weight assigned to the measure with Page 183	1 BY ATTORNEY CRAIN: 2 Q. Okay. 3 A. -- and because this is -- I'm not a 4 mathematician, so, to me, complicated to read, 5 mathematically -- we don't make hospitals figure 6 it out. I described a calculator that's 7 available on that website. When you enter data, 8 all of the calculations happen very 9 transparently, and so they can see exactly how 10 those weights are redistributed. 11 Q. Yeah, it is -- it is -- agreed. 12 Okay. 13 ATTORNEY CRAIN: Let's set 14 this aside for a moment. We will come 15 back to it, so hang on to it. Sorry. 16 BY ATTORNEY CRAIN: 17 Q. Can we shift -- are you okay? 18 A. Yeah. 19 Q. Okay. If you need -- we're -- we've 20 been going an hour. Are you -- okay. 21 You're still good to go? 22 A. Um-hum. Page 185

1 ATTORNEY CRAIN: I was 2 thinking maybe we drive towards lunch, 3 okay, if that's good with everybody. 4 ATTORNEY BLAIR: That's fine. 5 THE WITNESS: Yeah. 6 ATTORNEY CRAIN: Okay. 7 BY ATTORNEY CRAIN: 8 Q. I want to talk a little bit about 9 the Hospital Survey -- 10 A. Yes. 11 Q. -- and just -- because I think 12 you're the corporate representative for 13 Hospital Survey? 14 A. Correct. 15 Q. So start, again, 30,000-foot -- 16 A. Yeah. 17 Q. -- what is the Hospital Survey? 18 A. Just so I'm clear, do I -- would I 19 answer these questions any differently as the 20 corporate representative? Because this is, I 21 think, the first time that you've prefaced a 22 question with that. I just want to make sure Page 186	1 So . . . 2 Q. Yeah. Let's -- let's just make sure 3 it's really clear because I probably should have 4 laid that out at the start. 5 A. Okay. 6 Q. My -- my working assumption is 7 because this is a combo deposition -- 8 A. Yes. 9 Q. -- that unless you tell me 10 otherwise, and I'll give you an example to help, 11 that you're giving testimony for Leapfrog and 12 yourself. 13 Fair enough? 14 A. Yes. 15 ATTORNEY BLAIR: With one 16 caveat -- 17 ATTORNEY CRAIN: Yes. 18 ATTORNEY BLAIR: -- to the 19 extent you're going to ask her about a 20 topic that is not laid out in the 21 30(b)(6) -- 22 ATTORNEY CRAIN: For sure. Page 188
1 I'm giving you the right answer. 2 Q. I -- so that's up to you. It's up 3 to you whether your own personal knowledge 4 differs from the corporation's -- 5 A. Okay. 6 Q. -- I -- I don't know, I think, is 7 the answer. 8 A. Okay. 9 Q. You -- if you want to take a break 10 and consult with your counsel, I'm happy to -- 11 to do that, but I -- I've been proceeding along 12 the topics -- like, for in -- we talked about 13 the survey methodology -- 14 A. Right. 15 Q. -- and you were the corporate 16 representative for those topics. My -- my 17 expectation is you were talking, unless you told 18 me otherwise, as the corporate rep and in your 19 personal capacity, unless there's a divergence. 20 A. No. 21 And so I just wanted to make sure 22 that's appropriate for this as well. Page 187	1 ATTORNEY BLAIR: -- she will 2 only be testifying to that. 3 ATTORNEY CRAIN: Absolutely. 4 BY ATTORNEY CRAIN: 5 Q. So I will give you an example just 6 so we're, again, on the same page -- 7 ATTORNEY BLAIR: No, yeah, I 8 get it. 9 BY ATTORNEY CRAIN: 10 Q. -- when I asked you about the 11 website, Ms. Binder is the corporate rep for 12 that. 13 So you are -- from my 14 understanding, that is not the topic for which 15 you are the corporate rep, so I was asking in 16 your personal capacity. And I will try to be 17 clear as well, but if you have any questions, 18 just ask. 19 A. Understood. Thank you. 20 Q. And we can always take a break and 21 talk -- you can talk to your counsel, too. 22 Okay? Page 189

1 So with that understanding, 2 just tell me -- 30,000-foot, what is the 3 Hospital Survey? 4 A. The Leapfrog Hospital Survey is a 5 free annual voluntary survey where we collect 6 data on nationally standardized measures, 7 including patient safety measures, quality 8 measures, like maternity care and pediatric 9 care. And in the past, we also include measures 10 that are in a bucket called efficiency, and it's 11 things like readmissions. Today, no efficiency 12 measures are included on the Leapfrog Hospital 13 Survey. 14 Q. Okay. Did you have any role in 15 designing the survey originally? 16 A. I did not. 17 Q. Okay. It was already -- by the time 18 you came to Leapfrog, it had already been 19 created? 20 A. That's correct. Leapfrog was 21 founded in 2000, the first survey was mini -- 22 administered in 2001 and then I came to Leapfrog Page 190	1 Q. Yeah. In The Pitt. It's just -- I 2 have to bring it up at the time. 3 ATTORNEY BLAIR: We have to 4 show it to the Judge. 5 ATTORNEY CRAIN: It has to be 6 there. 7 ATTORNEY BLAIR: Yeah. 8 ATTORNEY CRAIN: It was just 9 so good. 10 (Laughter.) 11 ATTORNEY CRAIN: So -- see, 12 we're just having fun. 13 ATTORNEY BLAIR: That's 14 right. 15 BY ATTORNEY CRAIN: 16 Q. So the Hospital Survey, is that 17 under your authority? 18 A. It is. 19 Q. And who is the person responsible 20 for -- like, who owns that under you? 21 A. I own that. 22 Q. Oh, you own it. Okay. Page 192
1 in 2009. 2 Q. At -- at -- generally, has it 3 changed significantly since your first 4 experience in 2009 with the survey? 5 A. It has. 6 Q. Can you tell me again, just 7 generally, how has it changed over time? 8 A. We have expanded the content of the 9 survey to include other important areas of 10 hospital care, mostly based on one of two 11 things: interests and stated importance from our 12 employer/purchaser members and our board of 13 directors. For example, we have now more 14 maternity care measures because employers and 15 purchasers pay for about a third of the births 16 in the United States, but also emerging patient 17 safety topics. 18 As I described earlier, an example 19 would include hospital boarding in the 20 emergency department, which no one talked about 21 10 years ago, and today is even represented on 22 television. Page 191	1 A. Yes. 2 Q. You don't have a direct report that 3 runs the survey? 4 A. I have various people who help out 5 with various aspects of the Hospital Survey, 6 including Matt Austin and our 12 expert panels; 7 however, at the end of the day, I review every 8 word in that survey before it goes out. The 9 same is true for the Leapfrog Ambulatory Surgery 10 Center Survey, the same is true for Exhibit 3 -- 11 Q. Yeah. 12 A. -- that's been marked and the same 13 is true for the value-based purchasing program 14 methodology. 15 Q. So you review every page of the 16 Hospital Survey, each iteration? 17 A. Yes. 18 Q. Wow. How long does that take? 19 A. A long time. That's why I was so 20 disappointed in myself for not knowing that hand 21 hygiene system, right? I'll never forgive 22 myself. I may demote my own self on my way Page 193

1 home. 2 Q. I was pretty impressed before when 3 you cited the -- I think it was 6B. That was -- 4 that was very impressive. 5 Okay. So just breaking down 6 who -- who owns it, I -- are you, yourself, 7 drafting the revisions, or you're reviewing the 8 work of others as they draft? 9 A. I'm reviewing the work of others as 10 they draft it, though I do draft some revisions 11 personally myself. 12 Q. Okay. And just in -- in the last 13 year or two, have you drafted any -- any 14 revisions personally? 15 A. In the last year or two, I have 16 drafted revisions personally, yes. 17 Q. About which topics? 18 A. Three of the more complex measures 19 on our survey are those American Nurses 20 Association measures. People think doctors are 21 tough. Nurses are tough. 22 The measures are so specific in Page 194	1 Q. Okay. 2 A. -- for every section of the Leapfrog 3 Hospital Survey and every section of the 4 Leapfrog Ambulatory Surgery Centers Survey, 5 because we have 12 different national expert 6 panels, someone on my team is assigned as a 7 liaison between Matt Austin, the panel and me. 8 The role of those individuals is 9 limited and specific. We are the ones 10 answering questions about measure 11 specifications and reporting periods. They are 12 responsible for identifying themes, suggesting 13 frequently asked questions, suggesting 14 revisions for the purposes of clarity. So 15 we're collecting standardized, accurate, 16 high-quality data. 17 If the expert panel makes a 18 decision, like we're going to change the 19 reporting period from 12 months to 18 months, 20 those individuals physically mark up the Word 21 document and track changes. 22 So for CPOE, it's Robyn Nabi. I Page 196
1 their definition of what direct patient care 2 is, what is included and excluded, that we've 3 had to go through several iterations of 4 clarifying the specifications in order to 5 ensure that we're collecting standardized, 6 high-quality data. 7 I have worked directly with 8 individuals at one of the leading nurses' 9 qualities registries to do that. I felt it was 10 so important and that the information was, 11 frankly, so complex that I should take a bigger 12 role in actually doing that myself, just for 13 integrity. 14 Q. And presumably, efficiency if you -- 15 A. Yes. 16 Q. For the four imputed measures -- 17 A. Yes. 18 Q. -- is there any particular person at 19 Leapfrog that's responsible for owning those 20 sections under you? 21 A. There are. For computerized 22 physician -- let me take a step back -- Page 195	1 introduced her as one of my senior program 2 coordinators. For barcode medication 3 administration, it's Kathryn Stewart. I 4 introduced her as my director of healthcare 5 ratings. For hand hygiene, it's 6 Kathryn Stewart again, my director of 7 healthcare ratings. And for Total Nursing 8 Staff -- the nursing measure, it's Robyn Nabi, 9 who also oversees CPOE. 10 For these particular measures and, 11 frankly, many, many others on the survey, 12 however, even though we have assigned liaisons, 13 I tend to be extremely involved. 14 Q. Why is that? 15 A. It's important to me, as my role has 16 changed and evolved at Leapfrog, that I not lose 17 touch with getting feedback from the hospitals 18 and the ambulatory surgery centers. So I am on 19 help desk every day. Like, I want to hear what 20 people have to say. It's very important to me. 21 We want this to be as 22 straightforward as possible. And I put a high Page 197

1 value on data accuracy and integrity. And I 2 feel like if I move too far away -- not that my 3 team isn't excellent, that they do a good job, 4 but I need to be able to stand in front of a 5 hospital CEO at the end of the day and defend 6 all of these measures, not some of these 7 measures. 8 And so I guess I've made it just a 9 personal responsibility. It's certainly not 10 outlined in my job description. 11 Q. Extra credit. 12 (Laughter.) 13 THE WITNESS: Less sleep. 14 BY ATTORNEY CRAIN: 15 Q. Less sleep, yeah. I hear that. 16 Just talking about some of the 17 things you just mentioned -- so help desk -- 18 what does that mean? What is the process? Can 19 you just tell me more what the help desk is? 20 A. Sure. 21 At Leapfrog, I think I described 22 when I was talking about some of my early work Page 198	1 of our four ratings programs that I've 2 described. 3 Q. Can -- can you just give me a 4 ballpark so I know what we're thinking about? 5 Like, how many Zendesk -- is tickets -- is that 6 the metric? 7 A. Correct. 8 Q. How many tickets come in per week? 9 Per month? Just your best ed- -- educated 10 guess. 11 A. There's a lot of variation weekly 12 and monthly. Annually, it's over 6,000. 13 Q. Wow. Okay. That's a lot. 14 A. Yeah. I'm very busy. 15 Q. Sure. Well, thank you for spending 16 the day with us. 17 So -- so how many of those do 18 you process per month? 19 A. I try to put my hand on at least 20 probably 3 to 10 tickets a week. 21 Q. Okay. And does your -- your 22 in-house team handles the rest of the 6,000? Page 200
1 there -- we used to use Thomson Reuters to 2 provide all of the technical assistance. When 3 I say "technical assistance," I specifically 4 mean questions, like should this be included in 5 the numerator and denominator or not, right. 6 So it's technical assistance specifically 7 related to answering the questions in the hard 8 copy of the survey. 9 When we brought that in-house, we 10 needed some kind of a tool or a software to 11 manage, like, a ticketing system. So we used 12 something called Zendesk. It's actually, I 13 think, one of the most popular electronic 14 ticketing systems across industries where 15 hospitals, ambulatory surgery centers, you -- 16 anyone, basically come to our website; you put 17 in some contact information; you ask us 18 questions; we send you quest -- answers back in 19 writing. 20 If we need to have a call, we have 21 a call, usually a Zoom. But it's our mechanism 22 for providing technical assistance around any Page 199	1 A. Absolutely. It's the expectation of 2 every single member of the ratings team with the 3 exception of Kush Banerjee, who's the director 4 of licensure, that people are able to provide 5 technical assistance to hospitals. 6 And to be frank, the majority of 7 the questions are just showing them where in 8 the hard copy of the survey they can find that 9 response. So it's things like on Page 55, 10 you've indicated that actually IV bags that 11 can't have a barcode on it can be excluded from 12 the BCMA measure. 13 Q. Okay. And -- and so to that point, 14 the questions that are coming in -- are they 15 typically about how to answer the survey? 16 A. They're typically about ensuring 17 that hospitals are accurately doing their data 18 collection. 19 So in this instance, for example, 20 we ask about compliance, so how many drug 21 administrations that you've had. In some 22 hospitals, they may put a barcode on an Ensure Page 201

1 shake to give to a geriatric patient. 2 Should we consider this a 3 medication? Well, it has a barcode, but it's 4 not treating a condition or disease. So those 5 are the majority of the questions. 6 And, again, it's actually almost 7 all laid out in the hard copy of the survey, 8 but sometimes they just need to be directed to 9 the page of where that information lives. 10 Q. Okay. And the survey is about 350 11 pages, if I'm right. 12 A. It is. 13 Q. Yeah. 14 Do you have an understanding of 15 how long it takes hospitals to accurately 16 complete the survey? 17 A. So it varies. Since I've been at 18 Leapfrog, one of the things that I've been 19 responsible for is developing and helping to -- 20 and oversee and administer what's called our 21 "on-site data verification program." 22 The year that we developed and Page 202	1 In a large university medical 2 center, where there's thousands of patient 3 beds, it could be more. 4 But frankly, what we've learned 5 over time -- and, again, I'm directly talking 6 to a lot of hospitals around the country -- is 7 the first year, it takes longer because maybe 8 you've never collated your hand hygiene 9 observation data. Maybe you're not even doing 10 hand hygiene observations in all of the units. 11 Maybe you don't have quarterly audit processes 12 in place. But year over year, that time 13 commitment really gets reduced. 14 One thing I didn't mention about 15 the survey that I'd like to is that we have a 16 commitment -- an unspoken commitment but a 17 spoken commitment to try to maintain questions, 18 measure specifications and the scoring 19 algorithms we use to get to those four 20 performance categories we talked about -- 21 achieve the standard, et cetera -- for about 22 three years. Page 204
1 piloted our on-site data verification program, 2 which was originally designed for hospitals and 3 it now also includes ambulatory surgery 4 centers. I was fortunate to be able to 5 participate on a handful of the site visits to 6 hospitals that were helping us refine the 7 protocols -- 8 Q. Yeah. 9 A. -- to make sure that they weren't 10 wasting our time, we weren't wasting their time, 11 et cetera. 12 Through that process, I was able to 13 learn a lot about data collection and survey 14 administration, and the estimate of 40 to 80 15 hours came from those conversations -- 16 Q. Okay. 17 A. -- but it varies significantly. 18 In a small rural hospital that's 19 only offering a limited number of services, it 20 could take 10 or 15 hours because they're not 21 delivering babies. They don't have an ICU. 22 They're not doing pediatric CT scans. Page 203	1 And that way, if you do the work to 2 actually put the things in place, it doesn't, 3 like, change the next year and you're starting 4 again, and then change the next year and you're 5 starting again. 6 We also really want hospitals to 7 work towards a similar thing for a certain 8 amount of time so they can see their 9 improvements, if they have them, presented in 10 those publicly reported results that I talked 11 about. 12 So maybe the first year you get 13 started, based on what you have in place or 14 what you're able to do or what you know how to 15 do for a certain measure, you're only at 16 limited achievement. But because we're keeping 17 everything relatively stable for you, now 18 you're working on it all year. And now, the 19 next year, your considerable achievement -- 20 Q. Yeah. 21 A. -- and, in some cases, achieve the 22 standard. Page 205

1 So, again, we don't always do it. 2 We try to do it, and it's a real commitment. 3 Q. Are you aware there was a study, I 4 think, conducted by Oklahoma State University 5 about how long the Hospital Survey takes to 6 achieve? 7 A. I am. 8 Q. Can you tell me a little bit about 9 that study? 10 A. Sure. 11 So my understanding is it wasn't a 12 study, but I don't want to sort of parse words. 13 But I think I told you in the beginning that we 14 were founded by purchasers and employers. 15 Today, we've maintained that commitment and we 16 work with about 35 business health coalitions 17 or purchasing groups around the country. 18 They're generally state-based. 19 In Oklahoma, the purchasing group 20 that we work with there is called WelLOK, where 21 the "OK" stands for Oklahoma. 22 Q. I figured. Page 206	1 Q. That may be right, yeah. 2 A. Yes -- 3 Q. Okay. 4 A. -- yes, that -- 5 Q. Great. 6 Okay. One other thing -- you 7 mentioned that you -- you spend, it sounds like, 8 a lot of time talking to hospitals. 9 A. Yes. 10 Q. Can you tell me 30,000-foot -- 11 A. Yes. 12 Q. -- what types of things are you 13 talking about? What -- what are the contexts? 14 Like, I'm just trying to explore how -- how -- 15 what's -- what does that look like? 16 A. I describe that sometimes when 17 hospitals have questions on help desk, they need 18 a call. Somehow, something is getting lost in 19 writing. I jump at the opportunities to take 20 those calls. I love talking to hospitals and 21 ambulatory surgery centers about our measures. 22 I love talking about why they're important. I Page 208
1 A. They have a relationship with one of 2 the universities there, and they wanted to use 3 an intern that they got from the university to 4 basically shadow a first-time participating 5 hospital in doing the Leapfrog Hospital Survey. 6 And they wrote up her observations -- 7 Q. Okay. 8 A. -- I actually didn't know that they 9 published it. I just know that I've seen it. 10 Q. Got it. 11 Okay. Yeah. I mean, we're 12 happy to show you a document if it's helpful, 13 but I -- does it sound right that the conclusion 14 was it could take nearly 80 hours to complete 15 the survey? 16 A. Yes. I think I gave the range of 40 17 to 80 -- 18 Q. Forty to 80. 19 A. -- and -- and this is -- again, I 20 think it was a -- please correct me, but I think 21 it was, like, the large academic medical center 22 associated with the University of Oklahoma. Page 207	1 love answering their questions. 2 I learn a lot about how the 3 instructions are written to understand do we 4 need to clarify something, refine something. 5 So that's some portion of the calls. 6 Related to the Hospital Safety 7 Grade, if hospitals -- and it's usually maybe a 8 chief medical officer or a quality director. 9 Sometimes it's the CEO; sometimes it's a board 10 member -- if they have questions about the 11 Safety Grade methodology or why we're using CMS 12 data or any of the measures whatsoever, I take 13 a lot of those calls. 14 I do, like I said, a lot of 15 education, and I try to make that education as 16 interactive as possible. And so when I'm doing 17 webinars, whether it's with 10 hospitals or 700 18 hospitals, I'm always the one or often the one 19 actually on the other line of the Zoom 20 answering their questions. 21 So it really varies depending on 22 what people are interested in, but I try to Page 209

1 make myself really available. Pre-COVID, I 2 traveled to hospitals to meet with them 3 in-person, if they requested it, free of charge 4 because we really do want to engage with them, 5 hear from them. We're always trying to do 6 better, make it better. 7 And while, yes, I could send other 8 people -- and obviously, I don't like germs, so 9 I probably should -- but it's something that I 10 try to do -- 11 Q. Yeah. 12 A. -- I can't always do it as much as I 13 want, but -- 14 Q. No wonder you don't have a vacation. 15 A. I'm doing Alabama Hospital 16 Association next week, so . . . 17 Q. Good luck. 18 So a couple other questions -- 19 A. Yeah. 20 Q. -- just on -- and then I think we 21 may be getting close to a break -- oh, yeah. 22 So talking about the types of Page 210	1 because some of it comes from claims only, 2 because the data can be a little bit older, 3 hospitals and health systems have adopted our 4 measures on their board's quality scorecards, 5 which is, I think, a fairly common thing. 6 And so they've made the choice to 7 focus on any one or number of measures on the 8 Leapfrog Hospital Survey, and so it's not 9 necessarily a burden to them; it's -- it's part 10 of their culture. 11 Q. They were already doing it? 12 A. Yes. 13 Q. Yeah. 14 Do you -- are the hospitals 15 you're talking to -- what percentage of them are 16 participating versus nonparticipating? 17 A. At this point, I think we have about 18 80 percent of inpatient hospital beds 19 represented in the Leapfrog Hospital Survey 20 results, millions of admissions. So just by 21 nature of that fact, the majority of hospitals I 22 talk to are participating in the survey, but I Page 212
1 comments, you know, that -- your conversation -- 2 A. Yes. 3 Q. -- with hospitals, has the burden of 4 completing the survey ever come up before? 5 A. I would say early on, like, 6 2009/2010, that something was discussed a lot. 7 Today, no -- 8 Q. Okay. 9 A. -- and, in fact, what we've seen is 10 -- and most hospitals now are part of health 11 systems, which I'm sure you know. Most health 12 systems consolidate around the tasks related to 13 quality measurement and data reporting. And 14 that includes patient safety measurement in data 15 reporting. 16 And so we're seeing in some small 17 systems, large systems it's somebody's job to 18 do this, and Leapfrog is just one other thing 19 that they do. 20 We're also seeing that because our 21 measures are meaningful to hospitals in a way 22 that sometimes the CMS measures are not, Page 211	1 also talk to hospitals that are not 2 participating in the survey -- 3 Q. Yeah. 4 A. -- so just, like -- 5 Q. Fair enough. 6 A. -- participation's around 80/20 -- 7 I'm sorry -- 8 Q. No, no. It's -- it's a fair point. 9 A. Okay. 10 Q. So I -- I guess the -- the follow-up 11 question is, Can you tell me a little bit about 12 what are the conversations you have with 13 nonparticipating hospitals? 14 A. They vary. Sometimes they want to 15 talk about what it would take to participate in 16 the survey. Sometimes they want to get 17 introduced to a hospital of like size, teaching 18 status, patient acuity -- who's doing the 19 Hospital Survey, because they want to do it, but 20 they don't want to start from scratch. 21 A lot of times, it's questions 22 about the Hospital Safety Grade, the way the Page 213

1 methodology works. I do a lot of 2 demonstrations using Zoom with that Hospital 3 Safety Grade calculator that I showed you -- I 4 could probably do it in my sleep, I've done so 5 many -- and then me answering questions about 6 that. 7 Sometimes, like in the case of the 8 Alabama Hospital Association, it's a place 9 where we only recently got a -- a regional 10 purchasing group to work with. And so there's 11 not been, really, a -- a strong -- what I would 12 call "Leapfrog presence" in that state. 13 And so the Hospital Association 14 just wants to hear directly from the source 15 more information about the survey versus the 16 Safety Grade, the survey and the Safety 17 Grade -- 18 Q. Yeah. 19 A. -- how many dogs I have. I don't 20 know. 21 Q. How many -- how many? 22 A. Two. Page 214	1 Talking to -- I -- I can't recall 2 specific ones, so I want to be very clear about 3 that -- 4 Q. Yeah. 5 A. -- typically, it's related to what 6 we have -- the -- you know -- I'm sorry. 7 Typically, it's something like we 8 aren't going to do the survey this year, for 9 example, and we want to understand that's 10 going -- how that's going to impact our 11 Hospital Safety Grade. 12 And then I would explain to them if 13 you don't do the survey for one year, this is 14 the numerical scores that will be imputed for 15 these four measures. These are how the weights 16 will be redistributed, et cetera. If you don't 17 do the survey for two years, et cetera, if you 18 don't -- so it's typically just a very 19 informational call -- 20 Q. Got it. 21 A. -- I honestly don't try to talk them 22 back into doing the survey or advise them in any Page 216
1 Q. Two. 2 (Laughter.) 3 BY ATTORNEY CRAIN: 4 Q. That's under oath. 5 (Laughter.) 6 BY ATTORNEY CRAIN: 7 Q. So the other question I have -- so 8 we'll come to this a little bit more later -- 9 A. Okay. 10 Q. -- but the imputation methodology we 11 talked about a little earlier -- your 12 conversation -- how many -- do you have 13 conversations with nonparticipating hospitals 14 about the imputation methodology? 15 A. I'm sure I do -- 16 Q. Can you -- 17 A. -- I can't think of one in the past 18 six months, but it's my job to do that, yes. 19 Q. Do you recall any -- like, the 20 general tenor of those discussions? 21 A. I'm trying to recall the last one I 22 had. Page 215	1 way. I'm simply relaying the information as I 2 know it. 3 They get very frustrated. 4 Q. Okay. Tell me what -- what do you 5 mean? 6 A. Because they want me to give them 7 guidance. 8 Well, what would you do? Well, 9 what do you think? 10 It's not really appropriate for me 11 to do that. I give them the information and 12 tell them it's best to call in a larger team 13 and have those discussions, but it's not a 14 decision I can make for them. 15 Q. So this is the decision they are 16 going to make, and these are the repercussions 17 of that decision? 18 A. These are -- this is how that 19 decision would play out, correct -- 20 Q. Okay. 21 A. -- I've never used the word 22 "repercussions," but -- Page 217

1 Q. Consequence, repercussion -- the 2 "result" -- 3 A. Yes. 4 Q. -- may be a more neutral word. 5 A. Sure. 6 Q. Yeah. 7 And do you know -- in those 8 conversations, do you have a sense of why the 9 hospitals stopped reporting for those years? 10 A. It varies. I will tell you a very 11 common one right now, which I'm sure won't come 12 as a surprise to you. It's cybersecurity 13 events. 14 Q. Huh. Interesting. 15 A. We've been hearing an increase in 16 cybersecurity events specifically targeting 17 health systems -- 18 Q. Yeah. 19 A. -- insurance companies, et cetera. 20 And so that can be a reason why they have 21 limited access to data or limited staff -- 22 Q. Oh, I see -- Page 218	1 Q. Okay. So, like, a sys- -- a system 2 shutdown -- 3 A. So we're working off paper, 4 correct -- 5 Q. Got it -- 6 A. -- correct -- 7 Q. -- okay. 8 A. -- another really common reason, 9 actually, is every hospital right now is on 10 electronic health records. There's really 11 actually only a handful of major electronic 12 health record vendors in the space: Epic, 13 Cerner, Meditech, et cetera. 14 If hospitals decide to go from, 15 like, Epic to Cerner, it is apparently a very 16 big deal, and they take everything down. 17 There's a process to move over and train. And 18 that can be a reason that hospitals tell us 19 they're going to pause participation in the 20 survey for one year or more, because they're 21 going through a major -- what they call 22 "transformation." Page 220
1 A. -- additionally -- 2 Q. -- can I -- can I just follow up on 3 that -- 4 A. Yeah. 5 Q. -- because when you say -- it was 6 surprising to me, actually -- 7 A. Oh. 8 Q. -- it's not surprising to me that 9 they have these, but the connection is unclear 10 to me -- 11 A. Yeah. 12 Q. -- you're saying the cybersecurity 13 incident -- they, like, lock down the data so 14 they can't participate? 15 A. No. They can't record data. So 16 then -- 17 Q. I see. 18 A. -- because our survey sometimes asks 19 for, like, them to do something, they're like, 20 We're off-line right now -- 21 Q. Got it. 22 A. -- because everything got shut down. Page 219	1 Q. Process, yeah. 2 And then just thinking about, 3 like, during COVID -- 4 A. Yes. 5 Q. -- did hospitals ever tell you, We 6 just can't do it this year; we're overwhelmed? 7 A. Yes. 8 Q. Okay. Tell me a little more about 9 that. 10 A. Sure. 11 COVID was scary -- 12 Q. Say that again. 13 A. -- yeah -- for a lot of different 14 reasons if you worked in a hospital because you 15 were seeing things you had never seen before; 16 you were afraid to get sick and take it home. 17 So Leapfrog actually -- in 18 discussions with hospitals, our board of 19 directors and others, we actually did something 20 we had never done before. In 2020, our survey 21 launches -- I said it's rolling submissions -- 22 April 1st. They have until November 30th to Page 221

1 participate in this two-month data collection 2 period -- or data correction, with a C -- 3 correction period. 4 For the 2020 Leapfrog Hospital 5 Survey, we said that hospitals who wanted to 6 could do the Leapfrog Hospital Survey. 7 Otherwise, if they had done a 2019 Leapfrog 8 Hospital Survey, we would maintain those data. 9 And we just distinguished between the two on 10 our public reporting website, 11 leapfroggroup.org. 12 So if you were a consumer looking 13 at a C-section rate, you knew it was from the 14 2019 survey versus the 2020 survey. 15 Q. Do you recall how you denoted that? 16 A. I don't -- oh. We added a field in 17 the website file that we import. And I believe 18 we just displayed it -- 19 Q. Okay. 20 A. -- I don't exactly recall, though, 21 to be frank -- 22 Q. Okay. Page 222	1 their 2020 grade, right? 2 A. No. You asked me about the Leapfrog 3 Hospital Survey. 4 Q. Oh, I'm sorry. So you -- I -- I -- 5 I thought we were talking about the grade, too. 6 A. No. The Hospital Survey and the 7 Safety Grade are two completely different 8 programs, and -- 9 Q. Got it -- 10 A. -- our roles -- 11 Q. -- okay. 12 A. -- and protocols around those things 13 during COVID were not -- 14 Q. Okay. 15 A. -- the same. 16 Q. So tell me -- yeah, that -- fair 17 enough. I think -- 18 A. Yeah -- 19 Q. -- I conflated -- 20 A. -- okay. 21 Q. -- the two. Yeah, yeah. Let me -- 22 okay. Page 224
1 A. -- it was a wild time. 2 Q. And did that -- so that was sort of 3 like an imputation? 4 A. No. I would say it was -- we froze 5 the results for some hospitals and -- and -- we 6 thought about just freezing the survey. And as 7 we talked to different hospital groups about 8 that, there actually wasn't consensus around 9 that. 10 Some hospitals said No. We've been 11 working on improving this for two years. We're 12 ready to report. I want to report now -- 13 Q. Got it. 14 A. -- you know, other hospitals said, 15 We did a survey last year. We're getting 16 slammed right now. We just can't do it. 17 So we tried to find a solution that 18 worked and represented what both groups of 19 hospitals were telling us. 20 Q. So just -- just to make sure I 21 understand, for the hospitals that said we're 22 working on it, we want to report, you gave them Page 223	1 So you froze the survey. 2 Did you freeze -- 3 A. I'm sorry. 4 Can we just go back on the record, 5 and I can confirm we've been talking about the 6 Leapfrog Hospital Survey, correct? 7 Q. Yes, we've been -- yes. I think I 8 conflated the two. 9 A. Okay. 10 Q. Yeah. I think we're okay. 11 So why -- why don't -- just to 12 be clear, what -- what did you do during COVID 13 for the Safety Grade? 14 A. We calculated Hospital Safety Grades 15 based on the data that was publicly available on 16 those snapshot dates that I described -- 17 Q. Okay. 18 A. -- to you earlier. So if it was 19 2020 results, it was 2020 results. If it was 20 2019 results, it was 2019 results -- 21 Q. Okay. 22 A. -- and we represented those Page 225

1 reporting periods accurately, and I think on the 2 version of Exhibit 4 that you showed me, you can 3 see how those reporting periods are displayed on 4 that Hospital Safety Grade website. 5 Q. Yeah. 6 A. Okay. 7 Q. Okay. And then back to the survey 8 now. 9 A. Yes. 10 Q. I don't want -- I don't want to 11 confuse you, but I think I confused myself. 12 Back to the survey. 13 A. Yes. 14 Q. During COVID, certain hospitals told 15 you they were overwhelmed -- 16 A. Yes. 17 Q. -- and wouldn't be completing the 18 survey? 19 A. Yes. 20 Q. You reported their survey results, 21 said, basically, These are the 2019 results of 22 the survey -- Page 226	1 BY ATTORNEY CRAIN: 2 Q. So one other question. 3 On -- on the discussions with 4 hospitals -- 5 A. Yes. 6 Q. -- can you recall today any instance 7 in which a hospital said, We don't want to do 8 the survey because our performance has declined? 9 A. I can't recall a hospital admitting 10 that exact thing to me. 11 Q. Okay. I can follow -- 12 A. On a phone call. 13 Q. Otherwise? 14 A. Sometimes we get tickets to our help 15 desk, and it won't be someone necessarily a -- 16 the leadership of the hospital, but, basically, 17 like, someone may be lower level doing data 18 collection that would just ask because they 19 don't know or they were told to ask. 20 Like, a lot of times, this can 21 happen when there's, like, a switch to the CPOE 22 system, for example. We haven't finished Page 228
1 A. Yes. 2 Q. -- for the hospitals not 3 completing -- 4 A. Yes. 5 Q. -- and for the -- 6 CERTIFIED STENOGRAPHER: Just 7 let him finish. 8 BY ATTORNEY CRAIN: 9 Q. -- for the ones that did complete 10 the survey, you reported their 2020 results? 11 A. Yes. 12 Q. Okay. Thank you. 13 I think we're on the same page. 14 It's -- 15 CERTIFIED STENOGRAPHER: Can 16 we take a bio break soon? 17 ATTORNEY CRAIN: Yes. Yes, 18 of course. Give me five more minutes. 19 Is that okay? 20 CERTIFIED STENOGRAPHER: Yes. 21 ATTORNEY CRAIN: Okay. 22 Page 227	1 setting up our clinical decision support yet. 2 We don't want to retake the CPOE test right now 3 because we know the alerts aren't working, so 4 we're not going to take the test. 5 What does that mean? 6 Q. Okay. 7 A. So we do hear testimony -- not 8 testimonials. We do get questions from 9 hospitals and through them asking the question 10 about, What's going to happen? Because we can't 11 do this right now. They're telling us it's 12 because, We got worse. We stopped doing it. We 13 have a change in leadership, and we're not going 14 to do this anymore. 15 I'm trying to convince them it's 16 still worth it, that kind of thing. 17 Q. So you -- you -- just to make sure I 18 understand -- 19 A. But not on a phone call. 20 Q. Okay. And -- and so let me break 21 this down a little bit. 22 ATTORNEY CRAIN: And then I Page 229

1 promise, Cindy, we will break. 2 BY ATTORNEY CRAIN: 3 Q. So you get questions from which you 4 infer that there's declined performance? 5 A. No. I get questions, and in the 6 process of them answering the question, they add 7 that piece, which maybe they meant to or were 8 not meant to do. 9 Q. Okay. 10 A. So in the process of saying, What 11 happens if we don't take the CPOE test? they 12 will have described, Because we switched our 13 CPOE system, the new alerts aren't working. 14 Management doesn't want me to take the CPOE 15 test. 16 Q. Okay. 17 A. So, no, I would never infer 18 something like that. 19 Q. Okay. 20 A. I see it as maybe them accidentally 21 putting too much information in the ticket when 22 they were just supposed to ask a single Page 230	1 --oOo-- 2 (Whereupon, at 12:07 p.m. EDT, a 3 luncheon recess was taken.) 4 --oOo-- 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 Page 232
1 question. 2 Q. Okay. And then you -- you 3 emphasized "not on a phone call." 4 A. That I could remember. 5 Q. What about a Zoom? 6 A. I would consider that a phone call. 7 Q. Got it. Okay. 8 So any oral video you're 9 talking about? 10 A. (No audible response.) 11 Q. Okay. And -- okay. 12 ATTORNEY CRAIN: I think for 13 Cindy, let's take a break, if you're 14 good, Kim? 15 ATTORNEY BLAIR: Yeah, good. 16 ATTORNEY CRAIN: Okay. 17 Should we just do lunch now? 18 ATTORNEY BLAIR: Yeah. 19 ATTORNEY CRAIN: Okay. 20 THE VIDEOGRAPHER: Going off 21 the record. The time is 12:07. 22 Page 231	1 AFTERNOON SESSION 2 (1:15 p.m. EDT) 3 --oOo-- 4 MELISSA AMEE DANFORTH, 5 was called for continued examination and, after 6 having been previously duly sworn under penalty of 7 perjury by the certified stenographer to tell the 8 truth, the whole truth and nothing but the truth, 9 was examined and testified further as follows: 10 --oOo-- 11 THE VIDEOGRAPHER: Going back 12 on the record. The time is 1315. 13 --oOo-- 14 EXAMINATION (CONTINUED) BY COUNSEL FOR PLAINTIFFS 15 --oOo-- 16 BY ATTORNEY CRAIN: 17 Q. Welcome back. 18 A. Thank you. 19 Q. Okay. 20 ATTORNEY CRAIN: Oh, is my 21 mic on? 22 Okay. Good. Page 233

1 BY ATTORNEY CRAIN: 2 Q. I want to shift gears and talk about 3 the imputation model. 4 A. Yes. 5 Q. Do you prefer "model" or 6 "methodology"? 7 A. Either is fine. 8 Q. Okay. You're okay. You're good. 9 Why did Leapfrog establish an 10 imputation model? 11 A. So going back again when I was 12 referencing the New York and California 13 restaurant letters, there's this idea that 14 obviously, yes, transparency is important, but 15 we also felt that we could use this as an 16 opportunity to really educate patients, 17 families, employers, purchasers, others on what 18 are the asp -- what are some aspects of patient 19 safety, right. So some people may or may not 20 know that it includes things like pressure 21 ulcers, falls, medication errors, hand hygiene, 22 right. These are what we consider aspects of Page 234	1 available? And it just so happened at that 2 time there was only one, actually, CPOE. We 3 didn't even have BCMA on the survey. 4 So the original Safety Grade 5 included slightly different measures on both 6 the process and structural measure side as well 7 as on the outcome measure side. And when we 8 first started calculating Hospital Safety 9 Grades, identifying measures, looking for data 10 sources, we had secondary data sources for 11 some of the measures from the 12 American Hospital Association through their 13 various surveys. 14 So we had had the Safety Grade 15 around now 2013 to 2021. It was 16 well-established, particularly among hospitals. 17 They really understood it by that point. 18 When AHA decided they weren't going 19 to calculate Hospital Safety Grades anymore -- 20 or they weren't going to license as their data 21 to calculate Hospital Safety Grades anymore, a 22 discussion was, What are the other available Page 236
1 patient safety. 2 And as we examined a host -- when I 3 say "we," again, this would be our national 4 expert panel of which I was an observer, not a 5 participant. When the expert panel was 6 examining all of the various publicly reported 7 patient safety measures that were out there, my 8 recollection is that the idea of having a 9 Safety Grade that included as many available 10 patient safety measures as possible would be 11 the ideal situation. 12 Some of those measures ended up 13 coming from our own Leapfrog Hospital Survey. 14 I don't think that was ever a foregone 15 conclusion, but through deliberation and 16 processes, the expert panelists said, 17 Medication safety is actually the most common 18 medication -- medical error that happens to any 19 patient in a hospital; it's number one. 20 We have to have medication safety 21 represented in the Hospital Safety Grade. What 22 are the available measures that are publicly Page 235	1 resources? And at that point, there was 2 discussion around imputation for certain of the 3 measures. 4 But to be clear, as I described 5 earlier, going back even to the inception of 6 the Hospital Safety Grade, the idea of 7 imputation was always discussed, and it was 8 discussed from my earliest recollection related 9 to cultural of safety. So this idea of 10 imputation related to methodologies, 11 particularly composites, is not new. It's not 12 groundbreaking. It's not unique to this expert 13 panel. Their thinking and the evolution of the 14 model really did evolve almost organically over 15 time due to various factors. 16 Q. And -- and just, again, to what we 17 talked about earlier this morning, imputation 18 wasn't actually instituted, so to speak, until 19 2021, right? 20 A. Correct. 21 Q. Okay. So to my question of why 22 Leap- -- Page 237

1 A. I'm sorry. It might have been 2022. 2 I think the last time we used the data was 2021, 3 so it may have been one of the 2022 Grades, but 4 we've agreed it's around that time frame. 5 Q. Yeah. Okay. 6 And that's a helpful 7 clarification. I -- I take the point. 8 The decision to start 9 imputation presumably was '21, and the first 10 time you did it was '22? 11 A. I believe that's correct without 12 having the documents in front of me. 13 Q. Yeah, fair enough. 14 Going back to my question. 15 So I asked why did Leapfrog -- 16 why is Leapfrog, you know -- what's the purpose 17 of imputation? You talked about education, 18 right? That was how you started your answer. 19 A. Um-hum. 20 Q. Why do you need an imputation 21 module -- model to educate the public? 22 A. We don't need an education -- we Page 238	1 wasn't clear. 2 The idea of education is that they 3 didn't want to leave out those important 4 concepts of patient safety just because they 5 may not be available for hospitals that didn't 6 do the Leapfrog Hospital Survey. And that came 7 about specifically because medication errors 8 are the number one error in hospitals. And at 9 the time, we were the only source of any 10 measures related to medication safety. 11 Q. So that's very helpful. I guess 12 the -- my follow-up question to that is, You 13 said you didn't want measures in -- in the -- 14 let me just make sure I -- you said, "We don't 15 have them for every hospital where we -- 16 where -- sure we want to use them, or would we 17 still want to use them?" Meaning the -- you 18 know, the measures, right, going in? Why isn't 19 a different option to just not grade every 20 hospital? 21 A. From the very beginning of 22 conversations with the expert panel related to Page 240
1 don't need an imputation model to educate the 2 public; however, again, even very early on when 3 we start -- first started calculating Hospital 4 Safety Grades, there were discussions about, 5 Well, if we use measures from a Leapfrog 6 Hospital Survey and we don't have them for every 7 hospital, are we sure we want to use them, or 8 would we still want to use them? 9 And that's why, again, early 10 discussions around even imputing then -- for 11 example, the safe practices, the culture of 12 safety -- safe practice -- those discussions 13 took place. There was always an awareness that 14 because the expert decision -- made a decision 15 to include some measures that were from the 16 Leapfrog Hospital Survey, there was going to be 17 some hospitals that likely would not have those 18 data because it's a voluntary survey -- 19 Q. Yeah. 20 A. -- so concepts like imputation, 21 secondary data sources, et cetera, came to be. 22 And I apologize. I realize I Page 239	1 the Hospital Safety Grade, they had a commitment 2 to calculating Safety Grades for as many 3 hospitals as possible because unlike things like 4 delivering babies where maybe every hospital 5 doesn't do it or having a complicated cancer 6 surgery where maybe every hospital doesn't do 7 it, these patient safety measures are really 8 fundamental to pretty much any hospital that's 9 providing acute care, and so they thought it was 10 important to include as many as possible, but we 11 don't. I mean, clearly there's over 4,000-plus 12 hospitals in the United States, and we only 13 grade around 2,800 to 3,000 every round. 14 Q. Well, you -- you said earlier today 15 that you grade 80 percent of hospitals, right? 16 ATTORNEY BLAIR: Objection to 17 form. 18 BY ATTORNEY CRAIN: 19 Q. Explain to me -- 20 A. No. 21 Q. -- do you remember that number, 22 80 percent? Page 241

1 A. No, I said -- again, so that's when 2 we were talking about the 3 Leapfrog Hospital Survey -- 4 Q. Okay. 5 A. -- and I said we have about 6 80 percent of inpatient hospital beds 7 represented from hospitals who are participating 8 in a Leapfrog Hospital Survey, meaning that we 9 have the majority of hospitals -- 10 Q. Okay. 11 A. -- doing the 12 Leapfrog Hospital Survey. 13 Q. And so 20 percent are -- of 14 inpatient beds are at hospitals that do not 15 participate in the survey? 16 A. Yes. 17 Q. Why does Leapfrog need to grade 18 those hospitals? 19 ATTORNEY BLAIR: Objection to 20 form. 21 THE WITNESS: Again, the 22 expert panel's intention was because Page 242	1 individuals providing us with guidance and 2 expertise -- which over the years, has been 3 beyond the expert panel. 4 Over time, we've consulted with 5 Mathematica -- they're a leading analytics firm 6 in the U.S. -- and others, and because -- you 7 know, those are the folks that -- not just 8 Leapfrog, CMS, Joint Commission, other national 9 organizations -- are also trusting to provide 10 them guidance on performance, measurement, 11 et cetera. I feel confident in the panel 12 and -- and their guidance. 13 Q. Is it accurate that the expert panel 14 approved the imputation methodology Leapfrog 15 deploys today? 16 A. So as I've described, there's not a 17 voting process, there's a discussion and there 18 was agreement, correct. 19 Q. Are you referring to the April 12th, 20 2024 meeting? 21 A. We did meet on April 12th, 2024. 22 Q. Was that the discussion you were Page 244
1 this is a patient Safety Grade, to 2 grade as many hospitals as possible. 3 BY ATTORNEY CRAIN: 4 Q. What is -- is it to grade as many 5 hospitals as possible or to also grade them 6 accurately? 7 A. It's both. 8 Q. Okay. 9 A. Which we do. 10 Q. So -- and just to be clear, you're 11 saying the imputation model Leapfrog has 12 presents an accurate portrait -- depiction of a 13 hospital's performance? 14 A. I have confidence in our entire 15 methodology, including the imputation 16 methodology, yes. 17 Q. Okay. What's the basis for that? 18 Why do you have confidence in it? 19 A. I trust our expert panel. I have 20 said before I'm not a health science researcher, 21 a health services researcher. I'm not a 22 mathematician, but I believe that the Page 243	1 just referring to? 2 A. There were discussions both before 3 and after that meeting, and I would say 4 throughout the process of finalizing the fall 5 2024 methodology, there was agreement among the 6 expert panelists, yes. 7 Q. Okay. We'll come up to that. 8 Let's start -- so you had 9 mentioned there was a discussion over time 10 involving imputation; is that right? 11 A. Yes. 12 Q. I want to take you back to some of 13 those discussions and sort of get your 14 documents. 15 So I want -- excited. All 16 right. 17 ATTORNEY CRAIN: So this is 18 going to be Exhibit 6. 19 --oOo-- 20 (Danforth Deposition Exhibit Number 21 6, Leapfrog Hospital Safety Grade 22 Expert Panel In-Person Meeting Page 245

1 Agenda, June 14, 2017, Bates 2 stamped ARMSTRONG_0003576 through 3 ARMSTRONG_0003579, marked for 4 identification, as of this date.) 5 --oOo-- 6 THE WITNESS: Oh, thank you. 7 Sorry. 8 ATTORNEY CRAIN: Six, right? 9 CERTIFIED STENOGRAPHER: Yes. 10 ATTORNEY CRAIN: Good. Six. 11 (Sotto voce between cocounsel.) 12 BY ATTORNEY CRAIN: 13 Q. Okay. Ready? 14 A. Yes. 15 Q. Okay. Ms. Danforth -- Danforth, 16 Exhibit 6, if you see at the top, it is a 17 Leapfrog Hospital Safety Grade Expert Panel 18 In-Person Meeting Agenda. 19 Do you see that? 20 A. I do. 21 Q. And it's dated Wednesday, June 14th, 22 2017. Page 246	1 meeting. I couldn't recall if she attended 2 previous to this or after this any virtual 3 meetings that we would have. 4 Q. Okay. 5 A. But I would say that an in-person 6 meeting for sure she would be present. 7 Q. Do you have a best estimate of when 8 the last ex -- Hospital Safety Grade expert 9 panel she attended was? 10 A. I wouldn't. 11 Q. Okay. So if you go down a little 12 bit, specifically to the Unintentional 13 Consequences of How We Currently Treat Missing 14 Data. 15 Do you see that? 16 A. I do. 17 Q. And it says, Matt discussed some of 18 the unintentional consequences of how we 19 currently treat missing data, some of which are 20 driven by the Z-score methodology, and also 21 assigning grades to hospitals that may have more 22 or less data than others. Page 248
1 Do you see that? 2 A. I do. 3 Q. And I'm just going to tick down to 4 the meeting attendees. 5 Do you see it labels expert 6 panelists and board/staff? 7 A. I do. 8 Q. And among the folks who attended are 9 Ms. Binder, yourself and Dr. Austin. 10 Do you see that? 11 A. I do. 12 Q. And I -- just a question. I noted 13 Ms. Binder stops at some point attending these 14 meetings. 15 Do you recall when that 16 happened? 17 A. I remember that this was an 18 in-person meeting, which was unique. We don't 19 often meet in person with our technical expert 20 panels even prior to COVID because they live 21 around the country. It's very expensive. So I 22 know she would have attended this in-person Page 247	1 Do you remember the context of 2 that -- that note? 3 A. Unfortunately, I don't -- 4 Q. Okay. 5 A. -- this is from 2017 -- 6 Q. Okay. 7 A. -- eight years ago. I apologize. 8 Q. No, no. Don't -- no need to 9 apologize. 10 Do you have any present 11 understanding of what this could mean? 12 A. I don't. Only because in 2017, the 13 methodology was so different, including the 14 measures that we use both on the process and 15 structural measure side and outcome measure 16 side. I would need to read through the full 17 thing and any other meeting materials if I was 18 really going to speak to anything. 19 Q. Okay. Okay. 20 Let's go to Page 2. If -- you 21 see there's, at the top, a Number 2. 22 Do you see that in the bullets? Page 249

1 A. I do. 2 Q. And it says, Imputation of the score 3 when we have missing data. 4 Do you see that? 5 A. Correct. 6 Q. Is this one of the instances we've 7 been talking about where imputation has come up 8 before 2021 in these meetings? 9 A. I don't remember the specific 10 meeting. 11 Q. Okay. 12 A. As I've described, my most vivid 13 memory was specifically from Sara Singer related 14 to culture of safety. I don't remember this 15 specific incident. 16 Q. And you don't remember when the -- 17 when Ms. Singer made that comment? 18 A. I don't. 19 Q. Okay. And just walking through -- 20 you know, I understand if you don't remember, 21 but just to see if it refreshes your 22 recollection, it says, Matt mentioned that Page 250	1 is -- is specifically what I'm referencing. 2 Q. Okay. Okay. 3 And culture of safety was 4 Safe Practices 2 or 1? 5 A. Safe Practice 2, correct. 6 Q. Okay. And then it says, Imputing 7 scores for individual measures like safe 8 practices would incentivize them to report on 9 the survey. 10 Do you see that? 11 A. I do. 12 Q. Do you know what that means? 13 A. Again, I -- I don't have a good 14 recollection of this meeting, and we've never 15 imputed scores for the safe practices since the 16 inception of the Safety Grade. I only remember 17 a single discussion even involving the safe 18 practices and imputation, so I only know the 19 outcome of what this discussion must have been, 20 which is what -- that we've never imputed safe 21 practice scores. 22 Q. And so just looking at this sentence Page 252
1 expert panel discussed this in the past and did 2 not feel it supported the goal of the Safety 3 Grade. 4 Do you know what he means by 5 that? 6 A. I don't. 7 Q. Okay. Could he -- do you remember 8 any -- you know, do you have any sense of what 9 type of imputation did not support the goal of 10 the Safety Grade? 11 A. Again, my only recollection of 12 talking about imputation very early on was 13 specific took -- to the culture of safety 14 concept, which we've talked about extensively, 15 but I -- beyond that, I couldn't speak to this. 16 Q. Is that reflected in the next 17 bullet, Imputing scores for individual measures, 18 like Safe Practices? 19 A. I'm honestly not sure what that's 20 referring to, but my reference to Sara Singer 21 indicating that it would not be appropriate to 22 impute for something like a culture of safety Page 251	1 again -- 2 A. Yes. 3 Q. -- is it correct to say that 4 imputing scores for individual measures would 5 incentivize hospitals to report on the survey? 6 And I purposefully tweaked the sentence in my 7 question. So I'm asking a very precise 8 question. 9 ATTORNEY BLAIR: Objection to 10 form. 11 THE WITNESS: And I don't 12 know if it would incentivize hospitals 13 to report to the survey or not. Like 14 I said, we've been doing imputation 15 for the Hospital Safety Grade 16 perform -- participation in a 17 Leapfrog Hospital Survey has remained 18 relatively steady. Whether I, 19 personally, believe it's an incentive 20 is irrespective of the reality of what 21 the participation looks like, so I -- 22 I can't really speak to this. Page 253

1 BY ATTORNEY CRAIN: 2 Q. What do you personally believe? 3 A. That it depends. 4 Q. Depends on what? 5 A. I think if hospitals are generally 6 doing those elements already included in the 7 safe practices, it may incentivize them to say, 8 Oh, well, we're already doing this. Let's 9 report it to Leapfrog and have that included in 10 the Hospital Safety Grade. If hospitals are not 11 already doing those things or don't want to do 12 those things or don't agree with some of those 13 things, then it could disincentivize them. 14 I think an important thing to 15 remember is that hospitals that submit surveys 16 and get Safety Grades get Ds, get Fs. And so 17 participation in the survey isn't a straight 18 line to an A grade, a B grade, et cetera. 19 You know, in fact, we've seen time 20 and time again hospitals reporting to the 21 survey across all of the grades. So to speak 22 about a hospital's incentive or disincentive, I Page 254	1 Q. Let's see. 2 Is it fair to assume the worst 3 scores if hospitals are not transparent? 4 ATTORNEY BLAIR: Objection to 5 form. 6 THE WITNESS: Is this me, 7 personally, answering the question? 8 Is this me -- 9 BY ATTORNEY CRAIN: 10 Q. Personal -- 11 A. -- on behalf of Leapfrog? 12 Q. -- personal capacity. 13 A. I think, today, as we stand here in 14 2025, specific to the four measures that we 15 impute scores for in the Hospital Safety Grade, 16 given that actually we're imputing the same 17 score a reporting hospital gets if we know that 18 they have those structures in place but nothing 19 more and that we could actually impute 0, which 20 one expert panel has recommended, I wouldn't 21 even describe what we're doing now as being the 22 worst score we can impute. It is the worst Page 256
1 think there's a lot of variation. 2 Q. Okay. The panel is -- two bullets 3 down, The panel discussed whether or not we 4 should assume the worst score if hospitals are 5 not transparent. 6 Do you recall that discussion? 7 A. I don't. 8 Q. Okay. Do you -- do you have an 9 understanding of what that could mean? 10 A. I wouldn't be able to speak 11 definitively. It could mean imputing a 0 -- 12 unfortunately, I don't. I actually don't 13 remember this meeting at all, so I don't -- 14 Q. Okay. Is -- is -- 15 A. -- to be -- to be honest. I -- I'm 16 sure I was there. 2017 feels like a long time 17 ago. I don't remember this meeting at all. 18 Q. Anything pre-COVID is a blur. 19 A. It is a pre-COVID thing. 20 Q. Yeah. Yeah. 21 Then let me ask this question. 22 A. Yes. Page 255	1 score in the data set for these measures, as 2 we've indicated clearly on our public reporting 3 website. 4 But, frankly, there has been 5 discussion about imputing 0s, which probably 6 would be the real worst score. 7 Q. I thought, though -- so tell me if 8 I'm misunderstanding. 9 I thought, like, say, a 15 for 10 handwashing was the lowest score. 11 A. So today, that is the lowest score, 12 but it's specifically associated with that 13 performance category, as we discussed, that's 14 from the Leapfrog Hospital Survey. 15 So in some ways, we're still giving 16 a hospital that's not done anything related to 17 the survey the same credit that we're giving a 18 hospital that's done a Leapfrog Hospital Survey 19 and basically said, Yes, we have this but we 20 don't have these other things in place. 21 The scores that you see assigned to 22 those performance categories for each of those Page 257

1 four measures were not determined by this 2 Hospital Safety Grade expert panel. They 3 actually come from another program, and they 4 were determined by a separate independent 5 national expert panel. 6 So, for example, the lowest score 7 for CPOE, I believe, is 15. So let me check. 8 Q. I won't hold you to it. The 9 document says what it says. 10 A. I don't trust myself now after that 11 hand hygiene -- hand hygiene domain mishap. 12 It's shaken my confidence. 13 The lowest score associated with 14 CPOE is 15. However, the lowest score 15 associated with -- 16 Q. IC. 17 A. -- IC position staffing is -- 18 Q. Five. 19 A. -- 5. 20 So those were not arbitrarily 21 assigned. There are differences for a reason. 22 And that's because those numerical values Page 258	1 And then just to make it 2 concrete, when you say "the lowest score," for 3 handwashing, for instance, what is that, 4 presuming exists for the lowest reporting 5 hospital? 6 A. So in order to achieve limited -- in 7 order to earn limited achievement on the hand 8 hygiene standard, it is a structural measure, 9 and so there's a series of components. And 10 based on the yeses or noes -- you might refer to 11 it as, like, a scoring rubric. 12 So based on that scoring rubric, 13 the components that would equal limited 14 achievement are laid out. 15 Unfortunately, given the detail of 16 that, I would just need to have it in front of 17 me to reference it. And we can certainly 18 discuss it. 19 Q. Okay. And -- and just to be clear, 20 though, under the current structure, there is no 21 lower score than limited achievement for any 22 hospital; is that right? Page 260
1 associated with those four performance 2 categories were decided by another separate, 3 independent national technical expert panel for 4 the purposes of Leapfrog's value-based 5 purchasing program. 6 I've talked about that a few times, 7 when we take those performance categories and 8 assign these scores. 9 So the difference in the scores 10 represent relative importance that panel 11 thought, relative harm for having the highest 12 versus lowest achievement. And that's why IC 13 staffing has the lowest low score, because it's 14 the greatest harm because it can result in -- 15 in -- results in death. 16 And so -- though, today, we're 17 imputing the lowest score from a Leapfrog 18 reporting hospital, we could, theoretically, 19 given guidance from the expert panel, report a 20 lower score that could not be attained by a 21 Leapfrog reporting hospital. 22 Q. Got it. I think I understand. Page 259	1 ATTORNEY BLAIR: Objection to 2 form. 3 THE WITNESS: For these four 4 measures? 5 BY ATTORNEY CRAIN: 6 Q. For these four measures. 7 A. Currently, correct -- 8 Q. Okay. 9 A. -- correct, yeah -- 10 Q. Okay. 11 A. -- so even nonreporting hospitals 12 still get a score associated with a Leapfrog 13 reporting hospital -- 14 Q. Okay. 15 A. -- that's correct. We have -- 16 there's no score beneath that. 17 Q. Okay. And the -- just before we 18 leave this document -- 19 A. Yeah. 20 Q. -- I just want to make sure. 21 None of these -- particularly 22 Bullet 2 -- none of these bullets refresh your Page 261

1 recollection as to what was discussed? 2 (Whereupon, the witness reviews the 3 material provided.) 4 THE WITNESS: They don't. 5 BY ATTORNEY CRAIN: 6 Q. Okay. 7 Okay -- 8 A. And -- 9 Q. -- you can set that aside. 10 A. -- and -- yes -- 11 Q. Oh. Do you have something? 12 A. -- typically, we would only have, 13 like, an in-person expert panel meeting for a 14 specific reason, but there's nothing at this -- 15 you know, that -- on this agenda that jumps out 16 at me. 17 So I'm wondering -- and if it was 18 the panel hadn't met in-person in a long time 19 and we brought them all together -- but no. 20 And -- I mean, I see my name on the 21 agenda, certainly, particularly at the end, 22 Page 4, Discussion of the Landscape Ahead. Page 262	1 ATTORNEY CRAIN: You're 2 welcome. 3 BY ATTORNEY CRAIN: 4 Q. Okay. Ms. Danforth, this is an 5 e-mail from Andrew Card, who looks to be a 6 Leapfrog employee. 7 A. Yes. 8 Q. Was he -- was he, by chance, 9 Ms. Campione's predecessor? 10 A. So he was a program analyst on my 11 ratings team. He wasn't -- it ended up -- after 12 we hired Alex, she did some of his work but not 13 all of it. 14 Q. Not one-to-one? 15 A. No, it's not a one-to-one. Thank 16 you. 17 Q. So he -- he attaches what he says 18 are notes from a Safety Grade expert panel. 19 If you look at the next page, 20 Bates ending 5729 -- 21 A. Yes. 22 Q. -- and I'm going to refer -- do you Page 264
1 So I can see Missy shared 2 information on surgeon volumes and pediatric CT 3 dose, but I have no recollection of doing that. 4 If the notes said I did, I'm sure I 5 did. 6 Q. Okay. 7 Okay. You can set this one 8 aside. 9 Thanks for indulging the memory 10 lane. We're not off it yet. 11 ATTORNEY CRAIN: Let's go to 12 Tab 6. 13 So let's see. This will be 14 Exhibit 7. 15 --oOo-- 16 (Danforth Deposition Exhibit Number 17 7, E-mail with attachment, 18 LEAPFROG01918816 through 19 LEAPFROG01918821, marked for 20 identification, as of this date.) 21 --oOo-- 22 ATTORNEY BLAIR: Thank you. Page 263	1 know what a Bates number is? 2 A. Yes. 3 Q. Okay. You've been educated. All 4 right. 5 A. Yes. 6 Q. So if you look at Notes from Safety 7 Grade Expert Panel Call, June 8th, 2020 -- 8 A. Yes. 9 Q. -- by chance, do you remember this 10 meeting? 11 A. May I read this for a minute? 12 Q. Of course. 13 A. Okay. 14 (Whereupon, the witness reviews the 15 material provided.) 16 THE WITNESS: So I'm familiar 17 with some of these topics, and we 18 spoke extensively particularly about 19 the addition to PSI 90 and having to 20 update are we waiting methodology. 21 I don't remember being in 22 this specific meeting; but, again, I Page 265

1 am familiar with these topics. 2 BY ATTORNEY CRAIN: 3 Q. Okay. So let's walk through -- I 4 just want to get your understanding of these 5 terms to the extent you remember. 6 A. Yes. 7 Q. So focusing on imputation -- 8 A. Yes. 9 Q. -- and it says, Matt reviewed the 10 models that Mathematica put together for 11 Leapfrog that imputes scores for CPOE, BCMA and 12 IPS. The model that make the both -- the -- 13 sorry -- the model that make the most sense both 14 for minimizing miscalculation/bias and for 15 having face validity is as follows: Use the 16 most recent historic year if data was submitted 17 within the last three years; otherwise use the 18 most frequent value of the health system; 19 otherwise impute a score based on similar 20 hospitals (number of beds, region and 21 urbanicity). 22 Do you see those -- that -- Page 266	1 And then -- so he says -- if 2 you go to the top bullet, he's saying, The model 3 that may make -- he's saying, The model that 4 make the most sense both for minimizing 5 miscalculations and bias. 6 Do you have an understanding 7 what "miscalculations and bias" means in this 8 context? 9 A. I have an understanding that he's 10 speaking specifically to some work that 11 Mathematica did. I think I referenced it 12 actually right before you showed me this. I'm 13 prophetic. 14 I have an understanding that he's 15 referencing specifically the models that 16 Mathematica tested and put before the group. 17 Q. And -- and what does 18 "miscalculations and bias" mean in this context? 19 A. I don't remember the specific models 20 that Mathematica tested except to say that they 21 were many that were trialed and reviewed. I 22 would need to go back to those notes. Page 268
1 that -- 2 A. I do. 3 Q. This model -- the -- the three 4 bullets with -- with the white bullet -- was 5 that ever instituted? 6 A. I would need to reference the 7 specific scoring algorithm documents, like the 8 one you gave me today for spring 2025. 9 I can tell you as early as -- or as 10 recent as 2023, we were imputing recent 11 historical data within the last two years. 12 Q. Do you recall -- so my -- my 13 recollection -- and you tell me if it's wrong -- 14 is that you -- you did not institute the second 15 one; you used the most frequent value of the 16 health system. 17 Is that right or -- 18 A. I don't recall -- 19 Q. Okay. That's fine. 20 A. -- ever implementing that as part of 21 the Safety Grade. 22 Q. Got it. Page 267	1 But Mathematica would have used 2 those phrases. Most common -- likely, it was 3 them describing -- 4 Q. Yeah. 5 A. -- the analysis they had done and 6 then Matt reiterating back as accurately as he 7 could, I guess, what Mathematica had presented 8 to us. 9 Q. You've spent many years going to 10 these expert panel meetings, correct? 11 A. Yes. 12 Q. And they discussed imputation many 13 times, right? 14 A. They've discussed imputation over 15 the years, yes. 16 Q. Over the years. 17 Is -- is it fair to state that 18 as they have been discussing imputation, they 19 have been trying to avoid miscalculations of -- 20 of the Safety Grade through imputation? 21 A. It's fair to say that as they've 22 discussed imputation, they're thinking around Page 269

1 the use of imputation has evolved. And they do 2 have a concern about making sure that the Safety 3 Grades are accurate and reliable. 4 Q. And -- and what sort of bias are 5 they talking about in those discussions? 6 A. In these discussions, again, the 7 expert panel is not talking about bias. 8 My read and understanding of the 9 first bullet is that Matt is communicating to 10 this panel work that Mathematica had done on 11 our behalf. And that's what he's sharing. 12 In terms of conversations related 13 to bias in imputation that the current expert 14 panel has had -- and, again, I don't see a 15 attendance document here; so I don't know who 16 was present or not present. 17 But I think that over time, there 18 have been increasing concerns that the bias 19 actually exists in another way, which is that 20 hospitals are getting too much credit. 21 And, again, during this time, 2013 22 to 2025, the emphasis that I talked about early Page 270	1 my -- my read of -- of the discussions. That's 2 not verbatim any discussion I've been a part 3 of. 4 But so -- and I'm sure you have 5 transcripts of many of those meetings, and we 6 could revisit them if you have them 7 available -- 8 Q. Yeah. 9 A. -- so I'm giving my impression of -- 10 as a colleague, not as a member of the expert 11 panel. 12 Q. Yeah. Yeah. 13 So let me -- let me ask you 14 to -- specifically a corporate representative 15 question. 16 A. Yeah. 17 Q. Why does Leapfrog believe that they 18 were giving hospitals too much credit, as you 19 said? 20 A. Because we -- 21 Q. And -- and specifically 22 nonparticipating hospitals. Page 272
1 on about really focusing on patient safety and 2 reducing harm to patients, since that time, I 3 think only two or three additional papers 4 quantifying harm -- so deaths or harm to 5 patients in hospitals -- are really considered 6 definitive that have come out since the IOM. 7 And all of them are estimating things like one 8 in four CMS patients are being harmed by 9 preventable events in hospitals, that if we 10 were to do autopsies on every death in a 11 hospital, medical errors would be the third 12 leading cause of death. 13 And Marty Makary said that, the 14 head of the FDA. 15 So I think as the science has 16 changed, the understanding of preventable harm 17 has changed. Our expert panel's thoughts 18 around imputation have changed, and their 19 concern about biasing in such a way that 20 hospitals would appear safer than they might be 21 is a concern. 22 And, again, that's my conjecture, Page 271	1 A. Yes. 2 Do you want to ask the question 3 again -- 4 Q. Sure. 5 A. -- so she has it and I can -- okay. 6 Q. Yeah. 7 In your corporate 8 representative topic -- thank you -- 9 A. Yes. 10 Q. -- for your help -- why does 11 Leapfrog believe that it is giving 12 nonparticipating hospitals too much credit? 13 A. We had done some analysis -- and 14 when I say "we," not me. So let me actually 15 first clarify that I do no analysis. 16 I believe Hopkins -- Matt Austin or 17 one of his research assistants at Hopkins had 18 done some analysis which was shared with one of 19 our expert panel meetings -- so it may be in 20 the notes -- indicating -- looking at 21 performance over time, hospitals that had 22 dropped out of the survey coming back. So Page 273

1 there was a data analysis that I don't have 2 memorized or in front of me that helped inform 3 that particular opinion. 4 Q. Do you remember when that was 5 presented? 6 A. I don't. So I -- again, I do 7 oversee these programs. I don't do these 8 analysis. I am on the -- the meetings, clearly, 9 but I am doing that for all four of the Leapfrog 10 programs. 11 And I know the Hospital Safety 12 Grade is a big focus of this case, but in my 13 day-to-day work, all the programs are 14 important. And so I don't remember something 15 that specific about this one program. 16 Q. Yeah. And -- and, again, I'm not 17 trying to trick you, or anything to that effect. 18 I'm actually asking because I've never seen 19 it -- 20 A. Yeah. 21 Q. -- and I've looked at many documents 22 in this case. And it seems fairly material Page 274	1 A. No. I did prepare significantly to 2 be sure I could answer these questions; but, 3 again, like, something as specific as a meeting 4 where there's no attendance and I can only see 5 the notes, I'm not going to be able to recall 6 anything beyond that. 7 Q. Tot- -- totally get it. And I'm -- 8 I'm not asking you to do more. 9 And if -- if it's not in the 10 record, so to speak, it's just not in the 11 record -- 12 A. Okay. 13 Q. -- but to the extent we can find it, 14 I think it -- 15 A. Yeah -- 16 Q. -- it would be helpful -- 17 A. -- yeah, I know. 18 Q. -- so that's -- that's why I ask. 19 Okay. So keep going -- I 20 think -- is there anything else on that document 21 to ask? 22 Oh. So just going back to Page 276
1 to -- to Leapfrog's -- I mean, it was where you 2 went in your answer. 3 So I'm trying to triangulate 4 where it might be if it actually -- you know, I 5 don't mean -- 6 A. Yeah. 7 Q. -- discussed, but if it was 8 presented, I'm trying to understand where to 9 find it -- 10 A. Yeah. 11 Q. -- so any help -- help you can give 12 us in that regard? 13 A. I would have to consult or have you 14 consult with Matt Austin. 15 Q. Okay. So the -- so -- so the answer 16 is we have to ask Dr. Austin? 17 A. Yes. 18 Q. Okay. So we -- we'll ask him. 19 A. Okay. 20 Q. But, again, I'm not -- I'm not 21 trying to ask for a memory test. I'm just 22 trying to figure out, like -- Page 275	1 that -- so -- one, two, three -- four bullets 2 down from imputation, do you see There was? 3 A. Yes. 4 Q. There was an open question of how 5 punitive Leapfrog should be for hospitals that 6 do not submit data. 7 And just first question 8 might -- fair to say you don't remember the 9 actual discussion referenced here? 10 A. I don't -- 11 Q. Okay -- 12 A. -- and -- 13 Q. -- do -- please. 14 A. -- I don't. And actually, I'm 15 trying to just recall even the particulars of 16 the methodology in 2020, and nothing stands out 17 at me as being punitive. 18 So, again, if something was 19 discussed, it's not clear, to me, that any 20 action was taken in terms of any changes to the 21 actual methodology. 22 Q. Yeah. So I -- I -- I -- Page 277

1 A. Okay. 2 Q. -- take your point. 3 Prior to this period, there's 4 no imputation at all, right? 5 A. Okay. Yeah. 6 Q. Agreed? 7 A. Yeah. 8 Q. Okay. And then this appears to be 9 the period in which Leapfrog has retained 10 Mathematica to try to assess how it might 11 impute, correct? 12 A. Yes. 13 Q. Okay. And so it seems, to me, that 14 there's a discussion in -- in assessing the 15 right imputation model -- 16 A. Yes. 17 Q. -- of how punitive Leapfrog should 18 be for hospitals that do not submit data. 19 Is that a fair reading of this? 20 ATTORNEY BLAIR: Objection to 21 form. 22 (Whereupon, the witness reviews the Page 278	1 Leapfrog has imposed an imputation methodology 2 to be punitive? 3 A. Yes, absolutely. Leapfrog has never 4 imposed a methodology to be punitive. 5 Q. Even though there have obviously 6 been discussions about whether to be punitive? 7 A. I, personally, have never used that 8 term in my discussion of any of the Leapfrog's 9 rating programs. 10 I did not make these notes. I 11 don't know what the actual discussion was. 12 I guess, to me, that has a negative 13 connotation. It's not a term I use. It's not 14 a term people on my team use. I can't reflect 15 its accuracy here. 16 ATTORNEY CRAIN: Okay. Let's 17 look at Tab 10. 18 Okay. This will be Exhibit 19 -- oh, man. I lost it already. 20 ATTORNEY BLAIR: Eight. 21 THE WITNESS: Eight. 22 ATTORNEY CRAIN: See, Kim, Page 280
1 material provided.) 2 THE WITNESS: Again, I didn't 3 write these notes. I don't remember 4 the discussion, so I don't know if 5 that word, "punitive," is accurate or 6 not. 7 BY ATTORNEY CRAIN: 8 Q. Do you have a personal view as to 9 whether imputation is related to punitiveness or 10 not? 11 A. I have a personal view that 12 imputation in the context of a discussion at the 13 expert panel -- that term could have been 14 used -- 15 Q. Okay. 16 A. -- to -- in the course of a 17 conversation casually or haphazardly -- 18 Q. Is -- 19 A. -- I don't think -- and I know that 20 no one was suggesting that Leapfrog is punitive 21 or anything we're considering would be punitive. 22 Q. Is it your view that at no time, Page 279	1 you're always there for me. 2 ATTORNEY BLAIR: Eight. 3 ATTORNEY CRAIN: Eight. 4 BY ATTORNEY CRAIN: 5 Q. Don't write that. 6 A. Don't write that. 7 --oOo-- 8 (Danforth Deposition Exhibit Number 9 8, E-mail string, Bates stamped 10 LEAPFROG01918816 through 11 LEAPFROG01918821, marked for 12 identification, as of this date.) 13 --oOo-- 14 ATTORNEY CRAIN: I saw you 15 with the pen. I got nervous. 16 THE WITNESS: Thank you. 17 ATTORNEY CRAIN: This is 18 Tab 10. 19 BY ATTORNEY CRAIN: 20 Q. Okay. So this is fast-forwarding a 21 year to 2021. 22 Do you see that? Page 281

1 A. Yes. 2 Q. And it's an e-mail thread between 3 you, Dr. Austin and someone named Emma Domico? 4 A. Yes. 5 Q. Was he -- was she Dr. Austin's 6 assistant or -- 7 A. So Matt has students as assistants 8 throughout the years. Jourdan Dirk is one. 9 You've seen his name -- 10 Q. Yeah. 11 A. -- Preeti Joshi, now you see her 12 name. 13 Emma Dirk was in between. 14 Q. In between. Got it. 15 So if you go to the back page, 16 it starts -- and these e-mails run -- the last 17 one is the first one, the way it's produced. 18 So it starts from Dr. Austin to 19 you, Mr. Card, cc'ing Ms. Domi- -- Domico, 20 April 25th, 2021 at 4- -- 4:59 p.m? 21 Do you see that? 22 A. I do. Page 282	1 A. Oh, sorry -- 2 Q. -- orient you first -- 3 A. -- yes. 4 Q. -- you absolutely may read them. 5 But if you look at your e-mail, 6 the next one at 10:09 a.m. -- you see that? You 7 say, See below? 8 A. Yes. 9 Q. And I just want to make sure we're 10 on the same page. 11 My read of this e-mail is that 12 the black text is Dr. Austin's and the gray is 13 your responses; is that right? 14 A. I don't know. 15 Can I take a second -- 16 Q. Yeah, read it -- 17 A. -- just to read it? 18 Q. -- but I -- I wanted to make sure 19 you saw the See below. 20 A. Yeah. I understand what your 21 question is asking. 22 (Whereupon, the witness reviews the Page 284
1 Q. And he says, Missy, Andrew, Next 2 Friday is the HSG expert panel call. 3 "HSG" meaning hospital safety 4 group -- grade? 5 A. Yes. 6 Q. As Emma and I were walking through 7 the agenda items, we would benefit from your 8 input and expertise. Best, Matt. 9 Do you see that? 10 A. Yes. 11 Q. And then he puts a list of six 12 items. 13 Do you see that? 14 A. Yes. 15 Q. And there's different colors, black 16 and gray? 17 A. Yes. 18 Q. Now, if you go just -- we'll come to 19 them in a second. 20 If you go up one -- 21 A. May I read them, or no? 22 Q. Yeah. I just wanted to -- Page 283	1 material provided.) 2 THE WITNESS: Yes. I believe 3 that Matt asked for input on those six 4 items. I replied back and added my 5 responses underneath. Yes -- 6 BY ATTORNEY CRAIN: 7 Q. In the lighter -- 8 A. -- I think that's correct. 9 Q. -- in the lighter text? 10 A. Yes. 11 Q. Great. 12 Okay. So just now that 13 we're oriented, I want to focus on Bullets 2 and 14 4. 15 He says in 2 -- 16 This is -- these are agenda 17 items, right? 18 A. Um-hum. 19 Q. -- How to score hospital missing 20 process/structural measures. Are we looking for 21 suggestions on imputation methods? 22 A. Um-hum. Page 285

1 Q. And you say, Yes. And the idea to 2 impute for all missing, including Safe Practices 3 and HH "I will send a follow-up to the e-mail 4 Andrew sent. 5 Do you see that? 6 A. Yes. 7 Q. And so does this reflect that you're 8 still working together as a group to try and 9 figure out what the right imputation methodology 10 is going to be? 11 A. So I'm going to have to jog my 12 memory, but we have the Hospital Safety Grade 13 expert panel. For this particular subset of 14 that work where we were just working on 15 imputation, we asked for volunteers to form a 16 small subcommittee that would help us work on 17 the imputation with Mathematica and then report 18 back out to the group, and that's because these 19 people have regular jobs. They serve on a 20 voluntary basis. We don't pay them. They 21 receive no honorariums, and so we can't assume 22 they're all going to want to. Page 286	1 say, like, Matt, that's what I think the agenda 2 is. I might be reflecting back to him, That's 3 what we talked about with the smaller workgroup, 4 so, like, Patrick and Sara. Like, yes, that is 5 the agenda item. Specifically they wanted to 6 talk about this -- I believe is probably what's 7 happening here. 8 I wouldn't necessarily be the one 9 to decide what goes on in the agenda. It may 10 have been part of a smaller subgroup meeting. 11 And based on that discussion, my impression is 12 this is what they wanted to talk about at this 13 meeting. 14 Q. Okay. 15 A. That's all I was saying. 16 Q. Okay. No, I understand. 17 A. Okay. 18 Q. And "HH," is that hand hygiene? 19 A. Yes. 20 Q. Okay. 21 So I want to look at 4 now. 22 A. Yes. Page 288
1 My memory is that it was 2 Patrick Romano, Sara Singer and maybe a third 3 who participated in that smaller group, but I 4 don't -- I want to say Tim Vogus, but I can't 5 remember. 6 So on the record, I know it was 7 Sara Singer and Patrick Romano. 8 And so they -- I don't know at what 9 point we were talking to Sara and Patrick and 10 Mathematica versus the larger group, so I don't 11 -- so if this is the full agenda -- I'm just 12 trying to put all that in my brain the right 13 way. 14 Q. Do -- do you refer to "HSG expert 15 panel" to mean something else ever? 16 A. No. I think that's the full panel. 17 Q. Okay. 18 A. But where I say on Number 2 -- it 19 says, How does -- Matt's saying, like, Should 20 this be an agenda item? And on Number 2, it 21 says, Yes. And the idea to impute all 22 missing -- I'm not responding to him as if to Page 287	1 Q. And the agenda item he proposes is 2 Penalizing hospitals if they don't report, and 3 then he says, in brackets, [is this part of 4 Agenda Item Number 2? And is Leapfrog really 5 open to this idea? If not, I don't want to keep 6 asking their opinions]. 7 So you -- do you see that? 8 A. Yes, and I say, Remove "this is 9 really covered in Number 2. 10 Q. What did you mean by that? 11 A. That we were focusing on imputation. 12 Q. So focusing on imputation. 13 So he is asking is Leapfrog 14 really open to penalization, right? 15 A. I am -- can read the paper what he's 16 asking, yes. 17 Q. Do you agree with me? Is that a 18 fair read of it? 19 A. I'm going to read verbatim what he 20 said, yes. 21 Q. Yeah. Okay. 22 Is Leapfrog really open -- Page 289

1 okay. Got it. 2 And you say, We don't -- 3 remove. We don't -- 4 A. Correct. 5 Q. -- need this agenda item. 6 Right? 7 A. I'm saying, Remove this. We're 8 going to focus on -- remove "this is really 9 covered in Number 2, ideas for imputing. 10 I choked on water. I'm not getting 11 choked up. 12 Q. No, that's okay. I'm getting choked 13 up. 14 A. No, sorry. Wait. Let me clear it 15 up. 16 Q. Yeah, take a second. Take a second. 17 (Pause.) 18 THE WITNESS: Yeah, and I'm 19 saying, Remove this; we're going to 20 focus on imputation. 21 BY ATTORNEY CRAIN: 22 Q. When you say "this is really covered Page 290	1 hospitals if they don't report is really covered 2 in Number 2, correct? 3 ATTORNEY BLAIR: Object -- 4 objection to form: mischaracterizes 5 the testimony. 6 THE WITNESS: Not correct. 7 BY ATTORNEY CRAIN: 8 Q. Okay. Why -- 9 A. I'm saying that -- I'm telling him 10 for the purposes of the agenda it looks like I 11 want to focus on imputation and weighing it on 12 PSI 4, and that's it. So two out of the six 13 agenda items is where I wanted to focus. 14 Q. Okay. 15 A. I don't always write my e-mails in 16 full sentences, particularly with someone I've 17 been working with as long as Matt. So your read 18 and my read may be different, but my intention 19 is to say, I don't want six agenda items. I'd 20 like two. 21 Q. So just to be clear, your testimony 22 is that impu- -- the question of whether to Page 292
1 in Number 2" -- so I'm trying to understand is 2 it -- 3 A. I'm trying to explain. What I would 4 have meant is, We're going to focus on 5 imputation. Let's get the agenda probably just 6 to focus on imputation. 7 Q. But you didn't say to him, We're not 8 penalizing anybody. 9 Right? 10 ATTORNEY BLAIR: Objection to 11 form: asked and answered. 12 THE WITNESS: I didn't write 13 in a full sentence that, no. 14 BY ATTORNEY CRAIN: 15 Q. Okay. And you're saying that the 16 question of How to score hospitals' missing 17 process/structural measures, are we looking for 18 suggestions on imputation methods? 19 That's his Agenda Item Number 20 2, right? 21 A. Correct. 22 Q. You're saying that penalizing Page 291	1 penalize hospitals if they don't report is not 2 covered by the question of how to score 3 hospital's missing process/structural measures? 4 ATTORNEY BLAIR: Objection to 5 form. 6 THE WITNESS: I'm testifying 7 that I don't think I really answered 8 or addressed anything related to 9 penalizing hospitals, but I'm telling 10 him to finalize the agenda with these 11 two items. 12 BY ATTORNEY CRAIN: 13 Q. And not penalization? 14 A. I don't address that topic. 15 Q. Well, you said, "This is really 16 covered in Number 2." 17 ATTORNEY BLAIR: Objection to 18 form: asked and answered. 19 BY ATTORNEY CRAIN: 20 Q. You can answer. 21 ATTORNEY BLAIR: You have to 22 answer it again. Page 293

1 THE WITNESS: I'm testifying 2 that I really didn't address his 3 question of penalizing hospitals. I'm 4 telling him to focus in on an agenda 5 that includes two items -- 6 BY ATTORNEY CRAIN: 7 Q. Okay. 8 A. -- imputation and PSI 4. 9 Q. Okay. And -- 10 A. And do you have the agenda? 11 Q. I don't know. 12 ATTORNEY CRAIN: Do we have 13 the agenda? 14 BY ATTORNEY CRAIN: 15 Q. I'm not sure. We didn't get every 16 agenda, so I don't know if it's because they 17 didn't exist or they weren't produced, but we 18 don't have every agenda. 19 ATTORNEY BLAIR: Lord knows 20 we produced everything. 21 ATTORNEY CRAIN: Okay. Let's 22 go back in time a little bit. I just Page 294	1 ATTORNEY CRAIN: All the 2 lawyers are going to have a heart 3 attack. 4 CERTIFIED STENOGRAPHER: One 5 second. 6 --oOo-- 7 (Danforth Deposition Exhibit Number 8 9, E-mail with attachment, Bates 9 stamped LEAPFROG02383511 through 10 LEAPFROG02383517, marked for 11 identification, as of this date.) 12 --oOo-- 13 THE WITNESS: Thank you. 14 (Sotto voce between cocounsel.) 15 BY ATTORNEY CRAIN: 16 Q. Do you have this, Ms. Danforth? 17 A. Yes. 18 Q. So this is a -- it looks like a 19 performance review from Ms. Binder to 20 Shira Kavanagh. 21 Do you see that? 22 A. Yes. Page 296
1 want to jump there. 2 Let's go to Tab 7 -- 7(a). 3 BY ATTORNEY CRAIN: 4 Q. Now, this, Ms. Danforth, is one of 5 your performance reviews you're going to see. 6 ATTORNEY CRAIN: This is 7 Exhibit 9. 8 ATTORNEY BLAIR: Thank you. 9 ATTORNEY CRAIN: Did I get 10 it? 11 ATTORNEY BLAIR: Yeah. 12 CERTIFIED STENOGRAPHER: Yes. 13 ATTORNEY CRAIN: Okay. I'm 14 not good with the exhibit numbers. 15 THE WITNESS: Oh, I was going 16 to keep one open so I could tell. 17 ATTORNEY CRAIN: Don't write. 18 THE WITNESS: Okay. I'm not. 19 ATTORNEY BLAIR: You can 20 write on it. 21 THE WITNESS: I'll put the 22 cap on the pen so everyone can relax. Page 295	1 Q. And you'll see in the document it 2 shows your self-analysis, right? 3 A. Correct. 4 Q. If you look at the second page, the 5 Self-Assessment in Relation to Position 6 Description? 7 A. Yes. 8 Q. And this is dated December 16th, 9 2020? 10 A. Yes. 11 Q. And I want to -- I actually just 12 have one inquiry I want to focus you on. 13 If you go to Page 83514. 14 Do you see that? 15 A. Yes. 16 Q. And there's a Roman III -- 17 A. Yes. 18 Q. -- and it says, Professional Goals 19 for FY2021 Based On Board-Approved FY2021 Goals. 20 Do you see that? 21 A. Yes. 22 Q. And it says -- now, this is you Page 297

1 writing, correct? 2 A. Um-hum. 3 Q. It says, My professional goals over 4 the next year will include the following: 5 Number 1, Implement and refine the new 6 mathematical imputation model for the Hospital 7 Safety Grade to ensure we are well-positioned 8 not just now, but five years from now. 9 Do you see that? 10 A. I do. 11 Q. What -- what does the "five years 12 from now" refer to? 13 A. I have been on a mission to find 14 other sources of data for the Hospital Safety 15 Grade, who could expand the scope of those data 16 sources. What I said right now, it includes two 17 columns, primary, secondary; it could include 18 tertiary. 19 I was being hypothetical, but also 20 it's been something that I've been interested 21 in. 22 It's been disappointing that there Page 298	1 Medicare patients have Medicare Advantage 2 plans. Those patients aren't calculated when 3 CMS calculates the rates for those claims being 4 its measures. These state-based all-payer 5 claim databases were theoretically an 6 opportunity for us to generate other sources of 7 data that would be available for all hospitals 8 that had not really been available previously. 9 So it's really a specific focus on 10 making sure that we're constantly not just 11 relying on the data that we have today, but 12 thinking ahead to the data that we might need 13 in five years if other data went away. 14 Q. And, again, why do you need that 15 data? 16 A. So we can continue to advance and 17 refine the work that we do. I think I told you 18 the Safety Grade right now includes things like 19 falls, pressure ulcers, medication safety. Of 20 course, that's important, but there are many, 21 many other aspects of patient safety for which 22 we don't have any data because we don't have any Page 300
1 have, to date, been a limited number of 2 national data sources available for Hospital 3 Safety Grade measures. With the recent 4 discontinuation of the AHA data -- by this 5 point, we probably knew about it -- I had a 6 focus on identifying other ways to get data on 7 hospitals. 8 One, I'm sure, is probably talked 9 to in here, and if it's not, it's what -- I 10 talk about all the time, is around this time 11 there was the rise of something called 12 all-payer claims databases, all-payer claims 13 databases. It was an initiative at the state 14 level for basically all of the healthcare 15 providers to put all of their claims into a 16 single statewide database so researchers and 17 others could mine a full, complete claims data 18 set. 19 When I was talking to you about the 20 CMS claims measures, one thing about those is 21 it only includes claims from Medicare 22 fee-for-service patients. Today, a lot of Page 299	1 measures. 2 We're constantly on the lookout for 3 new data and new measures, not just for the 4 Safety Grade but also for the Leapfrog Hospital 5 and ASC surveys. 6 It, again, goes back to our 7 mission: If we're going to reduce harm to 8 patients from preventable medical errors, we 9 need more information about the different kinds 10 of preventable medical errors that occur in 11 hospitals. 12 I haven't even talked about some 13 surgical complications that are very common, 14 other kinds of medical -- 15 Q. Yeah. 16 A. -- complications that are very 17 common: Transfusion of the wrong blood. There 18 are so many harms that take place. We don't 19 have measures or sources of data, and it's my 20 literal job to constantly be on the lookout for 21 those, and actually our expert panel, but I do 22 have it reflected here. Page 301

1 Q. Okay. No, I -- I think I get it. 2 Okay. Let's keep going. 3 ATTORNEY CRAIN: Give me 7 -- 4 no, let's not do 7. 5 BY ATTORNEY CRAIN: 6 Q. Okay. 7 Okay. 8 All right. 9 Okay. I'm going to skip to 10 another topic. 11 A. Okay. 12 Q. I want to talk about 2023 and 2024. 13 Okay? 14 A. Yes. 15 Q. I want to start with -- first, are 16 you familiar with a -- a system called HCA? 17 A. Yes. 18 Q. Okay. In 2023, am I right that HCA 19 stopped participating in the Leapfrog Survey? 20 A. I believe that they did not submit 21 2023 Leapfrog Hospital Surveys, correct. They 22 paused participation for one year. Page 302	1 believe they were asked publicly and said, We're 2 not stopping participation in the survey 3 forever. We're pausing for a year. 4 Q. Got it. 5 A. But I don't think that was something 6 that I inferred. I believe that was something 7 I've seen in writing. 8 Q. Okay. Do you remember where or -- 9 A. I don't. 10 Q. Okay. If not, that's okay. 11 A. Okay. 12 Q. Again, just trying -- trying to, 13 like -- 14 A. I know. 15 And I have a good visual memory, 16 but -- 17 Q. I can tell. 18 A. Yes. 19 ATTORNEY CRAIN: Tab 13. 20 BY ATTORNEY CRAIN: 21 Q. Let's see. 22 So I want to go back to this Page 304
1 Q. Do you know why? 2 A. Yes. 3 Q. Why? 4 A. They had indicated, not to me 5 directly, that they did not want to report on 6 those -- I told you about those nurse staffing 7 and skill mix measures. We had actually only 8 recently added those to the survey probably 9 around 2020, 2023, and they communicated they 10 didn't want to or weren't ready -- I -- this is 11 not verbatim -- want to report on those nurse 12 staffing and skill mix measures. 13 It was not ever shared with me or 14 told to me, but my impression or some 15 assumptions were it had something to do with 16 nursing unions, but I know it was specifically 17 related to those nursing measures. 18 Q. You said "paused for a year." 19 Was -- did you understand their 20 intent was just to take a break and come back? 21 A. I didn't understand that it was 22 their intent. They communicated that. I Page 303	1 period, and there's a -- 2 ATTORNEY CRAIN: This will be 3 Exhibit 10, right? 4 ATTORNEY BLAIR: Yep. 5 THE WITNESS: Yes. 6 ATTORNEY CRAIN: Okay. 7 ATTORNEY BLAIR: By my count. 8 What do I know? 9 THE WITNESS: I'm keeping the 10 last one open now so I always know. 11 ATTORNEY CRAIN: You can 12 help. 13 THE WITNESS: Yeah. With my 14 capped pen. 15 CERTIFIED STENOGRAPHER: One 16 second. 17 --oOo-- 18 (Danforth Deposition Exhibit Number 19 10, E-mail string, Bates stamped 20 LEAPFROG00602604 through 21 LEAPFROG00602605, marked for 22 identification, as of this date.) Page 305

1 --oOo-- 2 THE WITNESS: Thank you. 3 CERTIFIED STENOGRAPHER: You 4 re welcome. 5 BY ATTORNEY CRAIN: 6 Q. Okay. 7 So do you have this in front of 8 you? 9 A. Yes. 10 Q. So this is a document Bates stamped 11 ending 602604, and it's an e-mail thread between 12 and among you, Ms. Campione and Mr. Banerjee. 13 Do you see that? 14 A. I do. 15 Q. And it's, I believe, from -- it's 16 all in November 2023. 17 Do you see that? 18 A. Yes. 19 Q. Okay. And you start the thread. 20 You write to Mr. Banerjee and Ms. Campione. 21 Do you see that? 22 A. Yes. Page 306	1 THE WITNESS: Well, I get 2 asked questions all the time. I'm 3 just used to, like, jumping right into 4 it. So I'm sorry. 5 An Accolade is sort of a 6 term of art. Basically it's a -- 7 it's a -- it's a specific copyrighted 8 logo that Leapfrog licenses to 9 hospitals or ambulatory surgery 10 centers who wish to use one of our 11 specific copyrighted logos only in 12 advertising or marketing. 13 So, for example, we do a top 14 ambulatory surgery center award 15 annually. If an ambulatory surgery 16 center, for example, wanted to put up 17 a billboard to say, We're a Leapfrog 18 top ASC -- they purchase or license 19 the -- we call it a "designated logo" 20 from us. 21 And we do have copyrights 22 protecting those logos, so we do have Page 308
1 Q. And you say, Hi, Kush and Alex, I'd 2 like to get a sense of the number of licensees 3 that don't submit a survey and the percentage of 4 Accolades revenue those facilities represent 5 for, say, the past two years (last four rounds) 6 -- can the two of you work together on this? 7 Do you see that? 8 A. Yes. 9 Q. Do you recall what your -- do you 10 know what you're asking them to do here? 11 A. I was asking them to do an analysis 12 of our Accolades sales. So an Accolade is -- 13 oh. 14 Q. Yeah. What's an Accolade? 15 A. Okay. 16 Q. You got it. 17 A. An Accolade is what -- 18 Q. You do your own follow-ups.. 19 (Laughter.) 20 THE WITNESS: I paused at 21 least. 22 (Sotto voce discussion.) Page 307	1 to show, obviously, that we are -- 2 we're protecting them. 3 Up until this time of 4 August, you would not have seen me 5 asking these questions because my job 6 was a little bit different. So 7 around this time, what's not in this 8 e-mail is we had had a -- I don't 9 know if she was a director -- I don't 10 know her exact title. 11 I apologize -- but either 12 director or vice president of finance 13 and operations. Around this time of 14 August, she had been let go from 15 Leapfrog. She was actually 16 responsible for this Accolade program 17 and also data licensure through 18 supervision of Kush. So Kush 19 reported to her, and her and Kush 20 reported on all of these things. 21 This was not my area of work 22 at Leapfrog at this time in 2023, and Page 309

1	with -- her name was Patrice Brown --	1	six months asking questions like
2	with Patrice's departure, I had a	2	this, and many, many others, just me
3	conversation with Leah where	3	trying to learn. Again, for the
4	basically I volunteered to take on	4	organization, but also because part
5	Kush's supervision, not just because	5	of what I was trying to do was assess
6	I thought it was meaningful to the	6	what our capabilities were and
7	organization, which obviously I do.	7	whether or not this is work he could
8	But, frankly, Kush and I had been	8	really do on his own, if maybe we
9	working together at this point for,	9	needed more staff or more people.
10	like, eight years.	10	So my terminology may or may
11	For a number of different	11	not be correct in some of these
12	reasons, he had reported to, like,	12	things. And I'm not exactly sure
13	four different people in that amount	13	however many other requests like this
14	of time, and I personally knew it was	14	I have. But during this time -- and
15	very difficult for him to have career	15	it would be reflected in his
16	growth within our organization. He	16	performance reviews in the future as
17	kept switching bosses, and then they	17	well -- this was me getting up to
18	would want to see what he was working	18	speed on this part of our business
19	on, and, Well, let's wait a year and	19	trying to assess both the actual
20	see where you're at.	20	business requirements of the
21	Then you switch bosses and,	21	organization but also thinking that
22	like, Oh, well, I'm just getting to	22	he might need extra staff and just
Page 310		Page 312	
1	know what you're working on. Let's	1	trying to really get a sense.
2	wait a year and see where you're at.	2	So Alex Campione is the
3	And I really felt an	3	other person on this e-mail, and
4	obligation and a desire to mentor	4	that's because Kush historically had
5	Kush and make sure that he really had	5	not had other staff to help him do
6	someone stable. I had been at	6	analyses or projects. Alex wasn't
7	Leapfrog at this point --	7	assigned this as part of her regular
8	(Whereupon, as the certified	8	role or job description, so this was
9	stenographer seeks clarification,	9	new to her as well, and it's me
10	colloquy will not be captured on	10	trying to just figure out what my new
11	the written record.)	11	job is going to be, basically.
12	THE WITNESS: Yes.	12	BY ATTORNEY CRAIN:
13	I had felt an obligation and	13	Q. So let -- so let's keep going
14	a desire to really mentor Kush. I	14	down --
15	had been at Leapfrog at this point	15	A. Yes.
16	for 13, 14 years. He had been here	16	Q. -- because I -- so a couple of
17	for eight years. So I said to Leah,	17	questions there.
18	I will -- you know, if it's okay with	18	A. Sure.
19	you, I'll start supervising Kush.	19	Yeah.
20	I didn't know very much	20	Q. So you want to get the sense -- so
21	about this part of the organization,	21	why are you focused on the number of licensees
22	and I spent probably four to	22	that don't submit a survey as opposed to the
Page 311		Page 313	

1 number of licensees that do submit a survey? 2 A. I guess I could have asked it the 3 other way as well. 4 Q. Okay. 5 A. I'm just trying to get a sense of -- 6 of those that license the Accolade, what's the 7 breakdown of those that do and don't submit a 8 survey. And interestingly, I think no one had 9 ever looked at that before. Maybe I asked for 10 some data, or something. Like, I don't know, 11 and I'm like, Oh, well, I'm going to go ask and 12 find out, but it was just something I was 13 curious about. 14 Q. Okay. 15 A. We watch, obviously, you know, the 16 sales data that comes in, but it's, like, 17 numbers. Like -- and I was just trying to get 18 more information. I come from the ratings team. 19 We look at a lot of data. I was just looking 20 for some data. 21 I could have asked the question in 22 a different way and gotten the same answer. Page 314	1 because hospitals were benefiting from the work 2 and resources and investments they were doing. 3 So it was a reflection of those things we were 4 seeing on our help desk. 5 Q. When -- when you say "skip every 6 year," though, doesn't that refer to Step 1 at 7 the time? 8 A. I'm just answering the question 1 9 what questions we are getting. 10 Q. Okay. So you don't think hospitals 11 were saying can we skip a year because our 12 historical score will be imputed? 13 A. Oh. There -- may have been saying 14 both. 15 Q. Okay. Got it. 16 Okay. And then you say, 17 There's the -- there's the risk of reducing 18 incentive to submit a survey every year. 19 Do you see that? 20 A. Yes. 21 Q. Is that referring to Step 1 or 22 Step 2? Page 316
1 Q. Okay. And you say, Due to Step 1 2 imputation and as the means for the Step 2 3 imputed data increase over time, there is the 4 risk of reducing incentive to submit a survey 5 every year --" and I'm starting to see this come 6 through in some of the questions we are getting 7 on help desk. 8 Do you see that? 9 A. Yes. 10 Q. What are you referring to there? 11 A. We were getting questions on help 12 desk -- 13 Q. About -- 14 A. -- from hospitals basically saying 15 could they skip a year submitting a survey. I 16 think I referred to some of those earlier. 17 Also we were starting to get 18 complaints from hospitals, that they felt that 19 the current imputation we were using at this 20 time in 2023, which was more reflective of the 21 means of hospitals that were reporting to the 22 survey, that they weren't fair or accurate Page 315	1 A. I don't know if I was being that 2 purposeful -- 3 Q. Yeah. 4 A. -- in this particular e-mail, but, 5 technically, it would have only referred to 6 Step 1. But to be honest, in this e-mail, I'm 7 not sure I'm focused on the methodology. It was 8 more really a data request. 9 Q. Yeah. 10 Just -- and just to be clear -- 11 A. Yeah. 12 Q. -- Step 1 is the one through which 13 Leapfrog imputes a historical score? 14 A. Correct. 15 Q. So there would be some incentive, if 16 you liked your score the last year, to simply 17 rest on -- 18 A. Potentially, yes -- 19 Q. -- let -- 20 A. -- that would -- 21 Q. -- let's finish -- to simply rest on 22 that score? Page 317

1 A. Yes. 2 Q. Okay. And then you say, I'd like to 3 understand how financial risk if we make changes 4 to how we display grades for hospitals that 5 don't submit. 6 I think there's a missing word 7 there, but -- 8 A. Okay. 9 Q. -- just looking at that, what -- 10 what is the -- we -- we've learned -- I think 11 Ms. Campione called it "Missy speak," I recall. 12 What is the financial risk 13 you're referring to here? 14 A. I don't know. 15 I do remember the first part very 16 clearly because I had seen no data on Accolade 17 licensure. 18 I don't recall specifically -- 19 well, we've made no updates the way that we 20 display Hospital Safety Grades since I've been 21 at Leapfrog. 22 Q. Okay. You don't know what financial Page 318	1 Q. And then Mr. Banerjee responds, 2 Could that be why H- -- HCA suddenly stopped 3 submitting? 4 Do you see that? 5 A. Yes, I do. 6 Q. And that refers to the HCA we 7 discussed a little while -- a few moments ago? 8 A. Yes. 9 Q. Okay. 10 And is -- is it right -- am I 11 understanding that he's theorizing that HCA took 12 a -- took a break, much like some of the other 13 hospitals that you were seeing? 14 A. Correct. And the information I 15 shared with you about HCA taking a pause due to 16 not wanting to report on the nursing measures is 17 not information that would have been shared with 18 him if it hadn't been public. It was likely a 19 conversation in a senior management team 20 meeting. 21 Q. But -- well, you said something was 22 public, right, that HCA said? Page 320
1 risk it could theoretically be? 2 A. I don't because we've never made any 3 changes to the -- 4 Q. Okay -- 5 A. -- display, so I apologize. 6 Q. -- let's go up through the e-mail 7 and see -- 8 A. Yes -- 9 Q. -- if it refreshes your memory. 10 A. -- yeah. 11 Q. Alex says, Not a problem. I already 12 have previous licensing data, but if we want to 13 include this round's licensing, I'll need that 14 data. Kush "Do you have the licensing so far? 15 We could wait a week -- a few weeks so it's more 16 accurate. 17 Do you see that? 18 A. Um-hum. 19 Q. And that reflects what you had said 20 before, that she generally didn't work on 21 licensing? 22 A. Never until then. Page 319	1 A. I read something -- 2 Q. Okay. 3 A. -- I said that I read something. 4 Q. And do you again remember what you 5 had read? 6 A. Just that they were taking a pause 7 and coming back. 8 Q. Okay. But didn't say why? 9 A. No. 10 Q. Okay. And when you say a senior 11 management meeting, who would that include? 12 A. Leah Binder. 13 Q. Okay. So you heard something from 14 Leah Binder about why HCA had stopped 15 participating? 16 A. Yes, specific to the nursing 17 measures. 18 Q. Got it. 19 Okay. So we have to ask her 20 how she heard that? 21 A. Yes. 22 Q. Okay. And then he says, I think we Page 321

1 looked at this trend many years ago, and I 2 believe there was correlation to survey 3 participation and A's, as well as participation 4 on licensing. It will be interesting to see 5 where it is now -- where it is at now. 6 Do you see that? 7 A. I do. 8 Q. So could that be the financial risk 9 that you're referring to, if participation goes 10 down, that revenue will go down? 11 A. It might have been. 12 And I guess at this point when I 13 was asking the question, I didn't know what I 14 didn't know. 15 Some months after this in a 16 different type of a request like this, I 17 learned that actually of all of the A's that -- 18 all of the hospitals that earned an A Safety 19 Grade -- I think about 22 percent were actually 20 licensing those grades. 21 If I had known at the time that our 22 licensure rate for the A designated logo was Page 322	1 Q. Yeah. 2 A. -- like, T-E-L-A-F-F-E-C-T-S. 3 They produce a summary for us. And 4 I believe 22 percent was on the summary deck 5 that I just saw from the spring cycle, so it's 6 fresh in my mind. 7 Q. Got it. 8 Okay. So let me -- 9 A. I -- I -- it would be TelAffects, 10 though, not Ms. Campione. 11 Q. Yeah. So let -- 12 A. Okay. 13 Q. -- let me show you Ms. Campione's 14 deck -- 15 A. Oh, okay. 16 Q. -- that's -- that's where I was 17 going next. 18 ATTORNEY CRAIN: This will be 19 Exhibit 11. 20 --oOo-- 21 (Danforth Deposition Exhibit Number 22 11, Calendar invite, Bates Page 324
1 that low, I likely would not have asked this 2 question as well. But, again, I'd only seen 3 total numbers, not, like, percentages. 4 So, clearly, there's low uptake of 5 licensing the Hospital Safety Grade A, so I 6 would not have been focused on financial risk, 7 since it was already so low. 8 Q. I see. 9 Okay. Well, I take it -- so 10 are you referring to the deck that Ms. Campione 11 prepared? 12 A. I don't know what deck that is. 13 Q. Okay. When you say "22 percent," 14 where are you getting that number? 15 A. We have a third-party licensure team 16 that we work with called TelAffects. 17 Q. Okay. Telemarketers? 18 Is TelAffect- -- 19 A. They're like telemarketers -- 20 Q. Yeah. 21 A. -- yes, but they're called 22 TelAffects -- Page 323	1 stamped LEAPFROG01073566 through 2 LEAPFROG01073581, marked for 3 identification, as of this date.) 4 --oOo-- 5 ATTORNEY CRAIN: And, 6 Ms. Blair. 7 ATTORNEY BLAIR: Thank you. 8 ATTORNEY CRAIN: You're 9 welcome. 10 BY ATTORNEY CRAIN: 11 Q. Okay. This is a document -- I don't 12 know why it's portrait -- or landscape, but do 13 you see it's an e-mail -- or it's a calendar 14 invite from Mr. Banerjee? 15 A. Yes. 16 Q. And it's to you, Ms. Campione and 17 folks from TelAffects, to your point? 18 A. Yes. 19 Q. And attached to this is a slide show 20 deck that Ms. Campione -- I believe it has her 21 name on it. 22 Do you see that? Page 325

1 A. Yes. 2 Q. Do you -- does this refresh your 3 recollection as to this -- this document? Do 4 you recall this? 5 A. Yes. 6 Q. What do -- what do you remember 7 about why she created this? 8 A. Because I didn't want to have to go 9 to the third party to get information. I wanted 10 to be able to generate that quest -- answers to 11 my questions in real time using people who 12 worked at Leapfrog -- 13 Q. Okay. 14 A. -- so I asked her to pull this 15 together herself instead of relying on 16 TelAffects. 17 Q. And then -- and you joined -- you -- 18 you presented it at a meeting with TelAffects, 19 or someone -- 20 A. No, no. I -- I had Alex do this as 21 an alternative to waiting for TelAffects to 22 provide something to us. So Alex would have Page 326	1 is, only about 22 percent of them actually 2 license and use that licensed logo -- 3 Q. Okay. 4 A. -- it had not been my understanding 5 previously that it was that low, frankly. I 6 just didn't know. I had only seen, like, a 7 total number -- 8 Q. Yeah. 9 A. -- and I'm saying that if I had 10 known then that it was only 22 percent out of 11 whatever the total was, I might not have been so 12 concerned with asking about financial risk 13 because the number was so low -- 14 Q. I see. 15 A. -- but this also -- I do see it 16 says, 22 percent licensed that are survey 17 participants and nonsurvey participants, which 18 makes sense. 19 Because, like I said, the majority 20 of hospitals submit surveys, so the majority of 21 hospitals receiving Safety Grades submit 22 surveys. The majority of hospitals -- pretty Page 328
1 done this. 2 Q. Okay. Do you recall if Ms. Campione 3 presented this on this meeting? 4 A. I know I've seen this slide deck. I 5 don't know if it was on the meeting that's 6 attached to this meeting invite, but I -- I know 7 I've seen this -- 8 Q. Yeah. Okay. 9 A. -- slide deck, yes. 10 Q. So just walking through the deck, I 11 want to just focus on -- you mentioned 12 22 percent, and I think that number is on 13 Slide -- there's no numbers, but it's 14 Bates 73575. 15 Do you see that? 16 A. Oh. That's not the -- I do see 17 22 percent, but that's not the 22 percent I was 18 referring to -- 19 Q. Oh, okay. 20 A. -- I was saying that overall, 21 only -- of all of the hospitals that have earned 22 an A Hospital Safety Grade, whatever that number Page 327	1 much every single letter grade is likely also 2 going to be a survey participant just -- 3 Q. Yeah. 4 A. -- by virtue of that. 5 Q. Yeah. 6 Yeah. So can you go two slides 7 back, 73573? 8 A. Yes. 9 Q. And it says, Survey -- you see 10 that -- yes -- bunch of -- 11 A. Yes -- 12 Q. -- little icons? 13 A. -- yes. 14 Q. Survey participants are 10 times 15 more likely to license. 16 A. Yes. 17 Q. And so could that be the financial 18 risk you've been referring to? Participants 19 lead to -- 20 A. No. I'm sorry. At this point, I 21 had no idea the number was this low. 22 This would not have rep -- Page 329

1 22 percent to 2 percent would not have 2 represented -- 2 percent would not have 3 represented a financial risk to me at all. 4 Q. But you didn't know that when you 5 sent the e-mail? 6 A. I had no idea what was -- when these 7 stats -- any stats were related to Accolade 8 licensure when I sent the e-mail, which is why I 9 was asking the question. 10 Q. So what -- what financial risk were 11 you referring to, then? 12 A. I was probably just, again, asking 13 the question. I had not been involved in the 14 finance side of our operations prior to 2023. I 15 may not have been using those terms correctly. 16 I was just asking to see what the 17 breakdown was for my own information. 18 I don't know precisely what 19 financial risk I was referring to at the time. 20 I -- I don't see any financial risk in these 21 numbers as I look at this deck right now. 22 Q. Is -- can financial risk mean Page 330	1 again -- we're talking about the survey -- as 2 possible. So that can grow so far, but it's 3 been incrementally increasing over time. 4 But we've been around 2300, 2400 5 now for several years. It might fluctuate a 6 little bit, but it's -- it's been steady at 7 23-, 2400 for several years. 8 Q. Okay. So still at about that 9 80 percent of inpatient beds over time? 10 A. Yes -- 11 Q. Okay. 12 A. -- yeah, 75 to 80 percent -- 13 Q. Okay. 14 A. -- yes. 15 ATTORNEY CRAIN: We've been 16 going for about an hour -- 17 THE WITNESS: Can I just say 18 one thing? 19 BY ATTORNEY CRAIN: 20 Q. Yeah, sure. 21 A. Sorry. 22 So one of the reasons for that, Page 332
1 something else than loss of revenue? 2 A. I'm -- I don't -- I mean, at the 3 moment, it could have been, like, potential loss 4 of revenue or potential change, or something 5 like that, probably. 6 Q. Okay. 7 Okay. 8 A. Yes. 9 Q. Okay. 10 A. Predeck, postdeck, yes. 11 Q. Okay. 12 All right. Oh, one other quick 13 thing on this deck -- let me just go back to it. 14 Sorry. 15 At this time, was it your 16 recollection that participating was increasing, 17 decreasing or staying the same? 18 A. It's been incrementally, I would 19 say, increasing over time, very incrementally. 20 I think that, you know, the goal is 21 to have as much transparent safety and quality 22 information in this -- coming from the survey Page 331	1 just so it sort of makes sense, is because we 2 do have a lot of health systems that have 3 100 percent participation in the survey. And a 4 lot of those health systems have large 5 hospitals, and so they -- they are large 6 hospitals. 7 Q. So, in other words, a large system 8 could account for a large number of beds, and 9 they stay in and they're stable? 10 A. Yes, yes. And so we don't -- we 11 just don't see a lot of fluctuation, correct. 12 Q. Okay. 13 ATTORNEY CRAIN: Take a 14 little break? 15 ATTORNEY BLAIR: Sure. 16 THE WITNESS: Yeah. 17 ATTORNEY CRAIN: Okay. 18 THE VIDEOGRAPHER: Going off 19 the record. The time is 1429. 20 --oOo-- 21 (Whereupon, a recess was taken from 22 2:29 p.m. EDT to 2:47 p.m. EDT.) Page 333

1 --oOo-- 2 --oOo-- 3 (Danforth Deposition Exhibit Number 4 12, E-mail string, Bates stamped 5 LEAPFROG00297580 through 6 LEAPFROG00297581, marked for 7 identification, as of this date.) 8 --oOo-- 9 THE VIDEOGRAPHER: Going back 10 on the record. The time is 1447. 11 BY ATTORNEY CRAIN: 12 Q. Okay. So I have given you what I 13 think has been marked Exhibit 12. 14 A. Yes. 15 Q. And it's an e-mail. The 16 Bates Number is ending 297580. 17 Do you see that? 18 A. Yes. 19 Q. Do you recognize this e-mail? 20 A. I know that I wrote it. I'm not 21 going to have a recollection on e-mails. I do, 22 like, 500 e-mails a day. But I wrote this Page 334	1 A. Yes. 2 Q. And now just so we're on the same 3 page, to the extent you remember -- 4 A. Yes. 5 Q. -- the -- the methodology at that 6 point had a Step 1 and a Step 2, right? 7 A. Correct. 8 Q. Let's slow down just a -- let me 9 finish. 10 Step 1 was an imputation of 11 historical store -- scores, correct? 12 A. I'm sorry. Are you talking about 13 the spring 2024 Safety Grade methodology? 14 Q. At that time. 15 A. Do you have that document? 16 Q. I think -- we'll -- we'll come to 17 it. If you don't remember, I can -- I can wait, 18 but -- 19 A. Okay. I would prefer to have it in 20 front of me -- 21 Q. Okay. 22 A. -- just so I can be as accurate as Page 336
1 e-mail. 2 Q. Fair enough. Fair enough. 3 Okay. I'll take that. 4 So you see it's February 26th, 5 2024? 6 A. Yes. 7 Q. And you sent to the ratings team? 8 A. Yeah. 9 Q. And is that all of the 10 folks who 10 report to you or a subset? 11 A. This particular e-mail group would 12 not include Kush. 13 Q. Got it. 14 So 9 of the 10? 15 A. Yes. 16 Q. Okay. And so you say, Hi, Everyone. 17 I wanted to let you know that we will be 18 convening the Safety Grade expert panel this 19 spring to discuss updates to the two-step 20 imputation model used to calculate SGs for 21 hospitals that don't submit a survey. 22 Do you see that? Page 335	1 possible. 2 Q. We'll come to it. 3 Okay -- 4 A. Okay. 5 Q. -- so -- so going down -- so you -- 6 you then say -- back to the e-mail -- you're 7 going to discuss updates to the two-step 8 imputation model. 9 And then in the next paragraph, 10 you say, Specifically due to the update to the 11 BCMA measure (i.e., the addition of preop and 12 postanesthesia care units), we will propose to 13 retire Step 1 of the imputation method -- 14 methodology (i.e., use of the most of the 15 current score from the past four rounds of 16 grades) and move entirely to only using Step 2 17 of the imputation methodology (i.e., mean score 18 of hospital's cohort based on first-year 19 performance). 20 Do you see that? 21 A. Yes. 22 Q. Does that refresh your recollection Page 337

1 of what the methodology was at that time? 2 A. So at that time, the methodology 3 would have been -- 4 Q. Don't write -- sorry. I thought you 5 were writing. 6 A. Oh, no. 7 Q. Okay. You're good. You're good. 8 A. I was just following -- 9 Q. Sorry. We're all on edge. 10 ATTORNEY BLAIR: We're all on 11 edge. 12 THE WITNESS: I capped this 13 last section. We have to have trust. 14 No. I -- 15 (Laughter.) 16 THE WITNESS: Yes, we had a 17 two-step methodology previously, if 18 that's the question. Yes. 19 BY ATTORNEY CRAIN: 20 Q. And -- and Step 1 here, it says, Use 21 of the most current score from the past four 22 rounds of grades -- Page 338	1 been -- at least had knowledge of those 2 conversations as well by this point. 3 Q. And -- and just to put a fine point 4 on it, when you say "analysis," does that come 5 in a certain documentary form? 6 A. It would probably be in Excel. 7 Q. Okay. And do you recall 8 specifically when that -- you know, do you 9 recall a specific Excel today? 10 A. No. 11 Q. Okay. 12 A. And to be frank, I often don't see 13 the original Excels. They tend to put it in a 14 easier-to-read table format to put in a Word 15 document for me -- 16 Q. Or -- 17 A. -- I'm not an Excel master. 18 Q. -- or an e-mail? 19 A. Maybe a table in an e-mail, yeah, or 20 a table in a Word document or a table in a 21 PowerPoint slide. I don't typically always see 22 the full Excel document. Page 340
1 A. That's correct. 2 Q. Okay. And Step 2, at that time, was 3 the mean score of hospital's cohort based on 4 first-year performance? 5 A. Yes. 6 Q. Okay. And do you recall why 7 first-year performance? 8 A. We had done some analysis in 9 previous rounds, and because, again, of those 10 concerns that hospitals who were benefiting from 11 these means, and the means were quite high. So 12 I think we looked to see if we could calculate 13 the means of the first years the hospitals 14 reported on these measures as a potential 15 solution. 16 In my recollection, however, I 17 don't know exactly the details of how that came 18 to be. 19 Q. And when you say "we" there, is that 20 Dr. Austin again? 21 A. It would have been myself, 22 Matt Austin. And Alex Campione would have Page 339	1 Q. Okay. But that analysis would have 2 come to you? 3 A. It would have come to me, or they 4 would have told me if there was a difference. I 5 would have known that it occurred. 6 I don't specifically remember 7 physically looking at it, no. 8 Q. Okay. Do you remember when you were 9 told? 10 A. In terms of, like, the mean score of 11 the cohort based on the first-year performance? 12 Q. Yeah. Well, you said there was some 13 analysis done, and I'm trying to figure out if 14 it's documented anywhere. 15 A. It would have been -- so whenever we 16 do things like this, it's going to be documented 17 in a public document called "Proposed Changes to 18 the" -- whatever round hospital scoring 19 methodology, which I know we produced. 20 So it would be, like, fall 2022 in 21 preparation for spring 2023 or spring 2023 in 22 preparation for fall 2022 [sic] a description Page 341

1 that -- actual tables themselves. All of that 2 made it usually in those documents, which we 3 publish on our website. 4 Q. Okay. Got it. 5 Okay. And -- and just sitting 6 here today, you have no present memory of 7 looking at that type of document for this 8 analysis that you're referring to? 9 A. No. 10 Q. Okay. And then you say, If you 11 receive questions about the impact of not 12 submitting a 2024 survey on the fall 2024 13 grades, please note to folks that we are 14 reviewing updates to the methodology, including 15 the imputation methodology, with the expert 16 panel and to announce updates later this spring. 17 A. Correct. 18 Q. Okay. Tell me more what -- like, 19 are those the questions where -- we were talking 20 about before on the Zendesk. 21 A. The review to the methodology? 22 Q. If -- if -- you say, If you receive Page 342	1 aside. 2 We're going to move forward. 3 Okay. So I want to talk about 4 -- you said the -- the expert panel met in 5 April? 6 A. Yes. 7 Q. And so are -- do you -- I want to 8 ask you first for your memories about that 9 meeting, and then we can go to some documents. 10 And we'll take it as it comes. 11 Fair enough? 12 A. Yes. 13 Q. So is it -- so the expert panel met 14 on April 12th, 2024. 15 Do you recall that date? 16 A. Only because, as part of this 17 preparation, I had to look at my calendar. 18 Otherwise, I would not have re- -- recalled that 19 date. 20 Q. So you would look back at your 21 calendar to -- to see when the expert panel met? 22 A. Correct. Page 344
1 questions about the impacts of not submitting a 2 2024 survey -- 3 A. Yes. Yes -- 4 Q. Okay. 5 A. -- we would have received those 6 through Zendesk, correct. 7 Q. Okay. One of the ones we talked 8 about before? 9 A. Yes. A's I said, like, we really 10 like to give hospitals advance -- as much 11 advance notice as possible. So I wouldn't want 12 my staff, if we are about to have the expert 13 panel meet, which they do end up meeting in 14 April, say something and then have to find the 15 ticket and say, I know I told you that in 16 February, but now that it's April, the answer's 17 changed. 18 So I always err around the caution 19 and ask them to just tell them to hold up, and 20 we'll be publishing proposed changes soon. 21 Q. Okay. 22 Okay. So you can set that one Page 343	1 Q. Okay. And did you -- you reviewed 2 Ms. Campione's transcript? 3 A. I scanned Ms. Campione's 4 transcript -- 5 Q. Okay. 6 A. -- which was quite lengthy. 7 Q. It was quite lengthy. We had a long 8 day. I think the one I saw was 500 pages. 9 Did you review her testimony 10 about the April 12th meeting? 11 A. Not word for word. 12 Q. Okay. But to some degree? 13 A. I know that she was asked questions 14 about that paragraph. 15 Q. Okay. So I -- I want to ask you 16 some of the same questions. 17 First, let's start high, 18 30,000-foot. 19 A. Got it. 20 Q. What do you remember about the 21 April 12th meeting? 22 A. Can I tell you what I remember? Page 345

1 Because it's based on what I had to look up to 2 remember. 3 Q. Whatever you remember today -- 4 A. Okay. 5 Q. -- that's what I'm asking for. Your 6 best memory. 7 A. Okay. 8 Q. If it's -- if there aren't memories, 9 that's fine, but your best memory. 10 A. No. So when I looked back at my 11 calendar, I saw that I had -- we had met -- and 12 when I say "we," myself, Matt Austin, Alex 13 Campione had met with one member of the expert 14 panel, Patrick Romano, before the larger expert 15 panel meeting had met. 16 I don't remember it precisely, but 17 my guess is that it was hard to find a date, 18 and the majority of people were available at a 19 certain date and time. And Patrick was 20 available at a different time, so we said we 21 would meet with him on -- one-on-one, but on my 22 calendar, that's how it's notated. Page 346	1 Q. And then any -- 2 A. I was in attendance. 3 Q. Okay. Fair. Yeah. 4 A. Peter Pronovost would have been in 5 attendance, Arjun Srinivasan was in attendance. 6 I know other people were as well. Again, I 7 couldn't recite them, but I did see the list -- 8 Q. Great. 9 A. -- in preparation for today. 10 Q. Okay. And we'll come -- we'll look 11 at that list together. 12 So . . . 13 A. Okay. 14 Q. And then it was over Zoom? 15 A. Yes. 16 Q. And do you know if it was recorded? 17 A. Yes. 18 Q. Okay. Have you watched the 19 recording since? 20 A. No. 21 Q. Have you resumed -- reviewed a Zoom 22 transcript? Page 348
1 Q. And that meeting was about 2 30 minutes? 3 A. The meeting with Patrick Romano was 4 scheduled for 30 minutes. 5 Q. And the -- the larger expert panel 6 meeting was later that day; is that right? 7 A. Yes. That same day for one hour. 8 Q. Between 4:00 o'clock and 5:00 9 o'clock? 10 A. That's how it's scheduled. I don't 11 know that either of them actually ended right on 12 time, both or none could have run over. 13 Q. Fair enough. 14 Now, you -- do you recall who 15 attended the larger meeting? 16 A. I looked at meeting minutes that 17 showed attendance. I could not recite their 18 names off the top of my head right now. 19 Q. Dr. Austin attended? 20 A. Yes. 21 Q. Ms. Campione attended? 22 A. Yes. Page 347	1 A. No. 2 Q. Okay. I want to know -- during that 3 meeting, do you recall whether imputation -- the 4 imputation model was discussed? 5 A. Yes. 6 Q. Okay. Do you remember -- did 7 Leapfrog present possible changes to the 8 imputation methodology to the expert panel in 9 that meeting? 10 A. I believe so, yes. 11 Q. Okay. Do you remember the nature of 12 those changes? 13 A. I don't, but I know they would have 14 been presented in a PowerPoint format. 15 Q. Okay. 16 A. Matt and Alex would have -- 17 Matt Austin and Alex Campione would have 18 prepared them together. I would have reviewed 19 them before the meeting. 20 Q. Yeah. 21 A. But I don't present them, so I 22 wouldn't be able to tell you verbatim what was Page 349

1 on the slide. 2 ATTORNEY CRAIN: Okay. Let's 3 go to the slides. That may be the 4 easiest thing. And -- oh, Emily has 5 the slides. She knew what I was going 6 to go to. 7 So this is Exhibit 13. 8 --oOo-- 9 (Danforth Deposition Exhibit Number 10 13, Calendar invite with 11 attachment, Bates stamped 12 LEAPFROG00437361 through 13 LEAPFROG00437379, marked for 14 identification, as of this date.) 15 --oOo-- 16 ATTORNEY CRAIN: Cindy's 17 nodding. 18 ATTORNEY BLAIR: Thirteen. 19 THE WITNESS: Thank you. 20 CERTIFIED STENOGRAPHER: Sure 21 . 22 ATTORNEY CRAIN: Okay. Page 350	1 believe that you have a copy of those. 2 Q. We'll get there next. 3 A. Okay. 4 Q. Yeah. 5 A. So these were the invitees -- 6 Q. Correct. 7 A. -- not the attendees. 8 Q. Fair enough. 9 A. Okay. 10 Q. And Dr. Romano is not an invitee, 11 correct? 12 A. Correct, because he was on the 13 meeting invite prior -- 14 Q. Correct. 15 A. -- yes. 16 Q. Okay. So going back, do you see the 17 slide deck? 18 A. Yes. 19 Q. Okay. Was this the slide deck you 20 were talking about a moment ago? 21 A. Yes. 22 Q. Okay. And you'll see there's an Page 352
1 Tell me when. 2 I'm waiting for Cindy. 3 CERTIFIED STENOGRAPHER: Than 4 k you. 5 ATTORNEY CRAIN: Of course. 6 Of course. 7 BY ATTORNEY CRAIN: 8 Q. Okay. So this is a meeting invite 9 from Dr. Austin. 10 Do you see that? 11 A. Yes. 12 Q. And this is -- this is the meeting 13 we've been talking about, the one-hour, 14 approximately, meeting for the Safety Grade 15 panel? 16 A. Yes. 17 Q. Okay. And you can see the names of 18 the attendees at the top? 19 A. So those are the people who are 20 invited. I don't know, except for the ones I 21 named, if every single one of those attended, 22 but it would be in the meeting minutes, and I Page 351	1 agenda on Slide 2? 2 A. Yes. 3 Q. And there are two -- there are three 4 points. I really just want to focus on Point 2. 5 Do you see it says, Feedback on 6 reevaluating imputational model? 7 A. Yes. 8 Q. Okay. And this has been a topic we 9 had seen in other expert notes or agendas from 10 earlier periods, correct? 11 A. Correct. 12 Q. Okay. 13 ATTORNEY CRAIN: So let's 14 skip military treatment facilities, 15 that we value them and appreciate 16 their service. 17 Let's go to Slide 4, 18 Reevaluate Imputation Model. 19 BY ATTORNEY CRAIN: 20 Q. Do you see that? 21 A. Yes. 22 Q. Okay. So this slide, I'll represent Page 353

1 to you, Dr. Austin drafted, at least from the 2 documents we've seen. And it says, The problem 3 we are working to solve. 4 Do you see that? 5 A. Yes. 6 Q. And it says Leapfrog -- History: 7 Leapfrog moved to its current imputation 8 approach in 2021 when the 9 American Hospital Association discontinued its 10 survey data license with Leapfrog. (AHA survey 11 had been a longtime secondary data source). 12 Do you see that? 13 A. Yes. 14 Q. Okay. And that was one of the 15 secondary data sources we talked about at the 16 start, right? 17 A. It was. 18 Q. Yeah. And it says, Leapfrog was 19 also seeking ways to grade additional hospitals. 20 Do you see that as well? 21 A. Yes. 22 Q. And -- and, again, why does Leapfrog Page 354	1 Q. Not that. The more favorable choice 2 for lots of hospitals and has de incentivized 3 true transparency performance. 4 A. Likely to anecdotal feedback and 5 stories we're hearing -- hearing, including from 6 some members of the expert panel, that they were 7 hearing that as well. 8 Q. Okay. So not -- not a specific 9 analysis? 10 A. I'm sorry. The part about making 11 imputation a more favorable choice for lots of 12 hospitals? 13 Q. Let me -- let me phrase it this 14 way -- 15 A. Okay. 16 Q. -- for nonparticipating hospitals, 17 you don't actually have the data to assess what 18 their performance is, correct? 19 ATTORNEY BLAIR: Objection to 20 form. 21 THE WITNESS: That wasn't the 22 point I was trying to clarify, so I -- Page 356
1 want to grade additional hospitals? 2 A. Again, because our goal is to 3 provide a public good, a public service, and 4 what's most helpful is for most patients to be 5 able to find information on their hospital. 6 Q. Okay. 7 Now, it says, We are currently 8 facing these challenges, and it has two 9 subbullets. 10 Do you see that? 11 A. I do. 12 Q. So Imputed scores have crept up, 13 making imputation a more favorable choice for 14 lots of hospitals, and has de incentivized true 15 transparency performance. 16 Do you see that? 17 A. I do. 18 Q. Okay. Do you know sitting here 19 today what that conclusion and that bullet is 20 based on? 21 A. That the imputed scores have crept 22 up? Page 355	1 I'm just trying to take us back to the 2 question. 3 BY ATTORNEY CRAIN: 4 Q. I'm -- I'm shifting questions. 5 A. Oh, you're -- okay. Now we're off 6 this question. Okay. 7 Q. We're -- yeah. We're going -- I'm 8 trying to get at it a different way -- 9 A. Okay. 10 Q. -- which, hopefully, will arrive at 11 a clear answer. 12 A. Okay. 13 Yeah. 14 Q. So -- so for nonparticipating 15 hospitals, you don't actually have the data to 16 assess their performance on every metric, 17 correct? 18 A. On those four measures and then the 19 three we talked about, yes. 20 Q. Okay. So is it possible to conduct 21 an empirical analysis to see whether imputation 22 is actually more favorable to them than Page 357

1 completing the survey and getting a report that 2 way -- a grade that way? 3 ATTORNEY BLAIR: Objection to 4 form. 5 THE WITNESS: Is it possible 6 to conduct an empirical analysis . . . 7 I'm not sure I understand 8 the question, so I'm hesitant. 9 BY ATTORNEY CRAIN: 10 Q. No, no. Yeah, always ask. 11 A. Yes, I thought you were asking about 12 the imputed scores have crept up. 13 Q. No. I'm asking about the second 14 part. 15 A. Right. And -- 16 Q. The more favorable choice part. I'm 17 trying to understand how did you all know. 18 A. And I just said it was anecdotal 19 feedback. I -- we hadn't done an empirical 20 analysis -- 21 Q. Okay. 22 A. -- and then you asked if we could Page 358	1 the core problem being raised at this meeting? 2 A. No. 3 Q. Okay. Tell me what you think the 4 core problem was, then? 5 A. The first bullet point, the imputed 6 scores have crept up. 7 Q. Okay. And why is that a problem? 8 A. Because they were getting so high, 9 as I've described before, that we are hearing 10 from other hospitals, members of the expert 11 panel, that they were so high there was concern 12 that they did not reflect performance. 13 And one way to think of it, or how 14 I think about it, is if you say "average score" 15 to someone or "mean score," if it's a 0 to 100 16 scale or a A, B, C, D, F, people think a 50 is 17 the mean or the average, a C is -- is the 18 average. But because these mean scores were 19 being calculated based on hospitals that were 20 actually doing the things that we're asking 21 them to do on the survey, the mean scores in 22 some cases were 90 to 87 -- Page 360
1 have done an empirical analysis, and I was 2 thinking about how we could have done that 3 and . . . 4 Q. Could you have? 5 A. I'm not sure. I wouldn't have been 6 the one to do it or think of how to do it. That 7 would have been Matt and the expert panel. 8 Q. Okay. Fair enough. Fair enough. 9 Thank you. And I appreciate -- the -- the recap 10 was helpful. 11 A. Okay. 12 Q. And then de incentivized true 13 transparency of performance, is that based, 14 again, on anecdotal evidence? 15 A. Yes. 16 Q. Okay. Then it says, Hospitals are 17 using Step 1 imputation (using their individual 18 hospital's historical data) as a reason to not 19 report on the current year's survey. 20 Do you see that? 21 A. Yes. 22 Q. And was that, to your recollection, Page 359	1 Q. Sure. 2 A. -- we were really getting away, I 3 think, from the intent -- what we would call 4 "the intent" of using the mean score, which is 5 really looking for an average score, average 6 performance, and we were imputing a near perfect 7 score. 8 And as these means started to creep 9 up -- again, because we're so transparent, 10 every hospital could see it, whether they're 11 doing a survey or not, because we publish the 12 mean scores in our public methodology 13 documents -- and so you can look back at them. 14 I know you have them all -- and see, Oh, it 15 started at a 79, and then it went to an 88, and 16 then it went to a 92. Isn't the highest score 17 a hundred? 18 Is this really a mean score? In 19 fact, anyone even looking at a table called 20 "mean scores" that see scores like 92 would 21 wonder, Hmm, that's kind of high. 22 And so as -- again, as I've Page 361

1 expressed earlier, we were hearing from 2 hospitals, you know, This is concerning. This 3 isn't fair. Phrases like, These other 4 hospitals are riding our coattails. We were 5 hearing from our subject-matter experts, that 6 they had concerns, Is this really 7 representative? 8 And as a reminder, just why 9 Leapfrog was founded -- I talk about our 10 mission a lot, but that's why I'm standing here 11 today, frankly. Our mission is to, you know, 12 on behalf of purchasers and employers, make 13 transparent information that's available for 14 patients. I think we really started to have 15 concerns that we weren't doing what was best 16 for patients by imputing these scores that were 17 near a hundred. 18 Q. So -- so just to follow up on that. 19 Let's take handwashing, right. 20 So the hand -- you're saying 21 the mean for handwashing for participating 22 hospitals had crept up, correct? Page 362	1 guidelines about one thing. The association 2 for infection prevention list had put out some 3 information about another component. Another 4 evidence-based group maybe had put out -- what 5 our expert -- expert panel did is actually look 6 across all of these different peer-reviewed 7 sources and said, In the creation of an 8 evidence-based hand hygiene standard that will 9 reduce incidences of healthcare-associated 10 infections and pneumonia and COVID, and those 11 kinds of things, what are across all of these 12 sources, all the things that should be in 13 place, and brought those elements together. 14 And that's why it includes those five domains 15 even though I can only remember four. 16 So maybe someone had been focusing 17 on education; maybe someone had been focusing 18 on observations. But no one that we know had 19 actually brought all of these components 20 together in the structured evidence-based way. 21 In the first year that we put the 22 standard out, hospitals told us -- and we Page 364
1 A. So, again, I'm not trying to be 2 nitpicky, but our hand hygiene standard, one 3 element is handwashing, but there are several 4 elements, yes, on our hand hygiene standard. 5 That mean had crept up, correct. 6 Q. Okay. How did you know that 7 nonparticipating hospitals' performance was not 8 also improving? 9 A. It would be difficult for me as 10 someone who's worked at Leapfrog for 16 years 11 talking to hospitals all the time, including 12 hospitals participating in the survey for the 13 first time, that they were doing all of the 14 things it takes to earn -- achieve the standard 15 on our survey. 16 Q. Why would it be difficult? 17 A. Because there was nothing like this 18 before Leapfrog came out with a standard that 19 emphasized these various evidence-based 20 practices. 21 So the WHO, which stands for the 22 World Health Organization, had put out some Page 363	1 published those comments -- that it was very 2 hard for them to do because they had never been 3 asked to do these things before. So I had a 4 good feeling that a hospital that had never 5 done them, that wouldn't be in place. 6 And I haven't had a chance to talk 7 about this, but whenever we publish changes to 8 the Leapfrog Hospital Survey -- we have a very 9 extensive public comment period, just like we 10 do when I publish changes to the 11 Leapfrog Hospital Safety Grade where publicly 12 we talk about, in this case, the new hand 13 hygiene standard. 14 I think that first year we got 600 15 comments from hospitals saying the standard was 16 really hard. We publish responses to those 17 comments, and you can see that process playing 18 out in a very public way in discourse. 19 So I would say just based on that 20 and those 600 comments, it would be difficult 21 for me to assume that a hospital that had never 22 done these things before through the survey was Page 365

1 voluntarily doing them without telling us. 2 Q. So -- so let's -- let's take Delray 3 as an example -- 4 A. Okay. 5 Q. -- right, because Ms. Binder 6 published an op-ed on Delray, which I know 7 you've seen. 8 A. I have not read. 9 Q. Oh, okay. It was sent to you? 10 A. Yeah, I'm sure it was. 11 Q. Okay. You don't know -- 12 A. I may not have -- I'm sure it was 13 sent to me. I did not read it -- 14 Q. Okay. 15 A. -- I don't read everything that gets 16 sent to me. 17 Q. Ms. -- fair enough. That's true of 18 us all. 19 Ms. Binder says that Delray had 20 been an A, right? 21 A. I'm sorry. Do you have -- 22 Q. Sure. We can get you the op-ed. Page 366	1 ATTORNEY CRAIN: Well, we'll 2 read it. 3 ATTORNEY BLAIR: Fourteen. 4 ATTORNEY CRAIN: Fourteen. 5 Okay. 6 --oOo-- 7 (Danforth Deposition Exhibit Number 8 14, Article, marked for 9 identification, as of this date.) 10 --oOo-- 11 ATTORNEY CRAIN: Okay. 12 That's simple work habits. 13 (Laughter.) 14 BY ATTORNEY CRAIN: 15 Q. So this is Ms. Binder's op-ed in 16 The Palm Beach Post. 17 Do you see that? 18 A. Yes. 19 Q. And it says -- if you look at the -- 20 the third full para- -- the last full paragraph 21 on the page, it says, I remember people who 22 worked at one of the hospitals â€” Page 368
1 ATTORNEY CRAIN: Do you want 2 to grab the op-ed? 3 THE WITNESS: I'll -- I'll 4 keep this -- I just -- I don't want 5 to -- 6 BY ATTORNEY CRAIN: 7 Q. No, no. Yeah. 8 A. Okay. 9 Q. Ms. Binder says in her op-ed -- and 10 we'll get you a copy in a second -- that Delray 11 had been an A and that her grandmother had 12 gotten care at Delray and had thought it was 13 very clean and that people were taking the 14 requisite handwashing -- you know, they were 15 doing the right handwashing habits. 16 And we will get you the copy 17 right now. 18 ATTORNEY CRAIN: This will be 19 Exhibit 14. 20 ATTORNEY BLAIR: I'll just 21 object to form: I'm not sure it says 22 that. Page 367	1 Delray Medical Center â€” from 2014. 2 Do you see -- are you with me? 3 A. Mine says, I don't relish this 4 fight, even if -- 5 Q. Yeah. I'm going a couple sentences 6 down. 7 A. Oh, I'm sorry. Yes. 8 Q. No, you're -- you're on the right 9 paragraph. 10 Do you see -- do you see "I -- 11 I remember"? 12 A. Yes. 13 Q. Okay. I remember people who worked 14 at one of the hospitals â€” Delray Medical Center 15 â€” from 2014 when I spent three days there 16 visiting my grandmother, now a blessed memory. 17 At that time -- at the time, the hospital earned 18 an A Safety Grade from Leapfrog, and it showed. 19 It was clear everyone working there paid 20 attention to the simple work habits that can 21 mean life or death for vulnerable patients, like 22 frequent handwashing and double-checking Page 369

1 medication orders. The staff was friendly and 2 kind. 3 Now, do you see that language? 4 A. I do. 5 Q. Delray subsequently stopped 6 participating in this survey, right? 7 How is it that -- so is your -- 8 you just gave me an assumption that hospitals 9 that were not working to achieve Leapfrog's 10 standards could be assumed that they are low -- 11 that their performance is lower than the mean, 12 right? 13 A. Can I correct one thing? 14 Q. Something I said, or something in 15 the op-ed? 16 A. Something related to both. 17 Q. Sure. Go ahead. 18 A. Okay. Because my -- my answer to 19 your questions aren't going to make sense if I 20 don't. I'm sorry. 21 Q. I want your answers to make sense. 22 A. So this says "Delray Medical Center Page 370	1 brain in 2014. 2 Q. And yet Ms. Binder's kind of drawing 3 that connection, isn't she? 4 A. I don't -- 5 ATTORNEY BLAIR: Objection to 6 form. 7 BY ATTORNEY CRAIN: 8 Q. You can answer. 9 ATTORNEY BLAIR: Yeah, you 10 can answer. 11 THE WITNESS: Oh, I don't see 12 her referencing our hand hygiene 13 standard. 14 BY ATTORNEY CRAIN: 15 Q. Well, she says, The hospital earned 16 an A Safety Grade from Leapfrog and it showed. 17 It was clear with -- clear everyone working 18 there paid attention to the simple work habits 19 that can mean life or death for vulnerable 20 patients, like frequent handwashing. 21 So -- 22 A. I don't think she's trying to make a Page 372
1 in 2014." 2 Q. Yeah. 3 A. Leapfrog didn't have a national hand 4 hygiene standard in 2014. Our hand hygiene 5 standard wasn't developed until -- oh, my 6 goodness -- later. 7 Q. Okay. 8 A. I would say -- not exactly sure, but 9 within the past five or six years. So I just 10 want to be clear that in 2014, Leapfrog didn't 11 have the hand hygiene standards we have in our 12 survey now. That's now included in the Hospital 13 Safety Grade. 14 So I can't answer any of your 15 questions related to hand hygiene specific to 16 our standard. 17 Q. I hear you. 18 A. And that's why I wanted to clarify 19 that because we've been talking about so much 20 about that standard, and I just gave you a long 21 response related to that standard. That 22 standard was not even a thought in anyone's Page 371	1 connection to Leapfrog's hand hygiene standard, 2 which didn't exist. I think she's trying to 3 reference something that she personally might 4 have visibly seen. 5 But, again, I -- I'm just reading 6 this now for the first time. I just wanted to 7 be clear that -- 8 Q. Yeah. 9 A. -- we did not have a hand hygiene 10 standard in 2014. That couldn't be what's being 11 referenced here because it did not exist, and I 12 don't want any comments that I might make 13 related to handwashing to be confused that I'm 14 talking about our hand hygiene standard. 15 Q. Okay. You don't think at all 16 reading this that she's connecting the A Safety 17 Grade with the frequent handwashing and 18 double-checking medication orders? 19 ATTORNEY BLAIR: Objection to 20 form. 21 THE WITNESS: So one 22 important aspect that's been a thread Page 373

1 throughout the entirety of the 2 Hospital Safety Grade from 2013 to 3 now -- and, in fact, many of our press 4 releases have actually highlighted 5 this specific set of measures -- are 6 those five healthcare-associated 7 infection measures that we talked at 8 length about from NHSN. 9 At that time in 2014, those 10 infection measures would have been 11 included in here. During that time 12 throughout history, people have 13 associated handwashing with 14 healthcare-associated infections. So 15 it's not unreasonable to think that 16 if a hospital had an A Safety Grade, 17 it may have been related that they 18 had a lower infection rate, which you 19 can't see infection rates, but she 20 may have seen handwashing. But I'm 21 saying there's -- there can be no 22 reference to our hand hygiene Page 374	1 orders? 2 ATTORNEY BLAIR: Objection to 3 form. 4 BY ATTORNEY CRAIN: 5 Q. In general. 6 A. I'm sorry. Is -- is that statement 7 in here as well? 8 Q. I'm -- I'm contrasting with -- 9 A. Oh, I'm sorry. 10 Q. -- yeah -- F hospital is no. 11 I'm just trying to understand. 12 Is it -- is it reasonable to 13 think that an F hospital does not have frequent 14 handwashing and double-checking of medication 15 orders, in general? 16 A. I -- it's really difficult -- can I 17 just read the whole thing? I just want to make 18 sure I understand the context of these things. 19 Q. It's not really a question about her 20 article -- 21 A. Oh, okay. 22 Q. -- it's just a general question. Page 376
1 standard because it just simply 2 doesn't exist. 3 BY ATTORNEY CRAIN: 4 Q. So is it unreasonable to think that 5 an A hospital has frequent handwashing and 6 double-checking medication orders? 7 A. Is it unreasonable to think that an 8 A hospital frequently washes -- 9 Q. Has frequent handwashing -- I'm just 10 using her language -- and double-checking of 11 medication orders? 12 ATTORNEY BLAIR: Objection to 13 form. 14 What year? 15 BY ATTORNEY CRAIN: 16 Q. In the present. 17 A. In general? 18 Q. In general. 19 A. I don't think that's unreasonable. 20 Q. Okay. Is it reasonable to think 21 that an F hospital does not have frequent 22 handwashing and does not double-check medication Page 375	1 A. Is it reasonable to think that an F 2 hospital doesn't have those things in place? 3 Not necessarily. I mean, again, 4 the Safety Grade is made up of 22 measures, so, 5 theoretically, a hospital could not have 6 things -- those things in place and be doing 7 well in the other areas. 8 I've seen all combinations on 9 performance across these 22 measures -- 10 Q. Yeah. 11 A. -- and there's so much variation. I 12 just -- an A hospital might not have it, and an 13 F hospital might not have it because there are 14 so many other things that go into calculating 15 hospital safety. 16 Q. Okay. Let's keep going on this 17 deck. 18 Do you have it up? This was 19 Exhibit -- 20 A. I'm sorry. Are we going back to -- 21 Q. Back to April 12th -- 22 ATTORNEY BLAIR: Thirteen. Page 377

1 BY ATTORNEY CRAIN: 2 Q. -- Exhibit 13 on April 12th. 3 A. Yes. 4 Q. Yeah. That's going to get 5 confusing. 6 Okay. So I want to take you to 7 Slide 7. 8 A. Yes. 9 Q. And we had talked -- you wanted to 10 see what the current imputation model was. 11 Is this an accurate reflection 12 of what the imputation model was at the time? 13 A. Yes, I'm sure it is if it's on this 14 slide. 15 Q. Okay. Do you want to take a second 16 to look at it, or are you confident of that? 17 A. If you're going to ask me detailed 18 questions about it, I will -- I will scan it. 19 Q. Okay. 20 (Whereupon, the witness reviews the 21 material provided.) 22 THE WITNESS: Yes, this is Page 378	1 the panel in the meeting? 2 A. On these slides or through 3 discussion? 4 Q. Either/or. 5 A. Through discussion, many other 6 options -- 7 Q. Okay. 8 A. -- were discussed, which is my 9 recollection -- 10 Q. Okay. 11 A. -- but we brought Proposed Future 12 Impu- -- Imputation Methodology, Slide 13, to 13 the panel. Through their discussion, other 14 ideas surfaced, but this is the only one that we 15 proposed. 16 Q. Got it. That's helpful. 17 Do you remember, sitting here 18 today, what the other ideas were at the meeting? 19 A. Through discussion, yes. And that's 20 why I remember Arjun Srinivasan being at the 21 meeting. My recollection is that he suggested 22 rather than imputing means, we should impute 0. Page 380
1 correct. 2 BY ATTORNEY CRAIN: 3 Q. Okay. That's all I wanted to know, 4 if it was accurate. 5 So let's go to Slide -- I'm 6 going to skip to -- let's see -- Slide 13. 7 A. Yes. 8 Q. And this slide says, Proposed Future 9 Imputation Methodology. 10 Do you see that? 11 A. Yes. 12 Q. And so I'm going to walk you through 13 this slide. 14 Here is -- to your 15 recollection, is this slide the methodology that 16 Leapfrog proposed to the safe -- to the Safety 17 Grade expert panel? 18 A. By virtue of it being in this deck 19 and attached to this -- attached to this e-mail 20 notice, yes. 21 Q. Okay. Do you have any reason to 22 believe any other proposal was put forward to Page 379	1 Arjun Srinivasan is a military 2 doctor. He's one of the highest ranking 3 military physicians at the CDC. He is a 4 lifelong epidemiologist. 5 One of his many roles is to oversee 6 that NHSN program, that healthcare-associated 7 infections program. He's one of the foremost 8 scientists in the world related to patient 9 safety and, particularly, infection 10 prevention -- just his criterion -- 11 Q. Get it -- 12 A. -- in case you don't know him -- 13 Q. -- yep. 14 A. -- I remember him suggesting that we 15 impute 0. 16 I believe Dr. Peter Pronovost had 17 suggested that we take a look at maybe 18 imputing, like, the lowest quartile -- instead 19 of the mean, the lowest quartile performance. 20 There may have been other 21 recommendations as well. The 0 stuck out the 22 most to me. Page 381

1 Q. Let me ask you, on -- on the lowest 2 quartile proposal, was he propose -- what -- 3 what does that mean? How does that -- is that a 4 mean of the lowest quartile? 5 A. So we had been imputing these means, 6 which, again, in my mind, weren't really 7 reflecting what we meant by mean or average 8 score. They were in the 90s, 80s, et cetera. 9 I think in proposing quartiles and 10 the lowest quartile, the bottom quartile -- I 11 don't remember exactly -- he was thinking we 12 need to impute a number that's less than this, 13 right. Like, these are clearly too high. 14 He had been one actually to share 15 that he was hearing from hospitals why would we 16 do the survey when I can get this phenomenal 17 score imputed? And so he was brainstorming 18 verbally, how about the lowest quartile. 19 I don't remember if it was the mean 20 or the lowest quartile -- or the lowest 21 quartile. And I would not have been the one to 22 calculate it, so I may not have been zeroed in Page 382	1 -- done, right? 2 A. Correct. 3 Q. Instead, you narrowed Step 1 from 4 four surveys to, I think, two; is that right? 5 A. No. It's close. 6 Q. How did -- how did I get -- confuse 7 that? 8 A. Okay. So it's not four surveys 9 because the surveys are annual -- 10 Q. Got it. 11 A. -- and so they're used in two -- 12 Q. Got it. 13 A. -- different safety scores -- 14 Q. Okay. 15 A. -- two different Safety Grades -- 16 Q. Yep. 17 A. -- so we narrowed it from the past 18 four rounds of the Safety Grade to the past two 19 rounds of the Safety Grade -- 20 Q. I'm always conflating. Yeah. Got 21 it. 22 Okay. So just to restate it -- Page 384
1 on that exact wording. 2 Q. Let -- let me ask just the question. 3 If it wasn't the mean of the 4 lowest quartile, do you know how it would 5 otherwise have been calculated? 6 A. It would just be the lowest quartile 7 scores. He would just array, I believe, all of 8 the scores. And I think there's a formula that 9 you can -- 10 Q. Fair enough. 11 It's beyond my pay grade, too. 12 Okay. Now, going back to this 13 Slide 13 -- 14 A. Yes. 15 Q. -- just walking through briefly, it 16 says, Retire Step 1 Imputation for all measures. 17 Do you see that? 18 A. Yeah. 19 Q. That was what -- one of the things 20 you proposed, right? 21 A. Yes. 22 Q. And that was not ultimately conduct Page 383	1 A. Yes. 2 Q. -- so you took it -- Step 1 you took 3 from the past four Safety Grades to two rounds 4 of Safety Grades? 5 A. Correct. 6 Q. Okay. Then Step B here says, An 7 imputation for all hospitals of CPOE, BCMA and 8 hand hygiene. 9 Do you see that? 10 A. Yes. 11 Q. And it looks like there are a few 12 options here. 13 Assign hospitals that do not 14 complete the most recently Leapfrog survey to 15 cohorts; Calculate the mean of scores obtained 16 in each hospital's first year of reporting on 17 the current standard by the Leapfrog Hospital 18 Survey -- 19 A. Yes. 20 Q. -- and then Hospital is assigned the 21 mean for their cohort. 22 Do you see that? Page 385

1 A. Yes. 2 Q. And that was ultimately not adopted 3 either, right? 4 A. Correct. 5 Q. Okay. And instead, for Step 2, 6 Leapfrog imposed the limited achievement score, 7 correct? 8 A. Leapfrog imputes the numerical score 9 associated with the performance category for 10 each individual measure as limited achievement, 11 yes. 12 Q. In Step 2? 13 A. Yes. 14 Q. And Step 1 is still historical, 15 correct? 16 A. Correct. 17 Q. Yeah. Okay. 18 Okay. And that is the end of 19 this slide deck in this topic. 20 Do you see that on the next 21 slide, New Measures Under Consideration -- 22 A. Yes. Page 386	1 refreshed in preparing for today. 2 Q. Okay. 3 Tell me -- tell me what you 4 remember -- what you refreshed on. 5 A. I just reviewed other documents 6 related to the meeting because I couldn't 7 remember the -- 8 Q. You mean the meeting minutes? 9 A. Yeah -- yeah -- 10 Q. Okay. Let's -- let's go to that -- 11 A. -- there are meeting minutes, yes. 12 Q. -- yeah, we have that next. 13 ATTORNEY CRAIN: Let's -- is 14 that 30A? 15 Yeah. 16 Okay. 17 All right. Oh, boy. This 18 is Exhibit 14 -- 19 THE WITNESS: Fifteen. 20 ATTORNEY CRAIN: Fifteen. 21 Okay. 22 ATTORNEY BLAIR: Oh, man. I Page 388
1 Q. -- talking about hypo- -- 2 hyperglycemia? 3 Do you see that? 4 A. Yes. 5 Q. Okay. Let's see. 6 So I think -- does this refresh 7 your recollection as to what was discussed at 8 the meeting? It sounds like it may, given what 9 you remembered about Arjun. 10 A. So I remembered the comments from 11 Arjun and Peter because I was surprised to hear 12 0 -- 13 Q. Yeah. 14 A. -- that felt interest -- that felt 15 extremely -- like, you -- you kept saying, Isn't 16 that the lowest number, and I was like, No, 17 that's not the lowest number. 18 So that -- and I remember Peter 19 specifically talking about hearing from 20 colleagues why do the survey because they could 21 have this other -- there are other details of 22 the particular meeting, though, that I Page 387	1 had them out of order. 2 THE WITNESS: Because we went 3 out of order. And the article is 14. 4 ATTORNEY BLAIR: Yeah. 5 ATTORNEY CRAIN: Okay. 6 --oOo-- 7 (Danforth Deposition Exhibit Number 8 15, E-mail string, Bates stamped 9 LEAPFROG00205986 through 10 LEAPFROG00205990, marked for 11 identification, as of this date.) 12 --oOo-- 13 THE WITNESS: Thank you. 14 BY ATTORNEY CRAIN: 15 Q. Okay. You ready? 16 A. Yes. 17 Q. Okay. These are the -- the -- 18 you've -- this is one of the documents you 19 prepared for today -- looking at? 20 A. Yes, because I couldn't remember who 21 attended the meeting, and this has them all 22 listed. Page 389

1 Q. I see you got excited there. 2 Okay. So let's start at the 3 top -- 4 A. Yes. 5 Q. -- this is Exhibit 15. It's 6 Bates Number 205986 -- 7 A. Yes. 8 Q. -- and it -- the last e-mail is from 9 you to Ms. Campione: Can you save in expert 10 panel folder? 11 Do you see that? 12 A. Yes. 13 Q. And what is the expert panel folder? 14 A. When Matt or Preeti send out the 15 materials we have on our shared drive, where 16 my -- the staff is supposed to save the document 17 so I don't have to search for them in e-mail -- 18 Q. Fair enough. 19 A. -- it happens about 50 percent of 20 the time. I want to be on the record for that. 21 Q. Documents started helping. 22 Yeah, I got it. Page 390	1 Okay. Now, this -- so let's 2 just walk down this -- this document together. 3 It says, Meeting Notes, at the 4 top. 5 Do you see that? 6 A. Yes. 7 Q. And Friday, April 12th, 2024, from 8 4:00 to 5:00 p.m. -- 9 A. Yes. 10 Q. -- you see that? 11 Wow. Late Friday meeting. 12 And do you -- just looking at 13 these attendees, do you have any reason to think 14 that this is incorrect? 15 A. No. 16 Q. Then it looks -- if you look just at 17 the document from the 30,000-foot level -- 18 A. Yes. 19 Q. -- you see it's three agenda points, 20 right? 21 A. Yes. 22 Q. And those correspond to the three we Page 392
1 A. Problem. 2 Q. All right. Let's -- let's go to 3 the -- the notes. 4 Now just -- just some -- some 5 table setting -- 6 A. Yeah. 7 Q. -- is there a process by which the 8 notes are created? 9 A. I don't create the notes -- 10 Q. Okay. 11 A. -- Matt's research -- Matthew 12 Austin -- Matt Austin's research assistant has 13 always sent out the notes. 14 I think Matt and his research 15 assistant take the notes, and then they 16 consolidate them and then they send them out. 17 No one at Leapfrog -- none of my 18 staff take any notes during any expert panel 19 meetings -- 20 Q. Okay. 21 A. -- that are used for the record. 22 Q. Got it. Okay. Page 391	1 saw in the deck, right? 2 A. Yes. 3 Q. Okay. 4 Slow down. Yeah. You've got 5 to not interrupt for -- for Cindy. 6 So I want to focus on Number 2. 7 And it says, Proposed changes to the imputation 8 model. 9 Now, it starts with Matt 10 provided the expert panel with a quick overview 11 of the current imputation model approaches 12 Leapfrog has been using and some of the 13 challenges those approaches have created for 14 issuing accurate grades. 15 Do you see that? 16 A. Yes. 17 Q. And then the next bullet lays out 18 the current model at that time, right? 19 A. Yes. 20 Q. Analogous to the slide we looked at, 21 right? 22 A. Yes. Page 393

1 Q. Yes. 2 And then it says, Leapfrog's 3 proposal was to retire Step 1 of the model and 4 use only Step 2, assigning hospitals the mean 5 score for their cohort. 6 Do you see that? 7 A. Yes. 8 Q. And that -- that -- to the best of 9 your recollection, that's what happened? 10 A. Yes. 11 Q. Arjun mentioned one of the concerns 12 with the current Step 2 imputation method is if 13 a hospital is performing very poorly, they could 14 choose to not submit a survey and get a better 15 score than their actual performance by just 16 being part of a certain cohort. 17 Do you see that? 18 A. Yes. 19 Q. And is that the -- the -- one of the 20 problems we saw on that first slide? 21 A. Yes. 22 Q. Okay. Peter asked whether Leapfrog Page 394	1 equivalent of Willing to Report to hospitals 2 that do not submit a survey. 3 Do you see that? 4 A. Yes. 5 Q. And what -- what does "willing to 6 report" mean? 7 A. So "willing to report" is the old 8 term we used to use instead of "limited 9 achievement" that was associated with one filled 10 cell phone bar. 11 So Leapfrog's public reporting 12 website has gone through some evolutions, and 13 those four descriptive performance categories 14 that we described have gone through some 15 evolution. 16 So if you looked at a survey from 17 probably 2020, 2021, 2022, instead of "limited 18 achievement," you would see "willing to 19 report." 20 Q. Got it. 21 Okay. 22 A. Um-hum. Page 396
1 has a way to keep the low-performing hospitals 2 in the lowest quartile using this Step 2 3 imputation model. 4 Correct? 5 A. Peter did -- that's noted here, yes. 6 Q. Yeah. 7 And -- and that -- that's 8 consistent with the memory that you talked about 9 earlier today? 10 A. Yes. 11 Q. Did you -- did you have that memory 12 before you refreshed yourself with this 13 document? 14 A. I didn't remember anything from this 15 meeting before I refreshed myself with this 16 document. 17 Q. Got it. Just to be clear. Okay. 18 Understood. Many years ago -- or actually, one 19 year ago. 20 The expert panel were in 21 support of having hospitals share their current 22 performance, so liked the idea of imputing the Page 395	1 Q. Do you have an independent 2 recollection of whether anybody specifically 3 raised the phrase "willing to report"? 4 A. I don't. 5 Q. Okay. So you're not -- you don't 6 recall today whether this bullet is accurate? 7 A. I don't. 8 Q. Okay. Then, Peter noted that 9 Leapfrog's message on this change will be 10 critical because, if done correctly, it can help 11 enhance focus on safety; otherwise, it has the 12 potential to backfire. 13 Do you see that? 14 A. Yes. 15 Q. Okay. Do you recall what he meant 16 by that? 17 A. Probably that hospitals would be 18 angry. And he knows that I take those calls, 19 and he likes me and cares about my health and 20 well-being. 21 Q. Fair enough. 22 And -- and to the -- and to Page 397

1 that point, you said, Missy asked the expert 2 panel to what extent the health systems that 3 wanted to partner with Leapfrog could help 4 deliver this message. 5 A. Yes. 6 Q. Do you recall raising that? 7 A. Yes. Probably when Peter said his 8 part, I said, Oh, Peter, you're volunteering to 9 help -- 10 Q. Okay. 11 A. -- I'll take your help and find 12 friends. Yeah. 13 Q. Do you -- do you recall thinking 14 that hospitals would be upset with this change? 15 A. I recall thinking that hospi- -- 16 hospitals are going to be upset with any change 17 that we make to the methodology. So -- and I -- 18 I think I told you a lot of the calls I take are 19 with hospitals, explaining changes. 20 And in this particular regard, we 21 had gotten some strongly worded e-mails from 22 hospitals on the other side saying how can Page 398	1 --oOo-- 2 (Danforth Deposition Exhibit Number 3 16, Text string, Bates stamped 4 LEAPFROG00139558 through 5 LEAPFROG00139561, marked for 6 identification, as of this date.) 7 --oOo-- 8 THE WITNESS: Thank you. 9 BY ATTORNEY CRAIN: 10 Q. Okay. Are we ready? 11 A. Yes. 12 Q. Okay. So, Ms. Danforth, this is 13 Exhibit 16. It's a Slack chat between you and 14 Ms. Campione and a Slackbot. 15 Do you see that? 16 A. Yes. 17 Q. And it's dated April 12th. 18 You see that? 19 A. Yes. 20 Q. Okay. And it -- it's -- that's the 21 date of the meeting, right? 22 A. Yes. Page 400
1 Leapfrog do this. I assumed we would be 2 getting strongly worded e-mails saying how can 3 Leapfrog do this now. 4 Q. Got it. 5 Okay. Is there anything else 6 you remember from the meeting besides the things 7 noted on this document? 8 A. No, except as I -- as I think I've 9 already described, there would be, like, a video 10 and a Zoom transcript. I just haven't rewatched 11 the video and haven't read the Zoom transcript. 12 Q. Okay. 13 Okay. Let's see. 14 ATTORNEY CRAIN: Sorry. Just 15 give me one minute. 16 BY ATTORNEY CRAIN: 17 Q. Okay. So I want to just go through 18 one other thing. 19 A. Okay. 20 ATTORNEY CRAIN: Let's go to 21 Tab 17. This is a Slack chat. 22 Sixteen. Page 399	1 Q. And I'm just going to focus you on, 2 first, 2:24. 3 Do you see that time stamp? 4 A. Yes. 5 Q. And it says, Missy, I can only be on 6 the phone during the SG panel call. Do you 7 think that will be an issue? 8 And Ms. Campione says, I don't 9 think so. Matt will be leading and is making 10 the case for the imputation change. I'm 11 assuming he brushed up on the new measures. 12 You say Okay, and then you say, 13 And I know the slides. 14 Do you see all that? 15 A. Yes. 16 Q. Okay. And then several hours pass 17 by and -- I want to focus you on 4:42. 18 Do you see that? 19 A. Yes. 20 Q. And you say, Sara ans Peter sold 21 this for us. 22 A. I think that's a typo. Page 401

1 Q. Yeah. I just wanted to read it 2 accurately before Kim objects. 3 So I assume you meant "and"? 4 A. Yes. 5 Q. Yeah. 6 Do you -- do you have a present 7 recollection of what you meant, "Sara and Peter 8 sold this for us"? 9 A. Yes, because I had to -- I reviewed 10 this -- 11 Q. Okay. 12 A. -- I had to review all of these 13 things to remember. And I think I was 14 indicating that they were strongly supporting 15 whatever our idea was. 16 Q. Okay. The idea on the deck or the 17 idea that ultimately became the model? 18 A. I don't know. Just that we were 19 going to make a change. 20 Q. Okay. And then you say, I wish 21 Patrick was on this call. 22 Any -- Page 402	1 So I did have to refresh my memory. 2 I did -- 3 Q. Yeah. 4 A. -- not have a strong memory of this. 5 Q. Okay. So -- so you say, 4:42, 6 pushing the bottom 25 percent idea -- 7 A. Yes. 8 Q. -- is that Dr. Pro- -- Pronovost's 9 quartile thought? 10 A. I think so -- 11 Q. Okay. 12 A. -- I mean, again, I -- I can't -- I 13 don't know what slide was up at the time or 14 where we were in the transcript, but that makes 15 sense based on the notes. 16 Q. Yeah. 17 And then you say, I secretly 18 love that. 19 Any idea -- with lots of 20 exclamation points. 21 Any idea why? 22 A. I thought it might help the idea of Page 404
1 A. Yes. 2 Q. -- recollection as to why? 3 A. Because he wasn't, one -- 4 Q. Fair. 5 A. -- but I -- probably because -- so I 6 didn't remember this, but I -- again, in my 7 preparation and review to make sure I was 8 prepared, in reviewing e-mails, I did see 9 e-mails from Patrick. 10 I am making the assumption that 11 when we had our call with Patrick, he was not 12 as enthusiastic about changes as Sara and 13 Peter. But I honestly don't remember the call 14 -- remember the call with Patrick. It is on my 15 calendar. I'm sure I was there. I just don't 16 have a recollection of the call. 17 And on this call, again, because I 18 said -- I was only on the phone, so I know -- I 19 do remember being on the phone. I'm sure I 20 reviewed the slides before they were presented, 21 but I must have been, like, on my phone 22 Slacking Alex. Page 403	1 using quartiles as something that is commonly 2 used. Everyone typically -- though 3 three minutes ago we said no one knew, but most 4 hospitals would know what quartiles were. So if 5 we said "the bottom of quartile," they would 6 understand this. 7 At this time, too, I think that we 8 all thought it would solve this creeping-up 9 problem and that the bottom quartile score 10 would be lower than the mean. 11 Q. And do you -- it sounds like you -- 12 you recall whether that was true? 13 A. When we -- my -- my recollection is 14 that when we looked at it, the bottom quartile 15 was not much lower than the mean -- 16 Q. Okay. 17 A. -- so, actually, it wouldn't have 18 solved this problem, and Peter would not have 19 supported that. 20 Q. Why do you think Peter would not 21 have supported that? 22 A. Because his -- the context of this Page 405

1 is they're getting scores that are too high. So 2 if the -- the mean is too high and the -- the 3 bottom quartile is just slightly lower, I don't 4 think he would have supported that. 5 Q. So -- but, again, how do you know 6 that they're too high? 7 A. Feedback from my -- the expert 8 panel. They were, like -- they -- they gave us 9 feedback that these scores -- these can't be 10 means. How can a mean be a 72 or -- we can read 11 off the chart, but . . . 12 Q. Okay. 13 But I guess the means are too 14 high for the nonparticipating hospitals, too? 15 Am I not understanding that right? 16 A. The means are too high to be imputed 17 for nonparticipating hospitals because there was 18 not face validity that nonparticipating 19 hospitals were even performing at this level. 20 And, again, I'll go back to hand hygiene. 21 I remember when we put out the 22 nurse staffing and skill mix measure, which we Page 406	1 imputation. 2 Q. Sorry. Which document -- you're 3 looking at the deck from the meeting? 4 ATTORNEY BLAIR: Exhibit 13. 5 THE WITNESS: Yes. That you 6 produced to me as Exhibit 13. 7 BY ATTORNEY CRAIN: 8 Q. Um-hum. All right. Let's see. 9 Sorry. I had set it aside. 10 Got it. Yep. 11 A. And can you go to Page 10? 12 Q. Um-hum. 13 A. And if you look in the right-hand 14 side -- 15 Q. Yep. 16 A. -- these scores were just extreme -- 17 extremely high. I mean, I think people were 18 just very concerned. And, again, this wasn't me 19 saying like, Wow. I bet the hospitals are doing 20 this or not doing this. It is so fresh in my 21 memory because I, personally, reviewed the 600 22 comments from hospitals saying, This is very, Page 408
1 knew would be hard because hospitals don't 2 necessarily want to tell people what their 3 nurse-to-patient ratio is -- and we knew that, 4 you know, unions can be a tricky issue, right. 5 We're funded by employers. We get that. But 6 they have some of the strongest evidence of 7 being tied to patient outcomes. 8 When this hand hygiene measure came 9 out, we got inundated with comments from 10 hospitals saying, This is impossible. No one 11 can do this. Like, these requirements are too 12 strenuous. And, again, these were all 13 published in that Leapfrog Hospital Survey 14 public comment document where we responded. 15 So to think again that a hospital 16 that had never done our survey might not even 17 be familiar with the elements of our 18 standard -- I'm going back to the document 19 where -- that includes the -- the PowerPoint 20 that we shared with the expert panel. 21 If you can go to Page 10 where we 22 have the spring 2024 cohort means for Step 2 Page 407	1 very difficult. It's very, very hard to do. 2 Q. This is -- so just to make sure I'm 3 on the same page, this -- the line -- it says, 4 Step 2 Hand Hygiene Score (Mean of Cohort)? 5 A. Yes. 6 Q. And they're mostly in the 50s and 7 60s? 8 A. Yes. 9 Q. Okay. And, ultimately, what's 10 imposed is 15, right? 11 A. Correct. 12 Q. Why such a big difference? 13 A. So, again, we had already -- oh, no, 14 we haven't talked about this. 15 In previous rounds of the Hospital 16 Safety Grade, we had identified this new data 17 source for ICU physician staffing called the 18 CMS cost report. We did talk about this. 19 Q. Yes. 20 A. Through that CMS cost report, we 21 could tell whether or not hospitals operated in 22 an adult or pediatric ICU. A's I said, that Page 409

1 response, if I was making a comparison to the 2 questions on the Leapfrog Hospital Survey and 3 you said, Yes, you operate in ICU, and then we 4 didn't know about the other things, would have 5 yielded a score of -- based on our public 6 scoring algorithms, those rubrics I keep 7 referring to -- of limited achievement, which 8 then has that numeric value assigned to it. 9 We had done that change, I think, a 10 full year, two rounds, before spring 2024 and 11 did two rounds of announcements and public 12 comments to give hospitals adequate time to 13 review the change so we can understand if there 14 would be any challenges or problems using the 15 CMS car -- or cost report. Maybe there's 16 something we didn't know. 17 And because previously using the 18 AHA data, hospitals had much higher scores. 19 Imputed from AHA are calculated based on AHA, 20 and we're going to get the score of 5. And, 21 actually, for all of the imputed measures, the 22 ICU physician staffing has the lowest numerical Page 410	1 together, that Spring 2025 Safety Grade 2 Methodology document -- 3 Yeah. 4 -- can we bring that up again? 5 Q. Uh-huh. 6 A. Exhibit 3. 7 Q. Uh-huh. 8 A. So these tables that we've been 9 looking at -- 10 Q. Yep. 11 A. -- that show the Leapfrog measures 12 and the four performance categories and the 13 scores associated, these tables have not changed 14 since the inception of the Hospital Safety 15 Grade. So these tables and these values are 16 very, very familiar to hospitals. So even if 17 you're not theoretically doing a 18 Leapfrog Hospital Survey, you've seen these 19 tables four times a year for as long as you've 20 been getting a Hospital Safety Grade. 21 So the familiarity aspect of it, 22 for me, was a positive. Page 412
1 score associated with limited achievement. In 2 other cases, it's -- it's 25, and got no 3 comments whatsoever about that change. 4 So that change of aligning the 5 point value imputed with limited achievement, 6 for that one measure, had been in effect for 7 two rounds of the Hospital Safety Grade. We 8 had not received comments from hospitals who 9 had that imputation used to calculate their 10 grade. 11 And so I think that when we were 12 looking at this particular change that ended up 13 coming about, I believe I said, Well, actually, 14 we have been doing this for ICU physician 15 staffing, and we've gotten no feedback -- 16 negative feedback whatsoever, and naively maybe 17 thought there would be acceptability around it 18 because we had been doing it for a year for 19 another measure already. 20 Q. Okay. 21 A. Because one thing to remember is 22 that that document that we keep looking at Page 411	1 Q. But how does that justify taking 2 means that were in the 50s and 60s and imputing 3 a score of 15? I just don't -- 4 A. We didn't think that the means in 5 the 50s and 60s were accurate. 6 Q. A's to -- as to nonparticipating 7 hospitals? 8 A. Correct. 9 Q. And why was that? Why is that? 10 A. A's I've described, we were 11 receiving feedback from participating hospitals 12 that these things were very difficult to do, and 13 the panel did not have strong beliefs that 14 nonparticipating hospitals would do these 15 things. 16 I can use another example, if that 17 would be helpful. 18 Q. No, I -- I'd like to focus back on 19 my questions, if I can. 20 A. Yes. Um-hum. 21 Q. Let's go back to this document with 22 the Slack Chat. Page 413

1 A. Yes. 2 Q. Okay. So you see Ms. Campione goes 3 back -- and I want to go to -- okay. 4:45, 4 Ms. Campione says, If we made Step 1 just the 5 previous survey, it would at least make the 6 lapse in survey participation short term, and 7 they can't fall back on Step 2. 8 You say, Oh, so, like, Step 1 9 or 0? 10 And then she says, The Step 2 11 means are so high, what if we used Step 1, 12 (limited to only, say, two round), then assigned 13 them to the bottom performance category? 14 Do you see that, 5:03? 15 A. Yes. 16 Q. And then you say, That would be 17 drastic, but let's talk about it, LOL. 18 Do you see that? 19 A. Yes. 20 Q. Okay. Is Ms. Campione's Chat at 21 5:03 the same as the model that was ultimately 22 imposed? Page 414	1 You can set this aside. Okay. 2 A. Set this aside? 3 Q. Yep. 4 A. Okay. 5 Q. Okay. 6 ATTORNEY CRAIN: Can we go 7 off? We've been going about an hour. 8 ATTORNEY BLAIR: Sure. 9 ATTORNEY CRAIN: Yeah? Okay. 10 THE VIDEOGRAPHER: Going off 11 the record. The time is 1545. 12 --oOo-- 13 (Whereupon, a recess was taken from 14 3:45 p.m. EDT to 4:06 p.m. EDT.) 15 --oOo-- 16 THE VIDEOGRAPHER: Going back 17 on the record. The time is 1606. 18 BY ATTORNEY CRAIN: 19 Q. Okay. 20 All right. So we're going to 21 look at a new document. I just want to talk it 22 through a little bit. Page 416
1 A. Yes. 2 Q. Why did you think it was drastic? 3 A. It was different from what we were 4 proposing. 5 Q. But you didn't say it would be 6 different. 7 Everything is different, right? 8 A. I really don't know why I used that 9 choice of word. I just -- it was very different 10 than what we were proposing. 11 Q. Okay. It was a significant change, 12 right? 13 A. It was a big change. 14 Q. And it was a change that as the 15 notes noted from Dr. Pronovost, could be taken 16 poorly, right? 17 A. Correct. 18 ATTORNEY BLAIR: Objection to 19 form: mischaracterizes the document. 20 BY ATTORNEY CRAIN: 21 Q. I just had one other question. 22 Oh, no -- let's see. Page 415	1 A. Okay. 2 Q. I want to talk a little bit about 3 Dr. Pronovost's quartile model. 4 A. Yes. 5 Q. So I just want to -- so do you -- 6 we'll have Cindy mark this as Exhibit 16. 7 ATTORNEY CRAIN: Right? 8 CERTIFIED STENOGRAPHER: Corr 9 ect -- no, 17. 10 ATTORNEY CRAIN: Seventeen. 11 ATTORNEY BLAIR: Yeah, I 12 didn't even know. 13 Thank you. 14 --oOo-- 15 (Danforth Deposition Exhibit Number 16 17, E-mail string, Bates stamped 17 LEAPFROG00220682 through 18 LEAPFROG00220686, marked for 19 identification, as of this date.) 20 --oOo-- 21 BY ATTORNEY CRAIN: 22 Q. Okay. So this is an e-mail, Page 417

1 Ms. Danforth. 2 A. Yes. 3 Q. The last one is from you. 4 Do you see that? 5 A. Yes. 6 Q. And I want to go to Ms. Campione's 7 e-mail, which I think leads off the discussion 8 at 5:41 p.m. on April 25th, 2024. 9 Do you see that? 10 A. Yeah. 11 Q. And that's that two -- almost two 12 weeks after the April 12th meeting, a little 13 under? 14 A. Yes. 15 Q. Okay. And she says, I have some 16 bad/good news. The Step 2 scores aren't what we 17 would like. Turns out the hospitals that do the 18 survey perform very well. The BCMA scores below 19 will likely drop with the methodology changes, 20 though. 21 Do you see that? 22 A. Yes. Page 418	1 Q. Okay. So then we have Mean of 2 bottom quartile. 3 A. Correct. 4 Q. Do you see that? Okay. 5 A. I do. 6 Q. And that is reflexive of 7 Dr. Pronovost's idea that we -- we look to 8 impute the bottom quartile in some capacity, 9 right? 10 A. Yes. 11 And, again, I don't recall if he 12 asked for the mean of the bottom quartile or 13 the bottom quartile, but I believe -- I 14 believe, as I just spoke to this, what I had 15 said is actually described here. So the mean 16 of the bottom quartile is 77 for CPOE. That's 17 very near the mean. 18 So the bottom quartile and the mean 19 are virtually identical. 20 Q. Yes. 21 A. When he made the suggestion, what I 22 was implying, and I believe what he was Page 420
1 Q. Okay. And -- and what it says here 2 is -- she -- she has a chart where it lays out 3 CPOE, hand hygiene and BCMA, right? 4 A. Yes. 5 Q. Yes. Sorry. We need verbal 6 answers, yeah. 7 And then the -- so do you have 8 any understanding of what 20 -- we have this 100 9 on 25th percentile column. 10 Do you know what that means? 11 A. Yes. 12 At the top 25th percentile, the 13 cutoff score would have been 100. So the top 14 25 percent of hospitals, their score is 100. 15 Q. Okay. Got it. 16 So that's -- so 25th percentile 17 basically means top 25th percentile? 18 A. Just based on the numbers being 100, 19 I'm interpreting it that way. 20 Q. Okay. Should be the first quartile, 21 basically? 22 A. Yes. Page 419	1 implying, is that he was expecting it to be 2 lower because in true regular distribution 3 quartiles, the top quartile would be, say, 75 to 4 a hundred and then 50 to 75 -- 5 Q. Sure. 6 A. -- and then 25 -- and the bottom 7 quartile would be somewhere between 0 and 25 -- 8 Q. Yeah. 9 A. -- not 77 -- 10 Q. Yeah. 11 A. -- so I didn't have this in front of 12 me earlier, but this is what I was trying to 13 describe in the previous questioning. 14 Q. Yes. 15 And then if you get to the top, 16 you say, This is sort of what I was afraid of, 17 but somehow more stark seeing the actual 18 numbers. I do think we at least need to 19 cowider -- 20 Which I think means "consider"; 21 is that right? 22 A. I bet that is right. Page 421

1 Q. -- going to limited achievement. 2 Do you see that? 3 A. Yes. 4 Q. Okay. And, again, limited 5 achievement for some of these scores is orders 6 of magnitudes less, right? 7 A. It's less. 8 Q. It's significantly less, right? 9 A. It's less. 10 Q. Well, a lot less or a little less? 11 A. It's less. Again, it depends. 12 There's a range. We're talking about 5, which 13 had already been in place for a year; in some 14 cases, it's going to be 25. A's you pointed 15 out, some of the hand hygiene scores were around 16 49 or 50. So it depends on the measure; it 17 depends on the cohort. It's less. 18 Q. Okay. And then what -- just to -- 19 just to be clear about it, when you say "this 20 was sort of what I was afraid of," what do you 21 mean there? 22 A. I thought the bottom quartile would Page 422	1 high, and we are afraid that it's not reflecting 2 what's actually happening in these hospitals. 3 And at Leapfrog, our actual mission on our 4 website, on our stationery. But in our life and 5 all the days and all the work that we do every 6 day, again, is to reduce harm to patients from 7 preventable medical errors. If we're 8 overassessing hospitals' performance on these 9 measures, we're not reducing harm to patients 10 from preventable medical errors. 11 And I realize it probably sounds 12 very simplistic when I describe it that way, 13 but that is really our intention. And the 14 intention of our expert panel as to our 15 researchers, specifically in patient safety, 16 who have been doing this work in some cases 30, 17 40 years, long before I've been to Leapfrog, is 18 also to reduce harm to patients from 19 preventable medical errors. 20 And so it was a genuine -- not just 21 as an expert panelist, right, but as 22 Dr. Pronovost and Arjun Srinivasan, I think a Page 424
1 resemble or be identical to those mean scores. 2 Q. Okay. 3 A. I thought they would be very 4 similar. I didn't think they would be that 5 similar, but I thought they would be very 6 similar -- 7 Q. Yeah. 8 A. -- and so that's exactly what I 9 meant. 10 Q. And why did you want them to 11 ultimately not be similar? 12 A. So, again, to go back, what we were 13 trying to do is address a problem that both 14 hospitals and the expert panel had communicated, 15 which is these imputed scores for these -- and, 16 again, I want to actually start calling it three 17 measures because by this point, we're already 18 computing a different score for IC physician 19 staffing. 20 Is that okay? 21 Q. IPS. Sure. 22 A. So for these three measures, is too Page 423	1 genuine concern that we weren't doing what was 2 best for patients in this methodology, if we 3 were overestimating what they thought was 4 realistic for hospitals that weren't submitting 5 a Leapfrog Hospital Survey. 6 And I realize I've said that in a 7 few different ways, but it's important because 8 our intentions are really aligned around this 9 mission. 10 And whether or not we're saying 11 every other sentence what's best for the 12 patient, what's best for the patient, what's 13 best for the patient, all of this dialogue is 14 focused on what we think, in our opinions, is 15 best for the patient. 16 Q. Is it -- is it best for the patient 17 to convey accurate information? 18 A. In this particular situation, I 19 personally felt that it was going to be 20 challenging to keep having the expert panelist 21 support these high means, and you -- you sort of 22 see that in this. They really didn't feel like Page 425

1 it was accurate. 2 A previous alternative imputation 3 methodology, which had been in place for a 4 year, reflected what ended up happening for 5 these three measures later, right. We're 6 imputing that numerical score associated with 7 limited achievement for IPS for a year, then we 8 end up doing this for these three. 9 At that time, based on the 10 discussion and based on the analyses and based 11 on what you've just showed me, I agreed with 12 the expert panel, that I thought this was the 13 right decision to make in terms of a next step 14 for the -- the methodology -- 15 Q. So I want to break that -- 16 A. -- and -- and to be clear, I have 17 confidence in this methodology. I -- I'm the 18 one that ultimately have -- has to talk to the 19 hospitals, be on the phone talking about the 20 methodology. 21 Q. So I want to break that down -- 22 A. Sure. Page 426	1 A. We do. 2 Q. Okay. And that's what you 3 communicate to consumers, right? 4 A. We communicate to consumers all of 5 the information on the Web page that we looked 6 at. 7 Should we bring that up again and 8 look at it? 9 Q. No. I want to ask you -- 10 A. Okay. 11 Q. -- my questions because I'm just -- 12 I'm mindful of our time. 13 A. Yeah, we communicate to consumers 14 all of the information that we've talked about 15 today, including the fact that if we don't have 16 information from a hospital because they've 17 declined to provide it, that we have assigned 18 them -- 19 Q. Yes. 20 A. -- the worst possible score. We 21 indicate that with an asterisk, and we call out 22 in 18-point font that is associated with the Page 428
1 Q. -- there's a lot in that answer. 2 A. Yeah. 3 Q. You said you have confidence in the 4 methodology. 5 A. Yes. 6 Q. Does that mean you believed that the 7 methodology conveys accurate information -- 8 A. I do, Melissa Danforth. 9 Q. Let me finish. Let me finish. 10 A. Sorry. 11 Q. Do you believe that the methodology 12 conveys accurate information about the 13 hospitals? 14 A. I do. 15 Q. Okay. And you said, "I do, 16 Melissa Danforth." 17 A. Yes. 18 Q. Does Leapfrog believe, in your 19 corporate representative capacity, that the 20 Hospital Safety Grade for nonparticipating 21 hospitals conveys accurate information about 22 those nonparticipating hospitals' performance? Page 427	1 worst possible score, that's correct. 2 Q. So a consumer going to the website 3 that says an F at Delray, is it Leapfrog's view 4 that what Leapfrog is communicating -- 5 A. I can't speak to the website. 6 Q. Fair enough. 7 You can speak to the Safety 8 Grade, correct? 9 A. Yes. 10 Q. Okay. When a consumer sees the 11 Safety Grade and they see it's an F, does that 12 communicate that the hospital has poor 13 performance, or does it communicate that the 14 hospital has not participated? 15 ATTORNEY BLAIR: Objection to 16 form. 17 BY ATTORNEY CRAIN: 18 Q. Nonparticipating hospital? 19 A. Neither. 20 Again, the Hospital Safety Grade is 21 a composite measure. It's made up of 22 22 different measures. There's a lot of measures Page 429

1 within the Hospital Safety Grade where we do 2 have lots of information. For example -- I 3 think you used Delray Hospital. 4 Q. Yes. 5 A. I believe at that particular 6 hospital, for example, we have all of their 7 patient experience measure scores for those five 8 patient experience measures. 9 We have scores for three -- what's 10 called hospital-acquired conditions: foreign 11 objects retained, falls and trauma, air 12 embolism. We have scores for all five 13 healthcare-associated infections. We have 14 scores for patient safety indicator 04, which 15 looks at death from treatable complications 16 following surgery, and also PSI 90, which, 17 again, is that 10. 18 So the Hospital Safety Grade, I 19 don't think, communicates a hospital does or 20 does not have one or two or three things. 21 That's why it's a composite. And that's why my 22 understanding is -- we make all those gas Page 430	1 earlier exhibits. 2 Q. Exhibit 3, I want to say. 3 ATTORNEY CARDONE: Exhibit 4. 4 ATTORNEY CRAIN: Four? 5 Oops. 6 THE WITNESS: And to be 7 clear, this is me speaking as 8 Missy Danforth about -- 9 BY ATTORNEY CRAIN: 10 Q. Yeah. 11 A. -- the gas gauges, which are on the 12 website. 13 Is it 4? 14 ATTORNEY CARDONE: Yes. 15 THE WITNESS: Oh. 16 ATTORNEY CRAIN: Are you sure 17 it's not 3? 18 BY ATTORNEY CRAIN: 19 Q. Yes. That one (indicating). 20 A. Okay. 21 Q. Okay. So I'm on this page, and I 22 see on Page 2, handwashing, right? Page 432
1 gauges available so consumers can go through 2 each one and look at performance on an 3 individual thing. 4 So, for example, if you're not 5 having surgery, you may not care about the 6 surgical measures or -- 7 Q. So, I -- I want to ask you about 8 those gas gauges now that you bring them up. 9 A. Sure. 10 Q. The gas gauge for handwashing has a 11 limited achievement, right, for Delray? 12 A. The gas gauges are a -- a graphical 13 depiction of a hospital's performance in 14 relation to the average score for that measure. 15 So the way you just described it is not correct. 16 Q. Okay. 17 A. Can we look at it -- 18 Q. Absolutely -- 19 A. -- together so I can show you? 20 Q. -- yes. 21 A. Okay. 22 So I believe that was one of the Page 431	1 A. So this isn't what it looks on the 2 website the way this printed, but can you go to 3 the second page of the printout? 4 Q. Yeah. 5 A. Okay. 6 So the gas gauges have three colors 7 that are displayed on them and then, like, a 8 little needle. 9 Q. Yes. 10 A. Okay. So this is meant to be, like, 11 the key, I think is the correct -- kind of like 12 the -- 13 Q. Sure. 14 A. -- key to say what the -- okay. 15 ATTORNEY BLAIR: For the 16 record, can she say what she's 17 pointing to? 18 THE WITNESS: Sure. 19 ATTORNEY BLAIR: Because I 20 can't see what -- 21 THE WITNESS: So this is 22 the -- Page 433

1 BY ATTORNEY CRAIN: 2 Q. Oh. 3 A. -- hospital performance key that 4 goes under the gas gauges, where, reading left 5 to right, worse than average is the color red, 6 and then average is the color yellow, and then 7 green is the color better than average -- 8 Q. Sure. 9 A. -- so what the gas gauges 10 communicate are: green, better than average; 11 yellow, average; or red, worse than average. 12 And then to provide context to 13 that, the scores are then listed on the side 14 here, on the left, where it says, This hospital 15 scores a 15 -- again, with that asterisk -- the 16 best hospital score is 100; the average 17 hospital score is 74.40. 18 So 15 is less than 74.40 because 15 19 is associated with the worst score. I'm not 20 looking at it, but the gas gauge should be red. 21 Q. So is Leapfrog confident that 15 is 22 an accurate reflection of Delray's handwashing Page 434	1 15 -- and I can't say it clearer than 2 it's written -- was assigned to 3 reflect the last of it -- lack of 4 information available based on 5 guidance from our national expert 6 panel. 7 BY ATTORNEY CRAIN: 8 Q. So why give a score? 9 A. Based on guidance from our national 10 expert panel. 11 Q. Okay. So you're -- you're -- 12 Leapfrog -- your speaking for Leapfrog because 13 we're talking about the scoring methodology, 14 right? 15 A. I am. 16 Q. And so Leapfrog gives this limited 17 achievement score because of guidance from the 18 national expert panel, right? 19 A. Yes. 20 Q. And where did that guidance come 21 from? 22 A. Discussions with the national expert Page 436
1 score? 2 ATTORNEY BLAIR: Objection to 3 form. 4 THE WITNESS: We've assigned 5 that numerical score -- 6 BY ATTORNEY CRAIN: 7 Q. No. Ms. Danforth, I'm sorry -- 8 A. -- to reflect the lack -- 9 Q. -- Ms. Danforth -- 10 A. -- of information available. 11 Q. -- I'm -- I'm sorry. I really would 12 like for you to answer my question. 13 ATTORNEY BLAIR: She is. 14 ATTORNEY CRAIN: She's not, 15 consistently. 16 BY ATTORNEY CRAIN: 17 Q. So is Leapfrog confident -- is -- is 18 the score of 15 an accurate reflection of the 19 hospital's performance on handwashing? 20 ATTORNEY BLAIR: Objection to 21 form. 22 THE WITNESS: The score of Page 435	1 panel that we've been talking about. 2 Q. Okay. Was it ever conveyed to 3 Leapfrog that the panel approved of limited 4 achievement for this type of a metric for 5 handwashing? 6 A. I'm not sure that we've ever used 7 the word "approved" or "disapproved." We 8 typically use things like "support" -- the panel 9 "supports," the panel "agrees." 10 We can go back to the notes. 11 Can we do that? 12 Q. No, we can't -- 13 A. Oh, okay. 14 Q. -- because I'm -- I -- I'm on a 15 limited time and I want to focus you. 16 A. Okay. Then I can't say that it's -- 17 it would be supports or agrees. 18 Q. Okay. Supports or agrees. 19 A. Um-hum. 20 Q. Who made the decision to impose the 21 limited achievement score for handwashing for 22 nonparticipating hospitals? Page 437

1 A. A's I've described earlier today in 2 my testimony, it is a process with all of the 3 people involved that I've previously testified: 4 the expert panel, including Patrick Romano on an 5 individual call; myself; Matt Austin. And that 6 would have been discussed with Leah Binder as 7 well. 8 Q. Okay. Let's go to Dr. Romano. 9 Let's -- 10 ATTORNEY CRAIN: This is 18? 11 CERTIFIED STENOGRAPHER: Yes. 12 ATTORNEY CRAIN: Okay. 13 THE WITNESS: I'm out of 14 order now. 15 ATTORNEY CRAIN: I'm getting 16 it. 17 Thank you. 18 ATTORNEY BLAIR: Oh, thank 19 you. 20 --oOo-- 21 (Danforth Deposition Exhibit Number 22 18, E-mail string, Bates stamped Page 438	1 the imputation approach used in Leapfrog's 2 Hospital Safety Grade, we met with the broader 3 safety expert panel to hear their input and have 4 drafted the attached language to share with 5 hospitals about the proposed changes. 6 Do you see that? 7 A. I do. 8 Q. Okay. Then he goes on. He -- 9 he's -- he's asking for Dr. Romano's expertise 10 and perspective, correct? 11 You see that on the last 12 sentence? 13 A. Yes. 14 Q. Okay. So he follows up -- if you go 15 up the chain, on May 14th, he had got no 16 response, so he -- he pings Dr. Romano again. 17 And then Dr. Romano writes 18 back. 19 Do you see that? 20 A. Yes. 21 Q. Now, have you reviewed this e-mail 22 in your preparation today? Page 440
1 LEAPFROG01081490 through 2 LEAPFROG01081491, marked for 3 identification, as of this date.) 4 --oOo-- 5 ATTORNEY CRAIN: Are we on? 6 THE WITNESS: Yes. 7 BY ATTORNEY CRAIN: 8 Q. Okay. I mean Cindy's on. 9 CERTIFIED STENOGRAPHER: I 10 am. 11 ATTORNEY CRAIN: You're the 12 most important person. 13 BY ATTORNEY CRAIN: 14 Q. Okay. So this is an e-mail. If you 15 look -- go to the bottom, it's -- it's an e-mail 16 from Matt Austin to Dr. Romano, cc'ing you and 17 Ms. Campione. 18 Do you see that? 19 A. Yes. 20 Q. And he's proposing -- he's saying, 21 Since our conversation with you a couple of 22 weeks ago -- this is May 7th -- about changing Page 439	1 A. Yes. 2 Q. Okay. So you're aware and, 3 presumably, you have memorized this document, as 4 you have many others, that Dr. Romano lays out 5 two hypotheses for why hospitals are not 6 participating in the survey. 7 Do you see that? 8 ATTORNEY BLAIR: Objection to 9 form. 10 THE WITNESS: So, first, I 11 haven't memorized it. And so, no, now 12 I don't see that. 13 BY ATTORNEY CRAIN: 14 Q. Okay. 15 Okay. So he says -- if you 16 look in the middle, he says, The underlying 17 hypothesis -- 18 A. Yes -- 19 Q. -- do you see that? 20 A. -- I do. 21 Q. The underlying hypothesis behind 22 your proposed Step 2B approach was that Page 441

1 hospitals start -- stop reporting because their 2 true performance deteriorated relevant -- 3 relative to their cohort. 4 Is that an accurate view of 5 your hypothesis at the time? 6 ATTORNEY BLAIR: Objection to 7 form. 8 THE WITNESS: A's we've 9 discussed, it was not that hospitals 10 just stopped reporting, but some 11 hospitals had never reported. 12 I'm not exactly sure what 13 this is referring to, but, no, that's 14 not how I would've described this at 15 all, and that's not how we've been 16 talking about it. 17 BY ATTORNEY CRAIN: 18 Q. Okay. Is it -- is it inconsistent 19 with your view that hospitals were not 20 reporting -- responding to Leapfrog's survey 21 because their true performance had deteriorated 22 relative to their cohort? Page 442	1 performance -- 2 Q. Okay. 3 A. -- and I have been influenced by 4 those papers. 5 Q. Can you identify any of those papers 6 today? 7 A. I couldn't, but -- off the top of my 8 head, no. 9 Q. Okay. He says, My hypothesis, by 10 comparison, was that most hospitals stop 11 reporting because it is too burdensome and 12 because the -- they only find market value in an 13 A grade, which proves impossible to attain or 14 maintain. 15 Do you see that? 16 A. I do. 17 Q. Okay. So his -- his theory, at 18 least for hospitals who stopped reporting -- I 19 take your point -- are -- is that it's too 20 burdensome, right? 21 A. That is his theory, yes. 22 Q. And did you disagree with that Page 444
1 ATTORNEY BLAIR: Objection to 2 form. 3 THE WITNESS: So, again, the 4 means are assigned to hospitals who 5 maybe have never done the Leapfrog 6 Hospital Survey. 7 So it's not like I did a 8 survey; I got bad; I stopped 9 reporting; they're assigning these 10 means. It's also I've never done a 11 survey in 20 years. 12 And so, no, this is not 13 correct. 14 BY ATTORNEY CRAIN: 15 Q. Okay. Fair enough. 16 Is it consistent with your view 17 that the hospitals who have never done a survey 18 are necessarily lower performances than the mean 19 of their cohort? 20 A. It is not necessarily my personal 21 view. I believe there have been public papers 22 indicating that transparency can be a driver to Page 443	1 hypothesis? 2 A. I don't see a response from me, but 3 I likely would not have agreed with that 4 hypothesis, correct. 5 Q. I -- I'm asking today. 6 Do you -- 7 A. Yes. No, I don't agree with that. 8 Q. And Leapfrog does not agree with 9 that hypothesis? 10 A. I don't think Leapfrog would agree 11 with that hypothesis. 12 Q. Okay. And then what he says, if you 13 -- if you look throughout the e-mail -- I want 14 to start at the top now. He -- he says, I like 15 the simpler, more direct approach here -- if the 16 goal is to penalize nonparticipants, you might 17 as well do so in a clear and unmistakable manner 18 while allowing for hospitals to manage their 19 burden and jump back on the wagon after a year. 20 Do you see that? 21 A. I do. 22 Q. What is your response to Page 445

1 Dr. Romano's view that the goal is to penalize 2 nonparticipants? 3 A. Complete disagreement. 4 Q. Okay. Tell me why. 5 A. Because we've never talked about 6 penalizing hospitals. We've talked about 7 incentivizing hospitals. We don't talk in terms 8 of penalizing hospitals. 9 And that's why I think I took 10 exception to the couple documents where you're 11 showing me it used the word "punitive." That's 12 not in the vernacular of how we speak at 13 Leapfrog. 14 We, again, are not in the business 15 of -- of penalizing hospitals. We're in the 16 business of making information available, in 17 this case, about patient safety to patients. 18 Q. And -- and who is "we" when you say 19 that? 20 A. The Leapfrog Group. 21 Q. Okay. So you're excluding the 22 expert panel in that -- in that "we"? Page 446	1 A. Not to my recollection. 2 Q. Okay. 3 Okay. So your perspective is 4 to the extent Dr. Romano thought the new 5 imputation model was designed to penalize 6 hospitals, he's just wrong? 7 ATTORNEY BLAIR: Objection to 8 form. 9 THE WITNESS: To the extent 10 Dr. Romano -- I'm sorry. Can you 11 repeat the question? I don't want to 12 represent his opinion. 13 BY ATTORNEY CRAIN: 14 Q. That's why I said "to the extent" -- 15 A. Okay. 16 Q. -- so you can -- you can fight the 17 premise in the next question. 18 A. Okay. 19 Q. In this one, take my premise. 20 A. Okay. 21 Q. To the extent he thought that the 22 new imputation methodology -- Page 448
1 A. I, personally, have no recollection 2 of any individual expert panelist talking about 3 penalizing hospitals through the Hospital Safety 4 Grade methodology. 5 Q. Besides Dr. Romano? 6 A. I think he's reflecting on his -- 7 he -- I think he's -- he's projecting. He says, 8 If the goal is to. 9 I don't think he's trying to. I 10 actually don't know where that statement came 11 from. We've never had that conversation with 12 him. 13 Q. That was not discussed, to your 14 recollection at the -- 15 A. No. 16 Q. -- let me finish. 17 That was -- just for Cindy. 18 That was not discussed, to your 19 recollection, at the April 12th meeting? 20 A. No. 21 Q. No one mentioned penalizing 22 hospitals -- Page 447	1 A. Yes. 2 Q. -- was designed to penalize 3 nonparticipants, he was wrong? 4 A. Yes. 5 Q. Okay. And you -- you're free to 6 fight me on the premise, although he says it 7 four times, that the goal is to penalize. 8 But do you see -- I mean, we 9 can go to it if you want to take a look, but -- 10 A. No -- 11 Q. -- okay. 12 A. -- so, actually, when I was shown 13 this e-mail as part of preparation, I didn't 14 remember this e-mail -- 15 Q. Okay. 16 A. -- and, again, like, I don't have a 17 lot of one-on-one interaction with the expert 18 panelists, but I actually didn't remember this 19 e-mail. 20 But I do know that there was 21 another e-mail from Dr. Romano that you 22 probably have, where he made sort of a Page 449

1 tongue-in-cheek joke about I guess it doesn't 2 do your hospital any favors if someone sits on 3 the expert panel, because his hospital had 4 actually had the imputation methodology 5 applied, Step 2, which is University of 6 California, Davis -- 7 Q. Yeah. 8 A. -- I think if he felt strongly and 9 disagreed with the methodology, we have a 10 collegial relationship enough and he has a 11 collegial relationship enough with Matt and 12 others to speak up at that time and say, I want 13 to reconvene the expert panel and talk about 14 this. I really strongly disagree with it. And 15 he did not. 16 Q. I agree with you. He did not. 17 And I -- so isn't it fair to 18 say he agreed with the proposal because he 19 thought the goal was to penalize 20 nonparticipants? 21 ATTORNEY BLAIR: Objection to 22 form. Page 450	1 doesn't believe it today, and he didn't believe 2 it when he saw the imputation methodology 3 applied to his hospital -- 4 Q. He -- 5 A. -- that's what I mean by that 6 statement. 7 Q. He doesn't believe that the 8 imputation -- he doesn't believe -- 9 A. Is -- is penalizing hospitals, 10 correct. 11 Q. How do you know that? 12 A. In the -- in the subsequent e-mail, 13 he doesn't say, See, you're penalizing -- 14 Q. Well, you said he doesn't think 15 it -- think it today. 16 Do you have conversations with 17 him about this topic? 18 A. I haven't. 19 Q. Okay. 20 A. My -- we've been working with 21 Dr. Romano for many, many years. It's not been 22 my experience that he waits for me to ask him if Page 452
1 THE WITNESS: I can't 2 interpret that question. I'm sorry. 3 BY ATTORNEY CRAIN: 4 Q. Okay. 5 A. Sorry. 6 Q. Well, you're saying that -- you're 7 interpreting his intent with respect to the 8 approval of the methodology, right? 9 A. Are we going back to this e-mail 10 now? 11 Q. Well, you said a few minutes ago if 12 he felt strongly and disagreed with the 13 methodology, we have a colle- -- collegial 14 relationship enough, and he -- I think -- 15 A. I was -- with that statement, I was 16 implying that if he truly believed we are 17 penalizing hospitals, and particularly his own 18 hospital, my -- my belief is that he would bring 19 that up to us and ask to have a conversation. 20 So I was using that as an example 21 that I don't believe when he says "penalizing 22 hospitals" here, he really meant it, and he Page 451	1 he needs to bring something up to Matt. 2 So I'm inferring -- I'm only 3 inferring that -- 4 Q. So -- 5 A. -- if something was wrong, he would 6 bring it up. 7 Q. -- so you're inferring that he 8 approves of it today and it's not penalizing 9 even though, in this e-mail, he says four times 10 -- 11 A. Yes, that's correct. 12 Q. Hold on. I want -- I want to 13 finish. I'm sorry -- 14 A. I thought you were done. I'm sorry. 15 Q. No, no. I was in the middle of a 16 word. 17 A. Oh. 18 Q. So you are inferring that he is 19 agreeing that this is not a penalizing 20 methodology today even though his e-mail from 21 last year says four times he's okay with this 22 because the goal is to penalize Page 453

1 nonparticipants? 2 ATTORNEY BLAIR: And I'm 3 going to object to form in that it's 4 missing the attachment. 5 ATTORNEY CRAIN: That's fine. 6 THE WITNESS: Can I -- 7 ATTORNEY BLAIR: Yeah. 8 BY ATTORNEY CRAIN: 9 Q. You may answer. 10 A. That is what I'm saying. 11 Q. Okay. 12 Okay. So you're inferring his 13 intent is to approval but not as to nonpen- -- 14 that it's a penalizing methodology? 15 A. I'm inferring that when he wrote 16 this e-mail, regardless of how it reads, I don't 17 believe that, today, he thinks that we are using 18 a penalizing methodology. 19 Q. Why? 20 ATTORNEY BLAIR: Objection: 21 asked and answered. 22 ATTORNEY CRAIN: Not Page 454	1 A. Yes. 2 Q. Okay. But he's specifically writing 3 in this e-mail he thinks it's fine because -- 4 A. And that's what we disagree on, that 5 it's penalizing. 6 Q. You disagree that he thinks that, or 7 you disagree that it is penalizing? 8 A. I disagree that he thinks that 9 today, and I disagree that it is. 10 Q. And you disagree that he thought 11 that when he wrote this? 12 ATTORNEY BLAIR: Objection to 13 form: mischaracterizes the document. 14 ATTORNEY CRAIN: No; I'm 15 asking. 16 THE WITNESS: I can't infer 17 what he might have thought when he 18 wrote this. I -- 19 BY ATTORNEY CRAIN: 20 Q. I just -- 21 A. -- don't know what his state of mind 22 was. Page 456
1 answered, but I'll give you maybe 2 asked. 3 THE WITNESS: Because based 4 on my knowledge and relationship with 5 Patrick Romano, if he believed that we 6 were using a penalizing methodology, 7 he would bring it up to us and/or with 8 the rest of the expert panel. 9 Since this e-mail has -- was 10 sent, he has never made any comments 11 like that. And, in fact, I forgot he 12 even said it in this instance. 13 BY ATTORNEY CRAIN: 14 Q. But that's because he was okay with 15 the approach, right? 16 ATTORNEY BLAIR: Objection to 17 form. 18 THE WITNESS: I don't think 19 I'm understanding your question. 20 BY ATTORNEY CRAIN: 21 Q. Okay. We agree that he's saying 22 this -- this new approach is fine, right? Page 455	1 Q. I want to be superclear. 2 A. Yes. 3 Q. You are inferring what his state of 4 mind is today without a document and without a 5 discussion, but you can't infer what his state 6 of mind is when you read this e-mail? 7 ATTORNEY BLAIR: Objection -- 8 THE WITNESS: If -- 9 ATTORNEY BLAIR: -- to form. 10 THE WITNESS: -- if I read 11 the e-mail as plain that he -- he 12 believed it was penalizing, I don't 13 believe it's penalizing. And I am 14 saying that I don't believe 15 Patrick Romano believes it's a 16 penalizing methodology today. 17 BY ATTORNEY CRAIN: 18 Q. And -- and what does "penalizing" 19 mean to you? 20 A. However he's used it here. 21 "Punitive," I think, is what we were using -- I 22 think what we were using before. Page 457

1 Q. So "punitive" means punish, right? 2 A. Yes. Because as a reminder -- and I 3 know I've said this lot, but I feel like maybe 4 I'm not saying it clearly -- whether or not you 5 participate in a Leapfrog Hospital Survey, you 6 can get an A, B, C, D, F. Whether you 7 participate in a Leapfrog Hospital -- you can 8 still get an A, B, C -- we have hospitals that 9 have never done a survey that have the Step 2 10 imputation model applied that have A's. 11 We have hospitals that have never 12 done a survey that have the same Step 2 13 imputation model applied that have B's. 14 The fact of that leads me to say to 15 you, I don't think the methodology is 16 penalizing; I don't think the methodology is 17 punitive. And I don't have to just think it. 18 I see it because I see hospitals that have 19 never done a survey and have the same 20 methodology applied and have A's, B's, Cs, 21 et cetera. 22 So it's not a conjecture. You see Page 458	1 Q. The documents speak for 2 themselves -- 3 A. Okay. 4 Q. -- I'll -- I'll come back -- 5 A. No. I mean with the -- with the 6 counts. I just -- I don't want to speak from 7 memory. 8 Q. No. I know. Those documents speak 9 for themselves -- 10 A. Okay. 11 Q. -- I will -- I -- my recollection is 12 the number is quite, quite small, but set that 13 aside. 14 A. Yeah. 15 Q. Is it your view that the 16 nonparticipating hospitals, if they started 17 participating, would not see their scores rise? 18 A. It is my view. And, in fact, I've 19 had many calls with very distraught directors of 20 quality because they participated in the survey 21 and their score went down. So it's not 22 necessarily true that when you start Page 460
1 it on our publicly reported website. That's 2 what I'm basing my statement on. 3 Q. So let me -- how many 4 nonparticipating hospitals have A's? 5 A. I would have to look. I don't -- 6 I'm not going to know that information off the 7 top of my head. 8 Q. Ballpark. 9 Is it 100? Is it 5? 10 A. It's . . . 11 Q. Best estimate. 12 A. I would estimate the majority of 13 hospitals at any grade level is a C. And so the 14 majority of hospitals, whether they submit a 15 survey or not, are going to be at a C. 16 I wouldn't want to make an estimate 17 on the other letter grades. I'm sorry. 18 I'm not -- I know that for the 19 purposes of this case, if there's other 20 documents where you have lists of hospitals, I 21 -- I'd be happy to look at them. I just don't 22 want to say something incorrect. Page 459	1 participating in the survey, your grade goes up. 2 Sometimes your grade goes down. Sometimes it 3 stays exactly the same. 4 Like I said, this is a 22-measure 5 composite, and so there's a lot of factors 6 going into it. So I could never say to you or 7 anyone definitively by virtue of answering the 8 questions on the survey, your grade's going to 9 go up, down or stay the same. I've seen all 10 three things happen. 11 Q. Because you don't actually know how 12 nonparticipating hospitals are performing, 13 right? 14 A. That's correct. 15 ATTORNEY BLAIR: Objection to 16 form. 17 ATTORNEY CRAIN: Okay. Did 18 we get it? 19 Okay. 20 THE WITNESS: And that's why 21 we're so clear that the score we're 22 assigning is based on that lack of Page 461

1 information. 2 BY ATTORNEY CRAIN: 3 Q. But -- but you're not clear, are 4 you? I mean, where are you clear in that? 5 Let's go back to Exhibit 3 -- 6 A. I, personally, don't I think I could 7 be more clear than the bold red sentence on our 8 website -- 9 Q. Well, let's -- 10 A. -- that accompanies the asterisk 11 that accompanies the measure score. 12 Q. I will show you how you can be 13 clear. 14 ATTORNEY CRAIN: Where -- 15 where's the document? Sorry. What 16 tab? 17 ATTORNEY CARDONE: Tab 64. 18 ATTORNEY CRAIN: Okay. 19 Tab 64, Exhibit 4. 20 There we go. 21 THE WITNESS: And, again, 22 website, Missy Danforth. Page 462	1 I'm sorry. Which gas gauge am I 2 looking at? 3 Q. The gas gauge on the right side -- 4 A. Yes. 5 Q. -- which is under Staff work 6 together to prevent errors. 7 A. Yes. 8 Q. Do you see that? 9 A. I do. 10 Q. So why isn't that clearer than a gas 11 gauge that says "red"? 12 ATTORNEY BLAIR: Objection to 13 form. 14 THE WITNESS: I'm sorry. I 15 don't understand that question. 16 BY ATTORNEY CRAIN: 17 Q. Okay. So you said you weren't sure 18 how it could be clearer on the website, that 19 you're -- you're -- 20 A. Correct. Web design is not my area 21 of expertise. 22 Q. Okay. But you -- you are an English Page 464
1 BY ATTORNEY CRAIN: 2 Q. Yes. 3 But you, Missy Danforth, has 4 been at Leapfrog for 16 years and know this like 5 the back of your hand, right? 6 A. Yeah -- 7 Q. Okay. 8 A. -- not the website so much, but, 9 yes, everything else. 10 Q. But -- you have it. 11 ATTORNEY CARDONE: No. 12 You're -- it's Exhibit -- 13 BY ATTORNEY CRAIN: 14 Q. You have it. 15 A. Oh. So -- 16 Q. You have it. I'm going back to the 17 Delray website. 18 A. Yes -- oh, 4. Yes. 19 Q. Right. So -- so you can see it 20 says -- within the gas gauge, it says, Declined 21 to Report? 22 A. I'm sorry. Page 463	1 major, so words are your area of expertise. 2 A. Free websites. 3 Q. Fair. Fair. I won't tell -- 4 A. I'm just saying -- 5 Q. -- I won't tell anybody. 6 So my -- my question is, How is 7 someone looking at this supposed to understand 8 that the handwashing gas gauge, the 15 score, 9 is -- is a reflexive of lack of data and not 10 performance? 11 A. The asterisk. 12 Q. But the asterisk says a score was 13 imputed. We -- we went through this six hours 14 ago. 15 ATTORNEY BLAIR: Objection to 16 form. That's not what it says. 17 BY ATTORNEY CRAIN: 18 Q. It says, So a score was assigned -- 19 excuse me -- to reflect the lack of information 20 available. 21 Right? 22 A. Correct. Page 465

1 Q. But it doesn't say how? 2 A. I guess I would argue that the 3 sentence, The hospital declined to report their 4 performance on this measure, so a score was 5 assigned to reflect the lack of information, 6 both tells them how -- and, again, because it's 7 directly associated with that specific asterisk, 8 for me reading this, I can easily make that 9 connection. I think even in 10 nonhealthcare-related things, people know when 11 they see an asterisk, it's likely associated 12 with a measure -- or I'm sorry -- a message, a 13 message. 14 Q. Is it Leapfrog's view that the 15 handwashing score for nonparticipating 16 hospital -- 17 A. Hand hygiene. 18 Q. Hand hygiene. Excuse me. 19 -- for nonparticipating 20 hospitals conveys a lack of information or lack 21 of performance? 22 A. It literally says exactly how we -- Page 466	1 I don't know how else to communicate 2 it. 3 BY ATTORNEY CRAIN: 4 Q. Okay. All right. I guess. 5 (Sotto voce discussion.) 6 ATTORNEY CRAIN: Emily has a 7 good question. 8 THE WITNESS: Yes. 9 BY ATTORNEY CRAIN: 10 Q. Couldn't you convey lack of 11 information by just not scoring? 12 A. Not scoring the measure? 13 Q. Yeah. 14 A. Based on the guidance of our expert 15 panel, they have suggested that for this 16 particular measure, and we're talking about hand 17 hygiene, we impute a score. 18 Q. And is the guidance from the 19 April 12th meeting? 20 ATTORNEY BLAIR: Objection to 21 form: asked and answered. 22 THE WITNESS: I'm sorry, but Page 468
1 what we are trying to convey. What we're trying 2 to convey with this asterisk is that the 3 hospital declined to report their performance on 4 this measure, so a score was assigned to reflect 5 the lack of information available. That's 6 exactly what we're trying to convey. 7 Q. But it also says worst hospital 8 score is 15, right? 9 A. Correct. 10 Q. So why doesn't it convey that this 11 is the worst hospital in that metric? 12 ATTORNEY BLAIR: It does. 13 (Sotto voce comments by counsel.) 14 THE WITNESS: My read of 15 this -- 16 ATTORNEY BLAIR: Objection to 17 form. 18 THE WITNESS: -- that is 19 conveyed. 20 Because the two scores are 21 equivalent, I -- that is conveyed to 22 me by the equivalence of the numbers. Page 467	1 the actual guidance on imputing scores 2 on hand hygiene happened years before. 3 In fact, these five hospitals have had 4 imputed scores for these measures, I 5 think, since 2023 or 2024. So, again, 6 the imputation for these measures did 7 not happen in April 2024, and we've 8 talked about that extensively today. 9 BY ATTORNEY CRAIN: 10 Q. Sure. But not for limited 11 achievement. 12 That's the new -- that's the 13 change, right? 14 A. Correct. 15 Q. Yeah. Okay. 16 Okay. Let me just make the 17 question. 18 Okay. Okay. Let's keep going. 19 Okay. 20 ATTORNEY CRAIN: Let's go to 21 Tab 34. 22 Okay. This will be Page 469

1 Exhibit 17? 2 CERTIFIED STENOGRAPHER: Nine 3 teen. 4 ATTORNEY CRAIN: Nineteen, oh 5 my goodness. 6 THE WITNESS: I'm out of 7 order now. I didn't want to take the 8 time to fix it. 9 ATTORNEY CRAIN: No, it's all 10 right. We'll deal with it later. 11 THE WITNESS: Okay. 12 CERTIFIED STENOGRAPHER: One 13 second. 14 --oOo-- 15 (Danforth Deposition Exhibit Number 16 19, E-mail string with 17 attachments, marked for 18 identification, as of this date.) 19 --oOo-- 20 THE WITNESS: Thank you. 21 BY ATTORNEY CRAIN: 22 Q. Okay. So do you recognize this Page 470	1 stipulated. We couldn't read it 2 before. 3 ATTORNEY CRAIN: We could 4 not. So thank you for sharing that. 5 BY ATTORNEY CRAIN: 6 Q. And so, Ms. Danforth, these are 7 responses to comments on the -- the imputational 8 model that you proposed in 2024. 9 Do you see that? 10 A. These are comments and responses to 11 comments. 12 Q. Correct. Exactly, correct. 13 A. Yes, correct, yes. 14 Q. And Ms. Campione drafted these, 15 right? 16 A. Yes. 17 Q. Okay. Now, she color-coded them 18 helpfully, and she sort of lays out the 19 different topics. 20 Do you see that? 21 A. Yes. Blue, green, pink, red. 22 Q. Exactly. Page 472
1 document, Ms. Danforth? 2 A. Only because I reviewed it as part 3 of preparation for today. 4 Q. Part of preparation. 5 So you have no preexisting 6 memory of this document? 7 A. Not this specific -- 8 Q. Okay. 9 A. -- document, no, but I'm -- I'm sure 10 it's as represented. 11 ATTORNEY CRAIN: Yeah, I 12 just -- I'll just note for the record 13 this was produced originally at 14 LEAPFROG00178623, and then counsel 15 sent over the native version with the 16 colors. So that's -- that's why this 17 one doesn't have a Bates. 18 Remember this one? 19 ATTORNEY BLAIR: Yeah. 20 ATTORNEY CRAIN: Yeah. Okay. 21 So stipulated? 22 ATTORNEY BLAIR: So Page 471	1 So blue, there's a -- a -- 2 Misrepresents Performance? 3 A. Yes. 4 Q. Green says, More time? 5 A. Yes. 6 Q. Pink says, Do not penalize hospitals 7 for not completing a resource-intensive survey. 8 Keep them separate or allow hospitals to opt 9 out? 10 A. Yes. 11 Q. And red says, Hospital performance 12 does not change that much in two years 13 (addressed in response to theme above). 14 Do you see that? 15 A. Yes. 16 Q. Okay. Does this refresh your 17 recollection at all as to the type of comments 18 Leapfrog received after proposing the 19 imputational model? 20 A. Yes. I'm -- I'm sure I reviewed 21 these at the time. 22 Q. Okay. Now, I just want to talk with Page 473

1 you a little bit about the responses to those 2 comments. 3 A. Sure. I just want to see how many 4 there are. Give me one second. 5 Q. Yeah, that's -- that's a great 6 point. 7 A. Five, yes. 8 So we did receive six comments, 9 but -- 10 Q. Yes. 11 A. -- as a reminder, over 800 hospitals 12 would have had this imputation applied -- 13 Q. Yes. 14 A. -- so 6 out of 800. So this is a 15 fairly small sample size. But, yes, I -- I'm 16 sure I would have reviewed these comments when 17 we received them, and I'm sure we would have 18 reviewed this e-mail. 19 Q. Yes. 20 A. I have no doubt, yes. 21 Q. Now, just going to the number point. 22 In prior changes to the Safety Page 474	1 A. -- two times -- probably two times 2 as many, three times as many. 3 Q. Okay. So I just want to look at the 4 responses here, and if you go to Page -- or 5 actually it's not a page number, but it's a 6 green bar. 7 Do you see that where it says 8 Responses to Public Comments? 9 A. Can you tell me just the hospital 10 name? 11 Q. No. Responses -- keep going. 12 There's no page numbers. 13 Do you see the green bar down 14 there? 15 A. Oh, yes. 16 Q. So just for -- for the record, 17 because there's no Bates number or page number, 18 it says, Responses to Public Comments. 19 A. Yes -- 20 Q. -- do you see that? 21 So it says, Four commentator -- 22 commenters supported the change to the Page 476
1 Grade Methodology, is this a representative 2 number of comments, more or less? 3 A. So this is 6 comments and then 4 4 additional comments, so 10 total. When we -- 5 not to harp on this nursing thing, when we first 6 proposed back in 2022, 2023 to include the Total 7 Nursing Hours Per Patient Day Measure in the 8 Hospital Safety Grade, the original proposal, to 9 my recollection, was that we were actually going 10 to include two measures: One was called total 11 Nursing Hours Per Patient Day, and that is the 12 one that got added to the program. One was 13 called RN Hours Per Patient Day, which we've 14 talked about, and that didn't get added to the 15 program. 16 My recollection is that the 17 proposed changes to add those nursing measures 18 received more comments than this. 19 Q. Okay. Just by an order of 20 magnitude, any sense? 21 A. Many more -- 22 Q. Okay. Page 475	1 imputation methodology it said. 2 Do you see that? 3 A. Yes. 4 Q. Okay. Two commentators expressed 5 concern about Step 2 imputation misrepresenting 6 the current procedures or infrastructure of the 7 hospital to the public. 8 Do you see that? 9 A. Yes. 10 Q. Okay. Now, if we look at that -- so 11 the -- the nonbolded text under there, is that 12 Leapfrog's response to that comment? 13 A. Yes. 14 Q. Okay. So it says, We recognize that 15 hospitals eligible for Step 2 imputation may 16 score higher if they complete a 17 Leapfrog Hospital Survey. 18 Is that -- is that consistent 19 with your current view? 20 A. My current view -- I think I just 21 described it -- let me see it again in this 22 specific context. Page 477

1 They may overall on the Hospital 2 Safety Grade, because it includes a lot of 3 things, score higher or lower or stay the same. 4 Q. Okay. So I -- I'm just a little 5 unclear to my question. 6 This says, We recognize that 7 hospitals eligible for Step 2 imputation may 8 score higher. 9 Is that correct or not correct? 10 A. It's partially correct. 11 Q. Okay. 12 A. I -- actually, I don't think I wrote 13 this. I'm not sure that's how I would have 14 stated it, but I agree that's what it says, and 15 I believe it's partially correct. Just like I 16 said, they may; they may not; they may be 17 exactly the same. 18 Q. Okay. However, we cannot ensure if 19 this is the case if we do not have the data. 20 Our analyses have shown that performance among 21 hospitals that intermittently complete the 22 annual survey is lower than those hospitals that Page 478	1 Q. Okay. 2 A. -- but . . . 3 Q. But if it exists, it would have been 4 something like that? 5 A. Yes. 6 Q. Okay. The expert panel recognized 7 that hospitals with a drop in performance may be 8 incentivized not to report via the 9 Leapfrog Hospital Survey, and scores calculated 10 using participating hospitals would misrepresent 11 their true performance. 12 Do you see that? 13 A. Yes. 14 Q. Okay. Where did the expert panel 15 recognize that? 16 A. That was the discussion of the 17 meeting we had on April 12th. 18 Q. Okay. Any other place that it was 19 discussed? 20 A. I -- I don't know. I apologize. 21 Again, to refresh my memory on the April 12th 22 meeting, I had to read the minutes, so I -- I Page 480
1 completed the most recent survey. 2 Do you see that? 3 A. I do. 4 Q. Okay. What is the analysis that 5 this refers to? 6 A. That's what we've spoken about 7 earlier today where I suggested that you might 8 want to ask Matt Austin because I wouldn't have 9 done that analysis. 10 Q. Okay. Would -- and -- and, again, 11 I'm going to ask the same question because I'm 12 still not sure where to find it. 13 Do you have any recollection of 14 whether it was sent to you in any written form? 15 A. It would have been probably, like, a 16 table, like, in this other e-mail that Alex sent 17 where she had a table that included that 18 information that we were looking at together, 19 something like that. 20 Q. You say "probably." 21 Do you have a memory of it? 22 A. I don't have a memory of it -- Page 479	1 can't say for sure either way. 2 Q. All I'm asking for is your best 3 memory today. 4 A. Yes, I know for sure it was 5 discussed on that meeting. 6 Q. Okay. And you don't have any other 7 recollection of it discussed elsewhere? 8 A. Not right now. 9 Q. Okay. And then it says at the 10 bottom, We do acknowledge the commenter's point 11 that the public may misrepresent the assigned 12 measure scores. In response, we will add a new 13 denotation to the Hospital Safety Grade website 14 for scores that have been imputed. 15 Do you see that? 16 A. Yes. 17 Q. Okay. And is that referring to the 18 asterisk? 19 A. Yes. 20 Q. Okay. Anything else it's referring 21 to? 22 A. I do not believe so. Page 481

1 Q. Okay. I want to keep going down. 2 We -- see four commentators towards the bottom? 3 A. I do, yes. 4 Q. Four commenters opposed penalizing 5 hospitals that choose not to devote resources to 6 completing a voluntary survey each year and be 7 allowed to opt out to the -- of the Hospital 8 Safety Grade. 9 Do you see that? 10 A. I do. 11 Q. Okay. Why doesn't Leapfrog permit 12 nonparticipating hospitals to opt out? 13 A. To opt out of what? 14 Q. Of being graded. 15 A. Because as I've expressed, from a 16 mission perspective, both Leapfrog and our 17 expert panel believe that in order for this to 18 be of good public use, we should grade as many 19 hospitals as possible because, again, so much 20 good safety data is available on the -- through 21 CMS, through Leapfrog, through this imputation 22 methodology. It's been a focus of ours to try Page 482	1 And it says, The choice to not 2 participate should not excuse a hospital from 3 being graded, nor should they be given a score 4 that unfairly awards them points. 5 Do you see that? 6 A. I do. 7 Q. Okay. And, again, what is unfair? 8 A. Again, to reiterate, it was the idea 9 that these hospitals were being given near 10 perfect points based on the performance of other 11 hospitals. 12 Q. And -- and why is that unfair? 13 A. Because we have no information to 14 indicate -- and just going back to the hand 15 hygiene example, we have no reason to believe 16 that hospitals that aren't participating in a 17 Leapfrog Hospital Survey are doing those things. 18 So to give them credit for doing them was a 19 concern of Leapfrog's and the expert panel. 20 Q. Okay. I'm still not understanding 21 why -- why is that unfair? 22 ATTORNEY BLAIR: Objection to Page 484
1 to make as much information available publicly 2 as possible. It's literally why we were 3 founded. 4 Q. And -- and you say to "grade as many 5 possible -- hospitals as possible." 6 Is it also to grade as many 7 hospitals as possible in an accurate way? 8 A. I believe that's literally embedded 9 in this -- in everything I -- in everything I 10 say. We're trying to do the best we could 11 possibly do, yes. 12 Q. So -- so the answer is yes? 13 A. Yes. 14 Q. Okay. 15 Okay. So then the response is, 16 The Leapfrog Hospital Survey is designed to help 17 hospitals benchmark their progress in quality 18 and safety. 19 Do you see that? 20 A. Yes. 21 Q. Okay. And then I'm just going to 22 keep reading down. Let's see. Page 483	1 form. 2 THE WITNESS: I unfortunately 3 don't have a better way to describe it 4 than to reflect the intentions in our 5 actual conversations. 6 BY ATTORNEY CRAIN: 7 Q. Okay. Okay. 8 All right. Let's keep going. 9 I want to talk about that asterisk a little bit. 10 Let's see . . . 11 Let's see . . . 12 ATTORNEY CRAIN: Actually, 13 let's go to Tab 62. 14 BY ATTORNEY CRAIN: 15 Q. Are you aware, Ms. Danforth, of a 16 document called Leapfrog's Guiding Principles. 17 A. I'm not off the top of my head. 18 Q. I'll show it to you. I'm just -- I 19 was curious if you knew of it. 20 ATTORNEY CRAIN: So this will 21 be Exhibit 20. 22 Page 485

1 --oOo-- 2 (Danforth Deposition Exhibit Number 3 20, Expert Panel's Guiding 4 Principles on the Development of 5 the Composite Leapfrog Hospital 6 Safety Grade for U.S. Hospitals, 7 marked for identification, as of 8 this date.) 9 --oOo-- 10 ATTORNEY BLAIR: And for the 11 record, this is the expert panel's 12 guide. 13 ATTORNEY CRAIN: Expert 14 panel's, yeah. 15 THE WITNESS: I'm sorry. 16 This doesn't have a Bates number 17 either. 18 Who produced this? 19 BY ATTORNEY CRAIN: 20 Q. It is pulled off the website, the 21 public website. Your public website. 22 A. I am not aware of this document. Page 486	1 the Development of the Composite 2 Leapfrog Hospital Safety Grade for 3 U.S. Hospitals. 4 THE WITNESS: So early on 5 when we were developing the Hospital 6 Safety Grade, we were, as I said, 7 working with Johns Hopkins Institute 8 for Patient Safety and Quality, and 9 Matt Austin -- we were also working 10 with another healthcare consulting 11 firm called Discern Consulting. 12 They had a convening role, I 13 believe, early on in bringing 14 together patient safety experts 15 because the review of existing 16 patient safety measures and 17 literature was quite extensive. 18 I cannot say for sure, but 19 this doesn't look like a, 20 quote/unquote, Leapfrog document. 21 This may have come from Discern 22 Consulting in their role of convening Page 488
1 Is it leapfroggroup.org or 2 hospitalsafetygrade.org? 3 Q. I don't recall. One of the two. 4 Let me see. 5 Yeah. 6 Hospitalsafetygrade.org. 7 A. Um-hum. Can you just tell me what 8 heading it's under? 9 (Sotto voce comments by counsel.) 10 ATTORNEY CRAIN: Yeah, we 11 just got to it. 12 Okay. Are we -- we're good, 13 Cindy? 14 Okay. Great. 15 BY ATTORNEY CRAIN: 16 Q. So this -- so you don't recognize 17 this document, you're saying? 18 A. No. 19 Q. Okay. 20 ATTORNEY CRAIN: This -- for 21 the record, this is a document titled 22 Expert Panel's Guiding Principles on Page 487	1 and/or facilitating very, very early 2 meetings of the development of the 3 Hospital Safety Grade. 4 Is that clear? 5 BY ATTORNEY CRAIN: 6 Q. Sort of. 7 A. Okay. 8 Q. I guess I'm just wondering why it's 9 on Leap -- Leapfrog's public website. 10 A. I've never -- I was not aware this 11 was on our public website. That's why I asked 12 you which website you saw it on. 13 Q. Yeah. 14 A. I -- I -- 15 Q. Okay. 16 A. -- was not aware that it was on our 17 public website. 18 Q. So I want to walk through this a 19 little bit. 20 A. May I read it just quickly? Just 21 so -- this is -- 22 Q. Sure. Page 489

1 A. -- the first time I'm seeing this. 2 Thank you. 3 Q. Yeah. 4 (Whereupon, the witness reviews the 5 material provided.) 6 THE WITNESS: Okay. 7 BY ATTORNEY CRAIN: 8 Q. You're a fast reader. 9 A. I scanned it. I'm not. 10 Q. Okay. Let's -- let's start at the 11 top. 12 So The expert panel guiding The 13 Leapfrog Group on the development of the 14 Leapfrog Hospital Safety Grade has reached 15 consensus that the following principles will 16 guide their recommendations to Leapfrog for 17 calculating the grade. 18 Now, you are the Leapfrog 19 representative for the expert panel, correct? 20 A. Yes. 21 Q. Okay. But you don't -- you're not 22 aware of this document? Page 490	1 A. I'm saying that in my many meetings 2 of meeting with the expert panel and the 3 materials you've shown me today, I've not seen 4 this as a meeting material. 5 Q. And are you certain of that? 6 Because there have been times where you -- you 7 couldn't remember all the meetings. 8 A. I'm not. 9 Q. Okay. 10 A. But the use of the term "construct" 11 really stands out to me. Again, like, it's 12 something that we would have used, like, very, 13 very early on as we were constructing the 14 methodology for the Hospital Safety Grade, and 15 that's why I believe it could have been 16 Discern Health. And I'm not questioning that 17 the document exists. I'm just orienting myself 18 to it. 19 And I don't have an immediate 20 recollection of it, but I'm sure that if you 21 found it on our website, it is from our 22 website. Page 492
1 A. As I said, I think it may have come 2 from before -- when we first were developing the 3 Hospital Safety Grade, we did briefly work with 4 Discern Health in a convening way before we got 5 the expert panel up and running and turned 6 everything over to Matt Austin at the Armstrong 7 Institute for Patient Safety and Quality. 8 (Whereupon, as the certified 9 stenographer seeks clarification, 10 colloquy will not be captured on 11 the written record.) 12 ATTORNEY CRAIN: Institute. 13 THE WITNESS: Institute for 14 Patient Safety and Quality. 15 So my best guess is -- and, 16 again, it would have been 2012, 2013 17 that this is a product of 18 Discern Health in their convening 19 capacity. 20 BY ATTORNEY CRAIN: 21 Q. So are you saying that you don't 22 think the expert panel adopted this? Page 491	1 Q. Give me one second. 2 A. And under Construct, I see where it 3 says, The focus of the composite score is 4 patient safety, which is being defined as 5 freedom from harm, and that reflects other of 6 our materials. 7 So . . . 8 Q. Okay. So I want to -- I want to 9 talk through some of these points, the purpose 10 of a composite score, right. 11 It says, The purpose of the 12 composite score is to create a simple metric 13 that will improve consumer and purchaser 14 engagement around patient safety in U.S. 15 hospitals. Ideally, this increased engagement 16 will create additional market forces for 17 hospitals to improve the safety of care of 18 delivery. 19 Do you see that? 20 A. I do. 21 Q. Do you know what "the market forces" 22 are referring to there? Page 493

1 A. I don't. 2 (Whereupon, Attorney Blair, exited 3 the proceedings.) 4 THE WITNESS: I can say in 5 general one thing that we talk about a 6 lot at Leapfrog is that we really want 7 hospitals competing on patient safety. 8 So instead of saying we have the 9 fanciest birthing suites, we want them 10 to say we have the best patient safety 11 track record. 12 So given those 13 conversations, I can assume that when 14 we say create additional market 15 forces for hospitals to improve 16 patient safety of care, we mean we 17 want hospitals competing on things 18 like low infection rates, low falls 19 rates and not just, you know, steak 20 dinners if you have a baby there, to 21 put it simply and concisely. 22 Page 494	1 safety is for the hospitals to make safety 2 itself a priority, which why Safe Practice 1, 3 that leadership structure is -- again, it's 4 leadership engaged in safety -- is one of the 5 only measures that has stayed on our survey 6 almost since its inception and also in the 7 Hospital Safety Grade. 8 And so, you know, I think one of 9 the best and most effective, I guess, ways 10 we've seen hospitals really improve in this way 11 is to make that decision to improve. 12 I don't know that I have any 13 examples of what you just described, which is 14 patients -- 15 Q. Voting with -- 16 A. -- I think you said voting with 17 their feet. 18 Q. Yes. 19 Okay. So -- all right. 20 So let's keep going down this 21 document. And before -- I just -- well, I'll 22 come back to it. Page 496
1 BY ATTORNEY CRAIN: 2 Q. I've been to different hospitals in 3 New York for that purpose, so I get it. 4 So -- 5 A. It's a big thing. 6 Q. -- I -- I hear you. 7 So it -- it -- I want to harken 8 back to what we talked about this morning about 9 the restaurant grades -- 10 A. Yeah. 11 Q. -- right. 12 Nobody goes to a C except for 13 the person when who wants the C pizza place, 14 right? 15 Is that the point of the 16 grades: the market forces of competition on 17 safety? People walk -- voting with their feet, 18 so to speak on safety, right? 19 A. So our experience is people don't 20 actually vote with their feet. I think we 21 really have seen that more than any other 22 affective way to drive hospitals to improve on Page 495	1 Let's go to Imputing missing 2 data on Page 2. 3 Do you see that? 4 A. Yes. 5 Q. It says, When a hospital is missing 6 data for a particular performance measure, we 7 recommend ignoring the measure and recalibrating 8 the weights within the domain so that hospitals 9 are scored only on the measures for which their 10 performance data are available. 11 Do you see that? 12 A. I do. 13 Q. Now, that is not what Leapfrog does 14 today, right? 15 A. It is not what we do today. 16 Q. Okay. Leapfrog could do that with 17 respect to the four imputed measures, right? 18 A. Leapfrog's methodology has evolved 19 over the past 13 years. We haven't been doing 20 this for a number of years. 21 Q. Okay. But you could exclude hand 22 hygiene, for instance, right? Page 497

1 A. If the expert panel provided us with 2 some guidance and rationale on why we might 3 exclude hand hygiene, we would certainly have 4 that discussion with them. 5 Q. Okay. And the guidance and 6 rationale, for instance, could be that you have 7 no data on hand hygiene for nonparticipating 8 hospitals, right? 9 A. The expert panel can bring to us any 10 guidance or rationale they have for any change. 11 Q. Can I go back to something we talked 12 about earlier today? We talked about primary 13 and secondary data. 14 A. Yes. 15 Q. What is the secondary data source 16 for hand hygiene for nonparticipating hospital? 17 A. The imputed measure score we've been 18 talking about today. 19 Q. But that's not data, right? 20 A. And, again, we'll have to go back to 21 the transcript, but I believe what we talked 22 about and what I described, hopefully in not in Page 498	1 data -- the score and put -- imputing it, right? 2 A. I'm sorry. I don't understand your 3 question. 4 Q. Yeah. Fair enough. It was a bad 5 question. 6 That was my first one today. I 7 admitted it was a bad question. 8 A. You looked confused too, so I was 9 like -- 10 Q. Fair question. 11 So you -- you have -- we talked 12 about lots of different secondary sources this 13 morning, right? 14 A. Yes. 15 Q. The aha data -- we had our aha 16 moment, right? We had the historical data, 17 right? 18 The imputation model takes 19 those data and puts it into the score, right? 20 A. So -- 21 Q. I just want an answer to my 22 question. Page 500
1 too much painful detail, is that those headings 2 are really meant to communicate that, first, 3 we'll look to see if there's a measure of score 4 available here and, if not, we'll go to this 5 other column or other category or other place to 6 look for a measure score. 7 We consider and the expert panel 8 considers imputed data data. And so that is 9 the secondary data source for those measures. 10 Q. So I -- I just want to make sure I'm 11 understanding this. 12 The -- the 15 score -- 13 A. Yes. 14 Q. -- right, the limited achievement -- 15 you're saying that is data? 16 A. Correct. 17 Q. Even though it's -- it could be 12, 18 it could be 20, it's still data? 19 A. An imputed score is a data point we 20 can use, correct. 21 Q. Well, I thought imputed -- im- -- 22 imputation was -- was the process of taking the Page 499	1 Yes or no? 2 A. I'm sorry, but I don't think the way 3 that you've explained that is correct -- 4 Q. Okay. So if -- 5 A. -- because -- 6 Q. -- you can't answer it, that's fine. 7 A. -- I think you're confounding the -- 8 the -- the term "imputation model" with imputed 9 data, which isn't -- and some other things. And 10 I'm sorry, but the way you're describing it and 11 the terms that you're using -- I don't believe 12 that that is correct, but, certainly, you can 13 ask again and -- 14 Q. We'll try. 15 A. -- I'll try. 16 Q. So imputed data is -- is -- is the 17 -- the historical score for Step 1 is imputed 18 data, right? 19 A. So Leapfrog has a two-step 20 imputation -- 21 Q. Yeah. 22 A. -- methodology, where Step 1, we Page 501

1 impute the historical past score from the last 2 two rounds of the Safety Grade -- 3 Q. Yeah. 4 A. -- so based on the way I just 5 described it, yes, that's correct. 6 Q. Okay. Yes, it's correct, but the -- 7 in that context, the historical score is the 8 imputed data? 9 A. Yes. 10 Q. Okay. In this Step 2, what is the 11 imputed data? 12 A. The numerical score assigned by 13 Leapfrog associated with the performance 14 category of limited achievement. 15 Q. And -- but that doesn't have an 16 external data source, right? 17 A. It is a reference to a point value 18 already assigned in other parts of Safety Grade 19 Methodology. 20 Q. Leapfrog just picked that number, 21 right? 22 A. It is associate -- Leapfrog did not Page 502	1 A. Right. 2 Q. The expert panel -- the separate 3 expert panel picked it. 4 I'm asking, Could that number 5 have been 20? Could it have been 5? Could it 6 have been 12? 7 A. Right. And what -- what I'm saying 8 is that when that panel went through that 9 process of assigning those values to each of the 10 four performance categories, my recollection -- 11 and actually, we worked with Discern Health on 12 this as well because they helped us develop the 13 methodology for a value-based purchasing 14 program. 15 But my methodology is they used, I 16 think, something called maybe a Delphi process, 17 where there's sort of a process of looking at, 18 like, evidence, peer-reviewed literature and 19 other things. 20 So no, it's not just a simple 21 random assignment of a number. It was based on 22 a literature review and a scientific process to Page 504
1 pick that number. As I described, a separate 2 national technical expert panel assigned those 3 values to each of the four performance 4 categories for each of those four measures, and 5 we aligned with those values for the purposes of 6 the Hospital Safety Grade. 7 Q. Okay. So let me -- let me go 8 passive voice. 9 The number was picked by 10 someone, right? 11 A. Yes. 12 Q. It didn't derive from an objective 13 calculation of data, right? 14 A. It was derived from a -- a separate 15 expert panel; that's correct. 16 Q. Okay. That's not my question, 17 though. 18 Is there any objective data 19 source where that number was derived from? 20 A. I'm sorry. Can -- 21 Q. You're telling me who picked it, 22 right? Page 503	1 assign those numbers to those performance 2 categories. 3 I just wasn't at Leapfrog when it 4 occurred. It actually predated even 5 Leah Binder. This would have happened probably 6 in 2006 or 2007 when these values were assigned 7 to these performance categories, but my 8 recollection and hearing how it was done is no, 9 it wasn't just someone saying how about 40; no, 10 35. It was a more scientific process than 11 that. I just can't speak to it. 12 So the way you worded your 13 question -- I'm not sure how to answer it based 14 on the fact that I know it wasn't a random 15 assignment of a number. It was a scientific 16 process that took into account peer-reviewed 17 literature, subject-matter expertise and other 18 components that I couldn't speak to. 19 Q. Okay. So for the imputed scores, 20 right, for hand hygiene again -- 21 A. Yeah. 22 Q. -- which I got right this time -- Page 505

1 A. Yeah. 2 Q. -- I'm learning -- you said it could 3 have been zero, right? 4 A. I said the imputed score could have 5 been zero. I did say that. 6 Q. So what's the objective basis of a 7 zero number? 8 A. I don't know because we -- we really 9 didn't have a long discussion about imputing 10 zero. One expert panelist, I think I mentioned, 11 made that recommendation. I don't remember any 12 discussion about the basis of imputing zero, and 13 we've never imputed zero. 14 Q. And I just want to make sure -- 15 A. Sure. 16 Q. -- you've not reviewed a transcript 17 of the meeting, right? 18 A. I have not. 19 Q. But your recollection is that one 20 panelist made a specific recommendation of zero? 21 A. Yes, because it surprised me. So it 22 -- that's why I remember. And I believe it was Page 506	1 give them zeros, or something to that effect -- 2 Q. Yeah. 3 A. -- and obviously, we didn't do that. 4 We kept on working our process with Mathematica. 5 But since Andy Bindman had said 6 that, I hadn't heard that really come up again. 7 And to me, it really represented, I think, a 8 shift in the focus of the expert panel to be, 9 you know, really locked in and zeroed in on -- 10 on patient safety. 11 Q. On patient safety or on 12 participation? 13 A. On patient safety and wanting 14 information about patient safety. 15 Q. Are those two concepts separate to 16 Leapfrog, participation and patient safety? 17 A. I would argue that without Leapfrog 18 or CMS, it would just be difficult to know 19 anything about patient safety. As I mentioned, 20 when we were looking at my performance review, 21 I've looked high and low to find other patient 22 safety data available that's not from Leapfrog Page 508
1 Arjun Srinivasan, but I -- we would have to 2 check the transcript. 3 Q. And was your recollection something 4 you recently were refreshed on or it's something 5 you remember? 6 A. No; it's something I remember. 7 Because it actually wasn't the first time that 8 someone had recommended that; it was the most 9 recent time. 10 On previous expert panel calls when 11 the expert panel makeup was slightly different, 12 we had a representative from the Agency for 13 Healthcare Quality and Research [sic]. I 14 talked to them -- I've talked about them a lot 15 today, AHRQ. 16 The representative's name was 17 Andrew Bindman, B-I-N-D-M-A-N. And I remember 18 during his conversations on the expert panel, 19 at one point, he threw out -- you know, we're 20 doing all of this work maybe with Mathematica 21 at that time, and he's like, We need hospitals 22 focused on patient safety. Let's -- I would Page 507	1 or not from CMS. I'd love for someone else to 2 take on some of our measures so I can do more 3 with, say, hospital board and the emergency 4 department, but today, in 2025, if we're talking 5 about publicly available sources of information 6 about patient safety, it's Leapfrog; it's CMS. 7 The CDC publishes aggregated data, 8 but, certainly, you know, we are one of those 9 sources. 10 Q. Okay. Can we go back to the 11 guidelines document? 12 A. Yes. 13 Q. So I want to go back to the imputed 14 missing data section. 15 A. Yes. 16 Q. Let's look at the second paragraph. 17 In the situations where a 18 hospital does not have data available from the 19 primary data source for a particular performance 20 measure but an alternative data source is 21 available, data from the alternative or 22 secondary data source can be used in composite. Page 509

1 If data are used from a secondary data source, 2 attempts should be made to provide a grade that 3 is equitable to what the hospital would have 4 earned had the data been available from the 5 primary data source. 6 Do you see that? 7 A. I do. 8 Q. Is it Leapfrog's view, in the 9 corporate representative time, that that is what 10 the current imputation model does? 11 A. The current imputation model does 12 not do that, and the methodology in general has 13 not followed these principles in some time -- 14 Q. Okay. 15 A. -- and that's why, like I said, I 16 think this must have been from the very, very 17 earliest days and, frankly, have not been 18 referenced by the panel, to my recollection or 19 knowledge, in any number of years. 20 Q. Yeah. The thing I -- I know you're 21 not the corporate representative for the 22 website, but I struggle with how a consumer Page 510	1 A. My view as Missy Danforth and the 2 corporate representative of Leapfrog is that the 3 thinking and guidance of the expert panel has 4 evolved over time, that's not captured in this 5 document. This document would not be considered 6 accurate in terms of expert panels guiding 7 principles. 8 Q. Okay. I just want to -- I'd like an 9 answer to my question. I get you have a 10 different point you want to make, but I -- and 11 so in this sentence, is this what Leapfrog 12 does -- let's see -- attempts should be made to 13 provide a grade that is equitable do what the 14 hospital would have earned had the data been 15 available -- available from the primary data 16 source? 17 A. Is this what Leapfrog does now 18 through our current Hospital Safety Grade 19 Methodology? 20 Q. The imputation method, yeah. 21 A. Yes. We make every attempt to find 22 other available data, which I've talked about Page 512
1 looking at this document would -- would 2 understand what Leapfrog is doing if there are 3 these big inconsistencies between this document 4 -- 5 A. I'm -- 6 Q. -- and the methodology. 7 A. -- struggling to understand how a 8 consumer could find this on our website. 9 Q. We found it. 10 A. I will -- the first thing I'll do 11 when I get home will be try to find it myself. 12 Q. Okay. So -- so I just want to go 13 back to that last sentence. 14 If data are used from a 15 secondary source, attempts should be made to 16 provide a grade that is equitable to what the 17 hospital will have earned had the data been 18 available from the primary data source. 19 Your view as a corporate 20 representative and personally -- if they 21 diverge, you can tell me -- is that is not what 22 Leapfrog does? Page 511	1 exhaustively. 2 If the fact exists that there is 3 not other available data -- but in terms of 4 effort to find other available data, 5 unquestionably, it is a significant focus of 6 all of the work we do, not just the Hospital 7 Safety Grade but also the Leapfrog Hospital 8 Survey. 9 Again, we spend lots of people time 10 and money to administer our free annual 11 Hospital Survey. We publish all of the survey 12 results for free on a free public website. And 13 we know over time, more and more important 14 patient safety and quality topics have emerged, 15 but we have limited room on our survey to ask 16 endless things. I think you pointed out it's, 17 you know, 300 pages long. 18 If CMS or the 19 American Hospital Association or the 20 Joint Commission or the Institute for 21 Healthcare Improvement were to take on any of 22 our measures in collection of that data and Page 513

1 publicly report it, we would absolutely use it. 2 We just have not been able to find anything 3 additional. 4 But in terms of effort and intent, 5 yes. Absolutely. 6 Q. So let me ask this question: Does 7 Leapfrog provide a grade that is equitable to 8 what the hospital -- nonparticipating hospital 9 would have earned had the data been available 10 from the primary data source? 11 A. So you're actually taking that out 12 of context -- 13 Q. I'm asking -- 14 A. -- because -- 15 Q. -- a different question. I'm not 16 asking about the sentence -- 17 A. Okay. 18 Q. -- I'm asking -- you can even 19 pretend the document doesn't exist. 20 A. Okay. 21 Q. If you want to look at it, because I 22 am reading the language, it may help. Page 514	1 Q. -- we have -- 2 A. -- scores for more than six process 3 and structural measures, more than five outcome 4 measures are not issued a grade. Imputed 5 measures are not considered missing data. It's 6 considered a measure score that's used in the 7 calculation. 8 Q. So -- so that's what I wanted to get 9 at. That was my question, right. 10 We talked about -- we went 11 through all four imputed method -- method -- 12 excuse me -- imputed measures -- 13 A. Yeah. 14 Q. -- this morning, right? 15 And we went through the three 16 measures that you don't provide scores on for 17 nonparticipating hospital, right? 18 A. Correct. 19 Q. Okay. Without the imputation 20 methodology, that's seven process measures 21 missing, right? 22 A. Yes. Page 516
1 A. I think that's why I'm confused. 2 Yes. 3 Q. I'm asking, Does Leapfrog provide a 4 grade for nonparticipating hospitals that is 5 equitable to what the hospital would have earned 6 had the data been available from the primary 7 data source? 8 A. Yes, I think we do. 9 Q. Okay. Let's go to the next page. 10 On top of 3, it says, If a 11 hospital is missing data for a large number of 12 performance measures, then a grade cannot be 13 reliably calculated. In this situation, no 14 grade should be issued for the hospital. 15 Do you see that? 16 A. I do. 17 Q. Does Leapfrog adhere to that 18 guidance? 19 A. Yes. And we've talked about it in 20 some detail -- 21 Q. Yes -- 22 A. -- hospitals missing measure -- Page 515	1 Q. Okay. So if the imputation 2 methodology was not applied, under Leapfrog's 3 guidance, you couldn't grade a nonparticipating 4 hospital? 5 A. No, not necessarily. 6 Q. Okay. Why? 7 A. So the missing data thresholds 8 themselves have actually evolved significantly 9 over the years. When we first started this in 10 2013, as I mentioned, we had slightly different 11 process and structural measures, slightly 12 different outcome measures, and the numbers of 13 the process and structural measures and the 14 numbers of outcome measures were slightly 15 different. 16 At any point, the expert panel can 17 evaluate -- as measures get added and removed, 18 added and removed -- those missing data 19 thresholds and determine if they agree or 20 disagree or recommend or provide guidance on if 21 those things should be changed. 22 So no, it's not necessarily true we Page 517

1 couldn't grade hospitals if they had more 2 missing data. Our expert panel could certainly 3 decide at any point they want to expand our 4 missing data threshold. And that's within 5 their role and capacity to do so. 6 They could say hospitals can be 7 missing 10 process and structural measures, 8 nine outcome measures, as long as they have 9 PSI 90. 10 Q. Absolutely. No, I -- so they could 11 -- forgive me. I'm going to say it this way: 12 They could juice the numbers in that way, right? 13 I know you'll say no because 14 I -- I said that that way, but that's what it 15 sounds like to me. 16 The question I have, then, is, 17 They -- they didn't do that, right? So 18 hospitals that don't participate are missing 19 seven process measures, right? 20 A. The expert panel does not view -- 21 Q. I -- I just want an answer to my 22 question. I'm running low on time. If we can Page 518	1 seven, right? 2 A. We're missing data from the 3 hospitals themselves. 4 Q. Okay. And so the only way to put 5 that data into Leapfrog's grading system is to 6 impute, right? 7 Let me -- let me revise it. 8 It's a long day for us all. 9 A. Yes -- no -- I know. I just want to 10 make sure I'm answering your question 11 accurately. So that one was long. I just need 12 to process it. 13 Q. Yeah, yeah. No. I get it. 14 If the imputation model was not 15 applied, there would be no way for Leapfrog to 16 have data for six process measures, correct? 17 A. If no imputation model existed, 18 theoretically, Leapfrog would not have measure 19 scores for those six process measures. 20 Q. Correct. 21 Okay. And then under 22 Leapfrog's guidance, which is publicly put on Page 520
1 just focus in. 2 A. No, they're not. 3 Q. The -- they're not what? Sorry. 4 A. They're not missing measure 5 scores -- 6 Q. Okay. 7 A. -- for seven process and structural 8 measures -- 9 Q. Okay. 10 A. -- they're missing measure scores 11 for three process and -- 12 Q. Okay -- 13 A. -- structural measures. 14 Q. -- fair enough. And you got me. 15 They're missing -- you are 16 missing data for seven of those measures from 17 the hospitals, correct? 18 A. Imputed scores are data points. Not 19 correct. 20 Q. Okay. You are -- I will go again. 21 You are missing any performance 22 data from the hospitals themselves for those Page 519	1 its website, it could not grade the 2 nonparticipating hospitals, right? 3 A. No. The missing data thresholds 4 that you just described weren't established. I 5 don't see those numbers in this document. 6 Do you? 7 Q. No. I'm talking about the ones that 8 you just mentioned before, the six process 9 measures. 10 Right? 11 A. But I'm saying that number has 12 evolved over time. When this document was 13 written -- 14 Q. Yes. 15 A. -- it would not have been that. 16 Q. I -- I -- I -- 17 A. Oh, okay. I'm sorry -- 18 Q. -- I'm setting that aside -- 19 A. -- okay. I'm not following. 20 Q. -- I'm saying patients today looking 21 at Leapfrog's website -- which I know you're not 22 a corporate representative for. We don't need Page 521

1 to rehash that -- patients today looking at the 2 website will see that the Leapfrog did not grade 3 hospitals that lack information for the six 4 outcome measures, right -- process measures? 5 A. We don't specify which of the 22 6 measures need to be missing in order not to get 7 graded. So the way that you just asked that 8 question is not true. 9 As I described earlier, a very 10 small hospital, for example, that didn't have 11 enough patients to return those patient 12 experience surveys would be missing those five 13 patient experience measures. Maybe they don't 14 have an ICU, so it does not apply for ICU 15 staffing. And theoretically, they're, you 16 know, missing one other thing that takes them 17 to seven. 18 Hospitals that are not graded 19 can -- we don't say this hospital can't be 20 graded because they're missing this specific 21 measure and this specific measure and this 22 specific measure and this specific measure. Page 522	1 word for it. 2 Q. Hospitals missing more than six 3 process measures . . . are not graded. 4 ATTORNEY WOOD: Objection to 5 form. 6 BY ATTORNEY CRAIN: 7 Q. Okay. I'll read it all for 8 Courtney. 9 Hospitals missing more than six 10 process measures, more than five outcome 11 measures, or PSI 90 are not graded. 12 Do you see that? 13 A. I don't see that. I -- 14 Q. I'm sorry. Are you aware of it? 15 A. I -- I believe that that's wherever 16 you say it is because you're reading from a 17 document. 18 Q. That's consistent with what you 19 testified today about what -- about the missing 20 numbers that are not graded, right? We talked 21 about the -- exactly those numbers earlier 22 today, right? Page 524
1 Q. So the Leapfrog's website says, 2 Hospitals missing more than six process measures 3 . . . are not graded. 4 A. Right. 5 But it's any six process measures. 6 You keep saying "these" six process measures, 7 and it's not correct. It's any six process and 8 structural measures. And as I've said, those 9 five patient experience measures are process 10 and structural measures, so they could be 11 missing those measures. 12 Q. Totally with you. 13 A. Oh, okay. 14 Q. I did not say "these" in that 15 question. 16 A. Oh, okay. I think -- 17 Q. Because it does not say that on the 18 website. 19 A. Okay. 20 Q. And I'm -- you can see it's 21 highlighted. 22 A. Okay. I can't -- but I'll take your Page 523	1 A. The six process -- yes. In terms of 2 the number of missing measure scores, yes. 3 Q. Okay. 4 A. Yes. 5 Q. So -- 6 A. Based on the 2025 -- Spring 2025 7 scoring methodology that we've been looking 8 at -- 9 Q. -- you don't think it's a little -- 10 A. -- yes. 11 Q. -- bit confusing that Leapfrog is 12 actually missing hospital performance data for 13 seven outcome measures -- process measures -- I 14 always say that wrong -- process measures but is 15 telling people on its website that they don't 16 grade when six are missing? 17 A. I don't think that's confusing 18 because they're not missing. If you look on, 19 like, the Delray, they don't have seven blanks, 20 process and structural measure scores. So I 21 don't -- I guess I don't think that's confusing. 22 Q. So what does "missing" mean? Page 525

1 A. Not available from the primary or 2 secondary or other sources. Again, like, I wish 3 I had a better way to describe this, but -- 4 Q. I do, too. 5 A. -- we're looking at the existence of 6 a measure score, and the existence of a measure 7 score includes imputed data, and I -- I 8 described with, say, CMS imputing that patient 9 racial and ethnicity data, that is real data. 10 That is real data they make calculations on -- 11 Q. For sure. 12 A. -- and they represent to hospitals. 13 When we impute data, it is also 14 real data that we make calculations on. We 15 don't consider imputed data missing data. It 16 is a data point that is used in a mathematical 17 calculation. 18 Q. And I'm totally with you for 19 historical data for the means. That is -- those 20 are real numbers. What I'm still not 21 understanding is -- limited achievement just 22 seems to be -- and I'll use Ms. Campione's word Page 526	1 Q. Got it. 2 A. -- and one of those people was from 3 Discern Health and said, Actually, I've been 4 working with Leapfrog for even longer, and I 5 actually was the one working on this value-based 6 purchasing program. 7 And so it's very fresh in my mind. 8 Q. So -- and I -- I don't mean to be 9 glib, and I'm -- I'm very sorry for her early 10 passing, but your understanding of how the 11 limited achievement numbers came to be is from a 12 memorial service, or is it from another source? 13 A. No; it's from -- I administer that 14 program now, and so I have some historical 15 background. I just don't have the physical 16 documents showing -- 17 Q. Okay. 18 A. -- the meeting minutes and all of 19 that because it happened before my time, and 20 those weren't necessarily passed on to me. But 21 I was made aware by Discern Health that that was 22 the process because I asked that same question Page 528
1 the other day -- an arbitrary number. 2 A. I understand that Ms. Campione used 3 that word. Ms. Campione didn't know the 4 historical background of how those numbers were 5 assigned, and, in fact, they're anything but 6 arbitrary. As I said, they were scientifically 7 assigned, and that's why there's variation among 8 them, by a technical expert panel that was 9 administered by Discern Health before I got 10 here. They're not arbitrary. They were done in 11 a -- a scientific way and in a scientific 12 process. 13 Q. And before Ms. Binder got there, 14 right? 15 A. Yes. I believe it would have been 16 2006 or 2007. 17 Q. Okay. 18 A. And the reason I know that is 19 because the original CEO of The Leapfrog Group, 20 Suzanne Delbanco, passed very young due to 21 cancer. And during her memorial, people were 22 sort of retelling stories -- Page 527	1 early on. 2 Long before we did the Safety 3 Grade -- again, those values are used in our 4 value-based purchasing program, and so, you 5 know, as we've added measures to the 6 value-based purchasing program, over time, 7 we've had to assign numerical scores to those 8 performance categories. And Discern Health did 9 that scientific process for that different 10 technical expert panel. I just don't have 11 access to the exact meeting minutes notes 12 process that they use. 13 Q. Okay. Have you reviewed the expert 14 reports in this case? 15 A. Have I reviewed the expert reports? 16 For our witnesses or your 17 witnesses? 18 Q. Any. 19 A. Yes. 20 Q. Which -- which ones? 21 A. Both. 22 Q. Okay. Page 529

1 A. And I would call it a thorough scan. 2 I'm not going to be able to word-for-word 3 recite, but I have seen expert witness 4 testimony. 5 Q. Okay. Just reports, not test -- or 6 there is some testimony. 7 Have you -- 8 A. PDFs. 9 Q. PDFs. Okay. 10 Is it a transcript that you've 11 reviewed, or it's like a written report? 12 A. No; it's -- it's a written report. 13 Q. Okay. And are you aware of any 14 explanation in those expert reports of how the 15 limited achievement number was assigned? 16 A. Am I aware of any explanation of 17 those expert reports of how the . . . 18 I'm not. 19 Q. Okay. 20 A. I don't know how they would have had 21 that information. 22 Q. Yes. Page 530	1 Six? 2 Q. Got it? 3 Oh, 6, yeah. 4 A. No. 5 Q. Oh, all the way at the bottom. 6 It's the last one. I think it 7 is. 8 Six? 9 A. No. This is 20, so -- I'm sorry. 10 Q. Here, let me just show you what I 11 have as Exhibit 6. 12 A. I did not lose any documents. I 13 want to be very clear. 14 Q. This is what I have as Exhibit 6, 15 and I just wanted to show you that point. 16 Do you see where it says 17 Guiding Principles? 18 A. I do now. I did not when I -- 19 Q. Okay. 20 A. -- originally -- oh, from 2017. No, 21 I -- 22 Q. 2017. Page 532
1 I just want to go to one last 2 thing. If you go back to Exhibit 6 -- just so 3 you know I'm not making it up. You'll see when 4 you get there. 5 A. Yeah. 6 Q. Exhibit 6 is the June 14th, 2017 7 meeting. 8 I don't think you have the 9 right document, do you? 10 A. No. 11 Oh, mine has two numbers. I'm 12 sorry. 13 Q. Oh, yeah, there may be -- 14 A. Each document has -- 15 Q. It's the pink 6. 16 A. Okay. Give me a minute. 17 Q. It's going to be hard for trial. 18 A. I said I put them out of order and 19 didn't want to -- 20 Q. No worries. 21 A. -- spend time putting them back in 22 order, but now I can't find it. Page 531	1 A. Oh, I do now see it -- 2 Q. Got it? Okay. 3 A. -- and -- 4 Q. Do you have any reason to think that 5 the document we looked at, the Guiding 6 Principles, is not the one referenced in that 7 meeting minutes? 8 A. Only because it's not dated, and -- 9 and, again -- so I -- I can't attest. I 10 apologize, but -- 11 Q. And you don't recall what was 12 discussed in that regard at the meeting? 13 A. No. And if you remember when I told 14 you about this in-person -- 15 Q. Yeah. 16 A. -- meeting, I said I actually didn't 17 remember even having in-person meetings. They 18 were very rare. It said we were in Alexandria, 19 Virginia. The last in-person expert panel 20 meeting I remember was in Baltimore because 21 everyone wanted to be near an airport. So I -- 22 Q. No worries. Page 533

1 A. -- didn't -- and I apologize. When 2 I scanned this -- I do see it now. So I wasn't 3 -- 4 Q. I just wanted to make sure -- 5 A. I just -- I just misstated. So I 6 apologize, for the record. 7 Q. No worries. I -- 8 A. And I can't confirm whether or not 9 that's what was reviewed because it's not dated, 10 and I don't know what those meeting minutes 11 would be. 12 Q. Great. Okay. 13 A. I have to stop scanning things. 14 Q. Yeah. 15 ATTORNEY CRAIN: Let's go 16 off. 17 ATTORNEY WOOD: Yeah. It's 18 got to be close. 19 THE VIDEOGRAPHER: Going off 20 the record. The time is 1730. 21 --oOo-- 22 (Whereupon, a recess was taken from Page 534	1 Q. And it's an e-mail -- it's a thread 2 between you, Ms. Campione and Paulina Litter. 3 Do you see that? 4 A. Yes. 5 Q. And I don't think we've -- I don't 6 recall talking about her today. 7 Who is Paulina Litter? 8 A. I believe her last name is 9 pronounced Litter. 10 Q. Litter. Okay. 11 A. But she was a employee at Leapfrog 12 whose position title I don't remember. 13 Q. It says senior specialist, 14 operations and special projects -- 15 A. Oh, sorry. 16 Q. -- at the top. 17 A. Yes. 18 Q. Okay. 19 A. Yes. She did not work on my team. 20 Q. Got it. 21 Okay. So I'm going to go to 22 the bottom, which is the first e-mail on Page 536
1 5:30 p.m. EDT to 5:47 p.m. EDT.) 2 --oOo-- 3 --oOo-- 4 (Danforth Deposition Exhibit Number 5 21, E-mail string, Bates stamped 6 LEAPFROG00244555 through 7 LEAPFROG00244558, marked for 8 identification, as of this date.) 9 --oOo-- 10 THE VIDEOGRAPHER: Going back 11 on the record. The time is 1747. 12 ATTORNEY CRAIN: Great. 13 BY ATTORNEY CRAIN: 14 Q. Welcome back, Ms. Danforth. 15 A. Thank you. 16 Q. Glad you're enjoying the -- the 17 sparkling water. 18 A. Oh, my gosh, you're telling me. 19 Q. So I -- I've given you a document 20 from May of 2024. 21 Do you see that? 22 A. Yes. Page 535	1 Page 244558. 2 Do you see that? 3 A. I do. 4 Q. And am I -- is it fair to say that 5 this is a -- this is the process through which 6 that footnote we've been talking a lot about was 7 ultimately drafted? Is that what this looks 8 like to you? 9 A. Probably, yes. 10 Q. Okay. So it's an e-mail from her to 11 you, and she says, Hi, Missy. Paulina is going 12 to talk to Devon tomorrow. I thought more on 13 it, and I don't think getting four columns to 14 flag imputation for the four measures is a big 15 lift. I think asterisks might create issues for 16 them, and having the imputation text for every 17 hospital will create confusion. 18 Do you see that? 19 A. Yeah. 20 Q. Okay. So I'm just going to take you 21 up where they start drafting what the footnote 22 is. Page 537

1 A. Yes. 2 Q. And if you go to Page 244556. 3 A. I am there. 4 Q. And Ms. Campione proposes, Is this 5 what you have in mind? And she says, Text. 6 Do you see the asterisk on the 7 bottom? 8 A. Yes. 9 Q. She says, The hospital declined to 10 report data for this measure, so secondary data 11 was imputed using Leapfrog's imputation 12 methodology. 13 Do you see that there? 14 A. Yes. 15 Q. And we've talked a lot today about 16 second data -- secondary data and the imputation 17 methodology, right? 18 A. Yes. 19 Q. Now, you respond as 4:07 p.m. 20 Do you see that? 21 A. Yes. 22 Q. And you say, Yes, maybe . . . -- or Page 538	1 I'm, like, familiar with. It's really to help 2 hospitals understand because, again, like, we 3 have tried to be as transparent as possible 4 with hospitals, so that's typically how we use 5 those terms. 6 And so here I was trying to convey, 7 you know, Let's use "impute." I think I say 8 something like that. 9 Q. Okay. And when you say -- just 10 going back, you said you don't use "primary" and 11 "secondary" data. 12 You use it on the 28-page 13 document we looked at, right? 14 A. Yes. 15 Q. Just not on the -- the website? 16 A. Like, on the gas gauge page -- 17 Q. Yeah. 18 A. -- we refer to data sources, and in 19 that table, you can see all those data sources. 20 That's actually where it's referenced. 21 But on these footnotes, I was just 22 trying to be as short and plain and Page 540
1 colon So a score was imputed for this 2 measure "instead of secondary data. 3 Do you see that? 4 A. Yes. 5 Q. So you took out the language 6 "instead of secondary data"? 7 A. So I was the one who actually 8 received the help desk ticket comment that we 9 reviewed today basically saying, You need to be 10 really up-front about how you're doing this on 11 the website. I took that to heart and really 12 wanted to be up-front that this was a score that 13 was imputed that was assigned, et cetera. I was 14 really trying to stay away from saying it was a 15 score that was calculated or a score that was 16 derived. I was trying to be -- to be frank, 17 just as plain as possible. 18 And so the score was "assigned"; 19 the score was "imputed." I think we ended up 20 going with "assigned." We don't use terms like 21 "primary data" versus "secondary data," really, 22 on this particular part of our website that Page 539	1 straightforward as possible in making a 2 suggestion or recommendation. 3 Q. Okay. And you said you didn't want 4 to use the word "calculated" -- 5 A. Correct. 6 Q. -- why is that? 7 A. As I've described, it wasn't 8 calculated. It was assigned. 9 Q. Okay. And the same thing with 10 "derived." 11 You said you didn't want to use 12 the word "derived"? 13 A. Oh, did I say that? I'm sorry. 14 Q. You did. I can read it back, if 15 it's helpful. 16 A. Okay. I didn't want to use 17 "calculated." 18 Q. Okay. Are you saying you -- you 19 were okay with "derived"? 20 A. I don't usually use that word. 21 Q. Okay. 22 A. I don't know where that just came Page 541

1 from, but I didn't want to use "calculated." 2 Q. Okay. Okay. 3 A. Sorry. 4 Q. Okay. And then Ms. Campione 5 responds. She goes, Like this? Text: 6 Asterisk, The hospital declined to report data 7 for this measure, so a score was imputed for the 8 measure. 9 Do you see that? 10 A. Yes. 11 Q. And then you say, Yes, in this 12 e-mail on the next page? 13 A. Yes. But there must have been more 14 e-mails because that's not what we went through. 15 Q. Yeah, subsequently you change it to 16 "assign." 17 A. Okay. Yeah, so this was just 18 spitballing, yeah. 19 Q. Yeah. And -- and you ultimately 20 land on the "assign" language. 21 A. Correct. 22 Q. And why "assigned" versus "imputed"? Page 542	1 talked about earlier today. 2 A. Okay. 3 Q. Just go back to something. So on -- 4 we talked about -- so we talked about the 5 financial risk e-mail. 6 Do you remember that 7 discussion? 8 A. Yes. 9 Q. You had -- you testified that you 10 had just gone into that role, and so you were 11 asking to figure out the way the licensing 12 system worked, right? 13 A. For accolade specifically, yes. 14 Q. Yes. And just to be clear, were you 15 more knowledgeable about other licensing? 16 A. No. I just -- 17 Q. For that e-mail, you're saying? 18 A. For this e-mail, I -- yes. 19 Q. Okay. I just wanted to make sure. 20 So you've been in the role now 21 for almost two years, right? 22 A. Yes. Page 544
1 A. I think someone must have said to 2 us, "Imputed" might not be a consumer friendly 3 word. How about "assigned"? 4 And I said, Yes, it was assigned. 5 I honestly have -- I have no idea. 6 Q. Okay. 7 A. I'm conjecturing. 8 Q. Okay. All right. 9 A. I -- I take it this far, and then 10 it -- all the rest of the e-mails will have 11 other people's names on it. 12 Q. I'm trying to see if we can get that 13 e-mail for you. 14 A. Yeah. 15 Q. Yeah. Okay. 16 ATTORNEY CRAIN: Let me -- 17 can you give me that -- the sequence, 18 Emily? 19 ATTORNEY WOOD: The -- 20 ATTORNEY CRAIN: Yeah. 21 BY ATTORNEY CRAIN: 22 Q. I want to ask you about something we Page 543	1 Q. Okay. And now that you are no 2 longer new in the role of overseeing both 3 ratings and licensing -- 4 A. Yes. 5 Q. -- what is the financial risk to -- 6 to Leapfrog from hospitals not participating in 7 its survey? 8 A. I couldn't quantify any financial 9 risk to Leapfrog for hospitals not participating 10 in its survey. 11 Q. Is -- are you saying there's no 12 financial risk to Leapfrog if participation goes 13 down? 14 A. I could not assess any financial 15 risk to Leapfrog if participation goes down. As 16 I mentioned, participation has fluctuated over 17 the years between 2,300, 2,400, approximately. 18 The way that our data sets are 19 priced -- and, again, it's Leapfrog Hospital 20 Survey results, those score results. So 21 basically instead of four cell phone bars, it 22 says in the Excel file "achieve the standard." Page 545

1 The Leapfrog ambulatory surgery center results, 2 same thing, instead of those cell phone bars 3 you see in our public reporting website, it 4 would say "achieve the standard." The Hospital 5 Safety Grades -- I'm sorry. 6 Q. I'm just confused because I don't -- 7 I don't see how it's responsive to my question. 8 My -- my question is -- and 9 forgive me for -- you know, my question is, Is 10 there any financial risk to Leapfrog from a 11 decline in participation? 12 Yes or no? 13 A. No, that I can assess. 14 Q. Okay. None at all? 15 A. None that I can assess. 16 Q. And why do you qualify with "I can 17 assess"? 18 A. I have been in this role for two 19 years. I don't necessarily do things like 20 financial modeling or -- I really just make sure 21 that the data is correct. I help coach -- 22 oversee contracts. I'm not necessarily doing Page 546	1 structure? 2 Q. Yes. I wanted to get the -- get 3 your opinion first. 4 A. Okay. 5 Q. So Leapfrog's view is if 6 participation declined -- 7 A. Yes. 8 Q. -- you would not lose revenue? 9 A. Correct. 10 Q. Okay. Why is that? 11 A. So the -- the way that our data 12 licensure contracts are structured now -- so now 13 we're not talking about the Accolades, those 14 designated logos. So the way our data licensure 15 contracts are structured is because they often 16 take a very long time to negotiate those 17 agreements -- it can be upwards of a year -- 18 Q. Yes. 19 A. -- or even longer, we often include, 20 like, auto renewal terms. And once we have a 21 data licensee enter into a data licensure 22 agreement with auto renew, we've historically Page 548
1 financial risk analysis in -- in any way. 2 Q. Okay. 3 A. I also haven't had any opportunity 4 to have input on basically what you just 5 described. Basically any kind of modeling, 6 looking at financial risk is not something I've 7 done in the past two years. 8 Q. Okay. And so you are -- you are the 9 corporate representative for licensing, right? 10 A. Correct. 11 Q. Leapfrog has no view as a corporate 12 entity that if participation declined, that 13 could reduce revenue? 14 A. Because of the way our contracts are 15 structured -- 16 Q. Hold -- hold on. 17 A. -- it would not necessarily reduce 18 revenue. 19 So I do have an opinion. I guess 20 the answer would be no. 21 Q. Okay. 22 A. Can I talk a little bit about the Page 547	1 seen that they continue to license those data 2 just empirically as the number of hospitals 3 included in the data sets that have data 4 available has fluctuated over time. 5 I've not known of any feedback that 6 now we don't want to license the data, we've 7 not seen any data licensee stop licensing the 8 data due to survey participation. I've never 9 had a data licensee ask me about survey 10 participation or the number of hospitals 11 participating. 12 So in that way, I -- the answer -- 13 my answer would be no. 14 Q. Okay. Let me ask this question, 15 then. 16 See, when I say it that way, 17 I'm buying time to frame the question in my 18 head. We all -- we all have our tricks, right. 19 If Leapfrog stopped grading 20 nonparticipating hospitals, just stopped 21 altogether, do you believe participation would 22 go down in the survey? Page 549

1 A. No. 2 Q. Okay. 3 A. No. We have hundreds of hospitals 4 that will never be eligible to receive a 5 Hospital Safety Grade who for years and years 6 have participated in the 7 Leapfrog Hospital Survey. Again, the Safety 8 Grade is really the sort of narrow construct -- 9 I think we just saw that word -- focused on 10 patient safety, but a Leapfrog Hospital Survey 11 includes measures about maternity care and 12 pediatric care, inpatient surgery, outpatient 13 surgery. It's used to compare outpatient 14 surgery in hospitals to ambulatory surgery 15 centers. 16 So there's all kinds of hospitals, 17 and I've spoken about this previously, like 18 pediatric hospitals, critical access hospitals, 19 that have and do and continue to do the survey 20 regardless of the Safety Grade and who have 21 never gotten a Safety Grade and still do the 22 surveys, so I wouldn't see that as being a Page 550	1 A. Would that make the data set that 2 Leapfrog collects less complete? 3 I guess I, personally, have never 4 talked about our data set as being complete or 5 incomplete. The data licensees that we work 6 with are oftentimes, like, state-based or 7 regional in nature. And so complete to them 8 may be hospitals in our network or hospitals in 9 our state, not necessarily hospitals across the 10 country. So I don't know that I've or Leapfrog 11 has made the connection between how many 12 hospitals are in the data file versus a data 13 being complete. 14 I think we talk about the data 15 being complete as these minimum data 16 requirements that we talked about earlier 17 today, meaning that all hospitals submitting a 18 survey are required to report on those 19 Sections 1, 2, 4, 5, 6 and 7. That's how we 20 tend to talk about data completeness, is that 21 we have those minimum requirements. 22 And to be clear, for the Ambulatory Page 552
1 factor. 2 Q. Is there any connection at all 3 between the Safety Grade and hospitals' 4 decisions to participate in the survey? 5 A. I'm sure some hospitals make the 6 decision to participate in the survey because 7 some of those measures are used in the 8 Safety Grade, but before we started doing the 9 Hospital Safety Grade, we had hundreds of, you 10 know, thousands of hospitals. 11 So, yes, the answer is probably 12 yes, some. 13 Q. Okay. So -- 14 A. Not all, and, again, hundreds of 15 hospitals do the survey that aren't even 16 eligible for a Safety Grade. 17 Q. Got it. Okay. Understood. 18 A. Okay. Yes. 19 Q. But if -- okay. So if fewer 20 hospitals ended up submitting data in the 21 survey, would that make the data set that 22 Leapfrog collects less complete? Page 551	1 Surgery Center Survey, all sections are 2 required. So there's five sections to that 3 survey, and all are required in order for them 4 to submit the survey. 5 Q. If fewer hospitals participate in 6 the survey, Leapfrog has less data, right? 7 A. We would have less data on those 8 hospitals, yes. 9 Q. Think -- think you had to go with me 10 on that one. It's just a numerical -- 11 A. Yeah. It just -- it's not a -- 12 Q. -- it's just a number? 13 A. -- a -- a value -- right. It's a 14 number. I can't assess a value to it, right. 15 Q. Okay. A data set that is less 16 complete is worth less than a data set that is 17 more complete, right? 18 A. Can you give me an example? 19 Q. If you had a data set of 30 20 hospitals, presumably, that would be less 21 valuable than a data set that included 2,000. 22 A. Right. And that's where I'm saying, Page 553

1 no, that's not the case. We have a health plan, 2 I think, in Massachusetts, and I think the data 3 that they request is probably for 30 hospitals. 4 And they've been licensing those data and 5 renewing it for years and years and years. And 6 so, again, it really depends. 7 The -- the uses are so variable by 8 each -- because it's not all these national, 9 you know, health plans or national employers. 10 A lot of times, it might be a small or regional 11 data user. It could be a researcher. And 12 maybe the thing they care about is, you know, 13 C-section rates. So to them, completeness is 14 actually just I need as many C-section rates 15 for as many years as you have. 16 So this question is not -- this 17 answer is not evasive. It is literally what 18 the data licensees tell me -- it's what they 19 tell me. This is first -- this is firsthand 20 what they told me, not what I've heard -- 21 CERTIFIED STENOGRAPHER: Excuse me. Sorry. Could you -- could you 22 se me. Sorry. Could you -- could you Page 554	1 Q. Out of how many? 2 A. Thirty -- 30 or 35. 3 Q. Okay. So 30 or 35 total licensees? 4 A. Yep. 5 Q. What are the two? 6 A. Elevance and . . . 7 Q. Is one of them Centene? 8 A. No. That's not a national health 9 plan. It -- so it's United, but it's not 10 actually United that licenses the data. They 11 have, like, a subsidiary -- 12 Q. Got it. 13 A. -- that licenses the data. But I 14 believe they're technically affiliated with 15 UnitedHealthcare. 16 Q. Okay. And how many employers? 17 A. How many employers licensee the 18 data? One employer group. 19 Q. Okay. Which one? 20 A. Purchaser Business Group on Health. 21 And they're in California. They used to be 22 Pacific Business Group on Health. Page 556
1 repeat that? 2 ATTORNEY CRAIN: She said, 3 This is first -- 4 THE WITNESS: This is 5 firsthand what they told me, not -- 6 not what -- not what I've heard. 7 And so, you know, the value 8 of the data to them is based on who's 9 in it and who they want to use. 10 BY ATTORNEY CRAIN: 11 Q. So you oversee the licenses, right? 12 A. Yes. 13 Q. And you are the corporate 14 representative -- 15 A. Yes. 16 Q. -- for licenses? 17 Can you tell me generally what 18 percentage of licensees fall into the different 19 categories you mentioned? So national 20 insurers -- approximate -- ballpark, how many of 21 your licensees are national insurers? 22 A. Two. Page 555	1 Q. Okay. And how many, like, 2 individual researchers? 3 A. I didn't include the researchers in 4 that number because they often get the data for 5 free -- 6 Q. I see. 7 A. -- so I included, like, the 0 or 35 8 -- these are organizations that we charge -- 9 Q. So -- 10 A. -- money to -- 11 Q. -- okay. Let me fix -- let me make 12 it easier on you -- 13 A. Okay. 14 Q. -- of the 35, what -- what are the 15 rough numerical buckets of -- that -- that's in 16 that 35? 17 A. Okay. So there's organizations, 18 like solutions providers, right, so what you 19 might think of as, like, healthcare vendors that 20 may license the data for, like, internal use, 21 like business development, that kind of thing. 22 We have a couple states -- Page 557

1 California, Massachusetts -- that license the 2 data so they can do some benchmarking just for 3 hospitals in their state. So one is called 4 CHIA, C-H-I-A, and they're, like, a public 5 health organization -- 6 Q. Okay. 7 A. -- in Massachusetts. 8 So there's a lot of little buckets. 9 I'm just -- 10 Q. Yeah. 11 A. -- I'm going to -- those are little 12 buckets. 13 So health care solutions providers 14 are vendors -- you might think of them -- 15 Q. Yeah. 16 A. -- a lot of those are for internal 17 use. 18 These state-based organizations or 19 agencies -- we talked about the national health 20 plan. We have some regional health plans. So 21 Health Net actually licenses the data, but they 22 only administer health insurance products in Page 558	1 Q. Okay. 2 A. -- and that would be another 3 category. 4 Q. Any others you can think of? 5 A. Yes. So the other category -- and 6 this is -- I'm not sure -- they are a healthcare 7 -- consultants -- I would call them 8 "consultants," so, like, Premier, which I think 9 is, like, a healthcare consulting organization. 10 So that would be the other group. And it's just 11 Premier. 12 So I would say the consultant, 13 value-added resellers, regional and national 14 health plans, solutions providers, employers 15 and purchasers. 16 Q. Great presentation. 17 My question -- 18 A. I had nothing to read off. 19 Q. Very impressive, your buckets. 20 Of those 35 -- and, again, not 21 a memory test, so I'm just asking for your best 22 estimate even though you are passing the memory Page 560
1 California and maybe part of Oregon. They're 2 not -- they're not national in scope. 3 Blue Cross Blue Shield, 4 North Carolina, Blue Cross Blue Shield of 5 New Jersey, and then Capital Blue Cross and 6 Blue Shield, which is just this little weird 7 market in Pittsburgh. 8 We also have -- I don't know how 9 you would define them in a way that's easy, but 10 we call them "value-added resellers." It's 11 basically organizations who have data of their 12 own. They license Leapfrog's data and combine 13 it with their own or other data, and they 14 resell it as their own independent product to 15 whoever they want. And we don't necessarily 16 know who that is, but we've given them 17 permission to do that. 18 And one example would be 19 Embold Health. They collect physician data, 20 and they do physician ratings. They pair some 21 of that with our facility-level ratings, and 22 they have a separate and independent product -- Page 559	1 test -- what -- what portion of those 35 or so 2 license Leapfrog's complete set of data versus a 3 smaller set of data? 4 A. So if the organization or an 5 individual wants a less -- like, not the full -- 6 Q. Yeah. 7 A. -- Leapfrog Hospital Survey results 8 but maybe they just want infection rates for 9 Connecticut for 2024, that falls under what we 10 call "data products." And I believe you've seen 11 our financial statements. So data licensure -- 12 data products is separate -- 13 Q. Okay. 14 A. -- we have very few organizations 15 that are licensing these one-time data products. 16 Q. Okay. So the 35 license the 17 complete set? 18 A. The 35 have an annual license. 19 Can I just describe what that 20 means? 21 Q. In brief. 22 A. Okay. So there's three different Page 561

1 data sets, and you can think of it as three 2 separate Excel files: Leapfrog Hospital Survey 3 results, Leapfrog ASC Survey results, Leapfrog 4 Hospital Safety Grades. 5 So 30 to 35 license one of those 6 three data sets I just talked about -- 7 Q. Got it. 8 A. -- for the Leapfrog Hospital Survey 9 and the Leapfrog Ambulatory Surgery Center 10 Survey. Because those surveys are on a rolling 11 basis, the data is delivered to them and 12 refreshed on a monthly basis beginning first in 13 July and going all the way to February. So 14 they're getting updates all the time. 15 For the Hospital Safety Grades, 16 because we're issuing grades twice a year -- 17 Q. Yeah. 18 A. -- they're getting those files twice 19 a year. 20 Q. Fair -- fair enough. No -- 21 A. Okay. 22 Q. -- so my question -- so on those Page 562	1 use it -- derived from our public reporting 2 website. 3 Q. And calculate -- no. 4 That's very helpful. 5 Okay. So all -- okay. 6 So another question we have -- 7 so if fewer hospitals participate in the survey, 8 would that impact Leapfrog's brand? 9 A. Not in the immediate term. I mean, 10 if every hospital in the country stopped 11 participating in the survey, that would impact 12 Leapfrog's brand. But like I said, over the 13 years, we've had fluctuations in survey 14 participation. I've not seen an impact on our 15 brand. I've not heard anyone talk about that 16 impacting our brand, and that's as Leapfrog. 17 Q. So -- so let me -- let me just, like 18 -- if -- if Leapfrog stopped grading 19 nonparticipating hospitals and some certain 20 percentage of hospitals say, Great, we don't 21 have to do the survey anymore because we won't 22 be penalized -- I know that's not your position, Page 564
1 three files -- 2 A. Yes. 3 Q. -- let's say it's the survey file -- 4 A. Yes. 5 Q. -- to take an example. 6 It's every hospital that 7 participates in the survey? 8 A. No; it's every -- 9 Q. Okay. 10 A. -- hospital on our roster. And so 11 whether a hospital participates in our survey or 12 not, they're included in the file. 13 So I believe you've seen -- 14 Q. I see. 15 A. -- our public reporting website, 16 leapfroggroup.org -- 17 Q. Yeah. 18 A. -- so you can see how you can search 19 for hospitals, and it comes up as Decline to 20 Respond. Any hospital searchable on that 21 website is in that file. You can think of that 22 file as a distillation derived from -- I will Page 563	1 but just -- 2 A. Yes. I -- I'm following. 3 Q. -- follow me. 4 Let's say a certain 5 decent-sized percentage decided not to 6 participate anymore -- 7 A. Yeah. 8 Q. -- would that have any financial 9 implications to Leapfrog? 10 A. I don't believe it would. And, 11 again, that's because, in the past, we've seen 12 those kind of fluctuations. And the way that 13 our licenses are structured and so few of them 14 being national, I -- I honestly can't imagine 15 that would have financial ramifications. 16 We -- 17 Q. What -- what if, like, half of 18 hospitals stopped participating? 19 Still no impact? 20 A. Maybe, but I -- I'm not sure. 21 So can I tell you the feedback that 22 I do get about -- so mostly what we hear from Page 565

1 people who don't license the data, right -- so 2 people who we talk to about the data are like, 3 No, we're not paying you for this; they don't 4 license the data -- it's not because there's 5 not enough hospitals or it's not because -- I 6 mean, I guess sometimes it might be there's not 7 enough hospitals in my state. 8 The biggest reasons have tended to 9 be you don't have the measures I'm looking for. 10 And I've talked a lot today about I -- I want 11 to -- I'd love to give some measures away and 12 add some more. 13 The hardest topics right now are 14 things like behavioral health safety and 15 quality; oncology care safety and quality; more 16 specific types of orthopedic care, like joint 17 replacement, spine safety and quality. 18 So when people tell us we don't 19 want to license your data, we don't want to pay 20 for the data, the resounding theme has been 21 because you don't have these behavioral health 22 measures, and that's what we're looking for; Page 566	1 Q. Let me ask this question -- I did 2 again -- If participation increases, does that 3 confer a financial benefit on Leapfrog? 4 A. No. 5 Q. None whatsoever? 6 A. No. 7 Q. There will be no revenue increase? 8 A. Not necessarily, because a lot of 9 our contracts -- because they're auto-renewal, 10 those organizations have also negotiated no 11 increases for some number of years as a 12 condition of auto-renewal. 13 Plus, to be frank, we don't value 14 the data or price the data based on the number 15 of hospitals. We've never done that. We don't 16 have a model to increase the prices based on 17 the number of hospitals. 18 So I could not, as Leapfrog, think 19 of a way that we could do that because we've 20 never done it. 21 Q. I -- I just want to be very clear in 22 my question, too. I'm not limiting my question Page 568
1 you don't have this oncology data, and that -- 2 and that's what we're looking for. 3 So when I think about sort of 4 growing the data licensure program, I'm looking 5 for opportunities to collect data on different 6 topics that potential data licensees tell us 7 they're interested in, like behavioral health 8 oncology, et cetera. That's how I, in this 9 role, have framed those conversations. 10 Q. Sorry. 11 A. It doesn't make me paranoid at all, 12 so . . . 13 Q. For the record, I was conversing 14 with my cocounsel, just briefly. 15 A. That's how -- and I -- I mean, I've 16 talked a lot about that today, but really, 17 that's -- I'm looking for opportunities. We 18 need the types of information that people are 19 asking us for. 20 We can't keep growing and growing 21 and growing the survey, so, like, how can we 22 start to -- to solve for some of those things? Page 567	1 just to licensing -- 2 A. Okay. 3 Q. -- is there any revenue stream that 4 increased participation would confer a financial 5 benefit on? 6 A. So the only revenue stream -- stream 7 associated with participation in the 8 Leapfrog Hospital Survey is the data that we 9 license. We also sell benchmarking reports to 10 hospitals that summarize their 11 Leapfrog Hospital Survey results using that 12 value-based purchasing program methodology I 13 described. 14 We have 23-, 2400 hospitals 15 participating in the survey today. We sell 16 maybe \$40,000 worth of benchmarking reports. 17 Theoretically, if more hospitals came in that 18 cared about benchmarking, maybe I could 19 increase my benchmarking report line, but it's 20 not a direct one-to-one. 21 Q. And you said the only one was 22 licensing, but there's also Accolades, right? Page 569

1 A. But that's not necessarily related 2 to participation in the 3 Leapfrog Hospital Survey. 4 Q. But Ms. Campione's deck that we 5 looked at before says there's a 10-times 6 correlation between participation and purchasing 7 Accolades. 8 A. She said that hospitals that part -- 9 that license to accolade -- again, just to be 10 back to my 80/20, the majority of hospitals in 11 the country are doing the survey before and 12 after the Safety Grade. The majority of 13 hospitals being graded are participating in the 14 Safety Grade. 15 The fact that the majority of 16 hospitals being graded, which is -- I don't 17 know -- a few hundred hospitals -- like, a few 18 hundred -- 200-and-something hospitals are 19 licensing the Safety Grade. 20 Do I think that would have an 21 increase in Accolade revenue? No, because 22 already hundreds more hospitals participate in Page 570	1 more things. I want to talk about the Safety 2 Grades again -- 3 A. Yes. 4 Q. -- in that bucket -- 5 A. Yes. 6 Q. -- there's a lot of buckets today -- 7 topics. 8 Hospitals that get A grades -- 9 A. Yes. 10 Q. -- fair to say an A grade helps a 11 hospital's reputation? 12 A. I'm just going to repeat back 13 comments hospitals have said to us, to my face, 14 not hearsay. 15 Many hospitals tell us -- and this 16 is reflected in our low Accolades licensure 17 numbers -- that they don't need to silence the 18 Safety Grade, that they already have a strong 19 reputation in the community. They're known for 20 surgery. They're known for -- so while some 21 hospitals may license a Safety Grade because 22 they think it does improve their reputation in Page 572
1 the survey and earn an A and have for many 2 years and have never licensed the Hospital 3 Safety Grade. 4 We've empirically seen no growth in 5 our Accolades program related to participation 6 in the survey. And that's why when we talked 7 about this, I was almost embarrassed that you 8 brought that up because I said if I had known 9 that number was 200 hospitals -- I see how 10 silly that question was -- I was just trying to 11 get -- get in the mix with question. 12 Q. So now, having been two years in 13 that mix -- 14 A. There's still no relationship 15 between participation in the survey. There's 16 been virtually flat number of sales. In fact, I 17 believe the spring 2025, we had exactly the same 18 or one or two different as spring 2024. 19 So it's -- it's not identical. 20 Fairly, fairly flat. 21 Q. Yeah, okay. 22 I want to ask about a couple Page 571	1 the community, other hospitals tell us 2 something different. 3 And, again, the majority of 4 hospitals, 700 plus, don't license the 5 Safety Grade at all, so I don't know how they 6 feel about the A Safety Grade. 7 Q. I'm asking your view. And let's -- 8 let's set aside licensing for a second, right? 9 A. Yeah. 10 Q. When the Leapfrog Safety Grades come 11 out, there's a significant press effort to 12 publicize those grades, right? 13 A. Yes. 14 Q. They're -- separate from licensing, 15 right? 16 A. Correct. 17 Q. Hospitals that get A grades try to 18 -- they or Leapfrog try to get stories about 19 those A grades, right? 20 A. Some of those hospitals do, yes -- 21 Q. Okay. 22 A. -- not all and a smaller percentage Page 573

1 than I would think. 2 Q. How small a percentage? 3 A. I think there are whole states where 4 I've actually never seen a press announcement. 5 I mean, we have a PR firm called Kyra, and they 6 combine things. But I hear, for example, 7 annually that New Jersey -- hospitals 8 in New Jersey get a lot of coverage. I've never 9 heard, for example, hospitals in Utah get a lot 10 of coverage or hospitals in -- so that's what I 11 mean by -- like, we have A's -- 12 Q. Yeah. 13 A. -- theoretically in every state -- 14 Q. Yes. 15 A. -- and in some places, I've never 16 heard Kyra or seen a report that hospitals from 17 those places have ever done a press release, 18 ever gotten media coverage. 19 So there does seem to be some 20 variable, is all I'm describing. 21 Q. Sure. But an A grade is a positive 22 thing, right? Page 574	1 hospitals. We ask them how they're using the 2 grade. And even when they license, it is 3 painfully hard to get -- for them to tell us, 4 so I -- you would think I would have more 5 visibility. 6 It's something TelAffects actively 7 does. They call these hospitals and say, You 8 licensed the grade. How are you using it? 9 I only have a handful of examples 10 of what I can speak to factually of how I know 11 hospitals are using it. And I'm happy to share 12 all of those right now. 13 Q. Sure. So I -- 14 A. Okay. 15 Q. -- I don't want you to share all of 16 those right now -- 17 A. Oh, okay. 18 Q. -- but I'm happy to talk about it 19 after. 20 A. Okay. 21 Q. Can we talk briefly about CMS STARS 22 scores? Page 576
1 A. I think so. 2 Q. And if a hospital already has a good 3 reputation in the community, an A grade can 4 solidify that reputation, right? 5 A. I think so. Theoretically, yes. 6 Q. And it could, in theory, improve 7 that reputation, right? 8 A. I've never seen or heard of any 9 stories about an -- a grade improving a 10 reputation. 11 So can I give an example? 12 It's like Brigham and Women's 13 Hospital in Massachusetts. Like, people travel 14 all over the world to go there. They, I do 15 think, maybe advertise and license their A. 16 Do I think -- is it a measurable 17 impact on their brand awareness? I don't -- I 18 don't think so. I don't know. You would have 19 to ask them -- 20 Q. Yeah. 21 A. -- and that goes for every hospital. 22 We've tried to collect data from Page 575	1 A. Yes. STARS -- STARS. Okay. 2 Q. Do you think -- so five stars is the 3 highest, right? 4 A. CMS has a five-star rating -- 1, 2, 5 3, 4, 5 -- correct. 6 Q. Five's the best. 7 Do you think a five-star rating 8 has the same or greater impact on a hospital's 9 reputation as a Leapfrog A? 10 A. Depending on the audience, yes. For 11 example, the majority of health plans around the 12 country -- you might notice I only named five 13 health plans -- 14 Q. Sure. 15 A. -- that license Leapfrog data. The 16 majority of regional and national health plans 17 around this country heavily rely on those CMS 18 star ratings over Leapfrog data, over almost any 19 kind of data, for a couple of reasons: One, 20 it's free. Obviously, CMS makes it available, 21 free and downloadable. And also my impression 22 is that they're trying to align with CMS who is Page 577

1 a very large national payer. So from a payer 2 perspective, meaning health plans, the CMS 3 five-star ratings probably, from my perspective, 4 have the biggest impact of anything. 5 Q. What about from other perspectives? 6 A. So the CMS five-star ratings are 7 really designed for Medicare bare -- 8 beneficiaries, but I know they're used by a lot 9 of other people. 10 I would say for private purchasers 11 and insurers, they're often looking at both. 12 We actually, very disappointingly, have a 13 regional leader in Wisconsin of all places, and 14 when they put out an RFP to have their health 15 plan use quality data in payment and 16 reimbursement, even though they're a Leapfrog 17 regional leader working to get participation in 18 our survey, they chose all CMS measures. 19 And so even employers and 20 purchasers -- there's just something about that 21 alignment with this big federal agency that for 22 the purposes of our constituents, they really Page 578	1 A. I have an acute sensitivity. 2 Q. Yeah, yeah. Understood. 3 Understood. Okay. 4 So I want to flip it a little 5 bit -- 6 A. Yes. 7 Q. -- talk about F grades. 8 A. Yes. 9 Q. F grades, would you agree, can 10 damage a hospital's reputation? 11 ATTORNEY WOOD: Objection to 12 form. 13 THE WITNESS: Again, 14 potentially. 15 And can I give empirical 16 evidence? 17 BY ATTORNEY CRAIN: 18 Q. No. I'm sorry. I'm just -- I have 19 so little time. I want you to just -- 20 A. Okay. 21 Q. -- answer my question, and you are 22 welcome to go on redirect after my time is done. Page 580
1 tend to gravitate to. 2 Q. Let me ask you -- do you believe the 3 CMS STARS are well known among patients? 4 A. Yes. Very. 5 Q. Okay. Do you believe they are more 6 or less or equally known to the Leapfrog Safety 7 Grade? 8 A. Sadly, probably more. 9 Q. Okay. So I want to -- 10 A. We've been asked, Have you thought 11 about moving to STARS? Like, we're told, like, 12 STARS are very easily understandable and -- but 13 they're very well known. 14 Q. Okay. 15 A. It's a touchy subject for me because 16 a lot of times -- now that I am responsible for 17 data licensure -- 18 Q. Yeah. 19 A. -- we're just going to use the CMS 20 data. 21 So . . . 22 Q. Got -- oh, got it. Page 579	1 A. If I -- then I would have to say no. 2 Q. Okay. 3 So your -- your answer is that 4 an F grade cannot damage a hospital's 5 reputation? 6 A. Oh, not "cannot." 7 Q. Okay. 8 A. I -- I can't speak definitively. 9 Q. Let me -- let me just say -- 10 A. Sure. 11 Q. -- let me go back to my question, 12 and I just want you to answer my question -- 13 A. Yeah. 14 Q. -- because I'm trying to get you out 15 of here on time, and I don't want to have to 16 keep you longer. 17 Can an F hospital -- can an F 18 grade damage a hospital's reputation? 19 A. Theoretically. 20 Q. Can an F grade damage a hospital 21 with a bad reputation? 22 A. Theoretically. Page 581

1 Q. Can an F grade solidify an already 2 existing bad reputation? 3 A. Theoretically. 4 Q. Can an F grade make it more 5 difficult for a hospital to repair its 6 reputation? 7 A. Theoretically. 8 Q. Okay. 9 A. I could answer more definitively if 10 I'm able to -- to share the examples that I 11 have, so it's totally up to you. 12 Q. If -- if your counsel's willing to 13 give me more time, I'm willing to hear it -- 14 A. Oh, okay. 15 Q. -- but if not, then I'm not willing 16 to hear it right now. 17 ATTORNEY CRAIN: Up to you, 18 Courtney. 19 THE WITNESS: No. 20 ATTORNEY CRAIN: Let's -- 21 let's go on break. 22 THE WITNESS: Let's keep Page 582	1 left: The first is I want to talk about the 2 certified coach program. 3 A. Yes. 4 Q. I understand you're the teacher of 5 that program, right? 6 A. I am the coach -- 7 Q. You are the coach. 8 A. -- of the certified coach's program, 9 yes. 10 Q. It's like King of Kings. 11 Coach of coach, right? 12 A. Yes. 13 Q. Yeah, so tell me -- when was the 14 coach program created? 15 A. We developed this program probably 16 two years ago, and we did it for one very 17 specific reason, which is that we wanted other 18 people who worked with hospitals who were 19 consulting with hospitals to not give hospitals 20 inaccurate information about the 21 Leapfrog Hospital Survey. 22 There's only one of me as we've Page 584
1 moving. 2 ATTORNEY CRAIN: Yeah, let me 3 take five. 4 THE WITNESS: Yes. 5 ATTORNEY CRAIN: Let's just 6 take a break. 7 THE WITNESS: Really five? 8 ATTORNEY CRAIN: Really five. 9 I'll do my best. 10 THE VIDEOGRAPHER: Going off 11 the record. The time is 1823. 12 --oOo-- 13 (Whereupon, a recess was taken from 14 6:23 p.m. EDT to 6:32 p.m. EDT.) 15 --oOo-- 16 THE VIDEOGRAPHER: Going back 17 on the record. The time is 1832. 18 BY ATTORNEY CRAIN: 19 Q. So we're almost done with the first 20 day of your deposition. Just kidding. 21 I have two more topics I want 22 to cover in the brief amount of time we have Page 583	1 talked a lot about today, and I only have a 2 team of 10. And so the idea was to basically 3 take other healthcare professionals who also 4 work with hospitals, show them the hard copy of 5 the survey, where to find the reporting 6 periods, a lot of what I did with you today, so 7 if a hospital asks them, we have a slightly 8 better chance of saying, I know where to find 9 that in the hard copy of the 10 Leapfrog Hospital Survey, instead of answering 11 it off the cuff and telling them something 12 totally wrong and inaccurate. 13 Q. And -- thank you for that. 14 And can -- can anyone 15 participate in the program? 16 A. So, technically, I guess, yes, 17 anyone could participate in the program. It's a 18 four-hour interactive webinar. I develop all of 19 the content. I deliver the webinar myself. 20 Like a lot of the education I do, there's a lot 21 of, like, polling and the use of something 22 called Slido so I can check as we go along to Page 585

1 make sure they're understanding what I'm saying. 2 So when I talk about performance 3 categories, are they following what I mean when 4 I talk about measure specifications. 5 At the end, they actually take an 6 exam. The exam has to be completed within two 7 weeks or 30 days of them finishing the webinar 8 part with me. And they take the exam, and if 9 they get a passing score, which we've 10 considered, I believe, 70 or greater, then they 11 become a certified coach. 12 On our website, it's explained in 13 detail that it means that they understand where 14 to find information about the 15 Leapfrog Hospital Survey, where to find 16 materials and resources on our website, like 17 the scoring algorithms in the binder. It's not 18 meant to replace our help desk. 19 And they aren't taught to, and are 20 actually emphatically advised not to, advise in 21 any way on our measures. I basically spend 22 four hours saying, If a hospital asks you Page 586	1 the game is scored. 2 And so I teach them the rules, the 3 scoring algorithms and the know-how to ask for 4 help. It's really quite focused around those 5 three components. 6 Q. How do they stay up-to-date as 7 things change? 8 A. If they want to continue to be a 9 Leapfrog certified coach, they would repeat the 10 course the next year with my new presentation. 11 But, again, the content may change, but a lot of 12 what I'm working on them with is, like, the 13 structure of the survey, documentation 14 requirements and how to find that on our 15 website, how to use a paper and pencil in our 16 scoring algorithms to help hospitals understand, 17 Oh, if I say, Yes, Yes, Yes, No, right, we have 18 those scoring algorithms rubrics. There should 19 be no surprises. Let's teach them how to do 20 that. But I still like to have them do a 21 refresher. 22 Q. And does it cost for the program? Page 588
1 something you're not a hundred percent sure of 2 the answer, please send them to the help desk. 3 So we do a lot training around that. 4 Q. When you say they can't advise new 5 measures, that means, like, what -- how to 6 respond to the measures or -- or what -- 7 A. So if there's a question about -- I 8 think earlier we were talking about those Ensure 9 shakes, and -- and they have a barcode. They 10 shouldn't be telling hospitals whether or not 11 those Ensure shakes are a medication based on 12 our definition. If it is not clearly to the 13 letter articulated in our measure 14 specifications, they are coached, trained to 15 have those hospitals come to the 16 Leapfrog Hospital Survey. 17 I really define their role in a 18 very specific way. I talk about it a lot. So 19 a coach's job is not to win the game for the 20 team. That's not what a good coach does. I'm 21 a coach for Brazilian jujitsu. My job is to 22 know the rules, know who to ask and know how Page 587	1 A. There is. 2 Q. How did Leapfrog decide what the 3 cost would be? 4 A. That's a good question. 5 We wanted it to -- it was designed 6 for healthcare professionals, not individuals 7 from hospitals. And so we wanted it to be more 8 than whatever we charge hospitals because we 9 didn't want hospitals to think we were trying 10 to get them to pay more to learn about the 11 survey. We keep all of their education under 12 \$400. I think it's \$395 for a same similar 13 four-hour educational thing. 14 So I think someone just decided, 15 How about a thousand dollars -- 16 Q. Okay. 17 A. -- or \$995? 18 Q. And so the hospitals -- what -- 19 what's the name of the hospital education 20 program? 21 A. They're called Leapfrog Deep Dive 22 Series, and I offer them on various topics Page 589

1 throughout the year, very similar to what I just 2 talked about, what we deep dive into a 3 particular area. And so if it's someone who is 4 maybe new to doing the survey at that 5 hospital -- it's like a very hands-on sort of 6 coaching experience, again, where I just show 7 them where to find everything, how this works. 8 If someone says, How do we know 9 this is evidence-based? This is where you find 10 our fact sheets. It's a lot of that. 11 Q. And so it's just -- just so I 12 understand, the -- both educational programs are 13 about how to respond to the survey, not change 14 the underlying performance; is that right? 15 A. Correct. We -- we do no guidance or 16 advice on how to actually improve on the 17 measures. What we do do, however, is our 18 communications department does what we call case 19 studies, where they interview hospitals -- 20 Q. Yeah. 21 A. -- on various topics, like reducing 22 C-sections or staffing your ICU with Page 590	1 Q. Yeah. 2 A. And I do a poll at the end. I say, 3 What is your confidence now in leading your 4 hospital's -- Leapfrog Hospital Survey? And 5 most of the time, people say, I feel more 6 comfortable, or, I feel -- 7 Q. Sure. 8 A. -- much better. I'm still nervous, 9 but the goal is for them not to be so nervous. 10 Q. And then last question on this line. 11 A. Yes. 12 Q. How many folks have gone through the 13 certified training program -- coach program? 14 A. For the certified coaches, maybe 20. 15 Q. Okay. Since the -- 16 A. I can't see the people, so that's a 17 really good question on the coaches, so I don't 18 know how many are joining. I don't check on 19 purpose because I don't want it to psych me out. 20 I would say 20 to 30. 21 Q. Okay. One last topic. I want to 22 talk about the white paper, which is one of your Page 592
1 intensivists. 2 On my slides, I point them to the 3 resource of the case studies that they can use 4 but make it clear that's not us saying, That's 5 what you should do. It's just a resource that 6 we offer. 7 Q. Okay. 8 A. We do no advising whatsoever on how 9 to improve on the measures or how to do quality 10 improvement in any way. 11 Q. And just ballpark, how many 12 hospitals participate in the Deep Dive program? 13 A. So I usually offer two or three a 14 year, and I have maybe 50 to 60 hospitals on 15 each one. We do cap it because I want to be 16 able to answer all of their questions -- that's 17 why I'm used to these long-form responses -- 18 because the goal is that they are getting more 19 personalized attention, if they need it, to 20 answer all of their questions. And when they 21 leave, they should feel like, Okay. I really 22 got this. Page 591	1 topics. 2 A. Yes. 3 Q. Now, first question, Leapfrog has 4 said that C, D and F, or just D and F hospitals, 5 that you're twice as likely to die if you go to 6 one of those hospitals as opposed to an A 7 hospital. 8 Are you familiar with that? 9 A. I'm familiar with the graphic you're 10 referencing. I don't know that those are 11 exactly the stats -- if you have it to pull 12 up -- but I'm familiar with the graphic, 13 correct. 14 Q. Okay. Is that -- is that Leapfrog's 15 view of the mortality difference in those 16 hospitals today? 17 ATTORNEY WOOD: Objection to 18 form. 19 (The witness mumbles under breath 20 while reviewing the material 21 provided.) 22 Page 593

1 BY ATTORNEY CRAIN: 2 Q. Let me revise. 3 A. I'm sorry. 4 Q. Is a patient twice as likely to die 5 if they go to a C, D or F hospital today as 6 compared to an A hospital? 7 A. Again, I don't know that the 8 original graphic says that. 9 Does someone just quickly have it 10 so I can look at it? 11 Q. I -- I'm just asking a different 12 question. 13 A. Okay. Okay. 14 Q. Setting aside the graphic -- 15 A. Okay. 16 Q. -- is -- 17 A. I have not estimated mortality based 18 on Spring 2025 Safety Grades -- 19 Q. Okay. 20 A. -- where I could answer that 21 question as of today. 22 Q. Has Leapfrog? Page 594	1 again -- 2 CERTIFIED STENOGRAPHER: I 3 got it. I got it. 4 ATTORNEY CRAIN: Okay. 5 BY ATTORNEY CRAIN: 6 Q. And they have not done it, at least 7 publicly, since, right? 8 A. Correct. 9 ATTORNEY CRAIN: Okay. Just 10 give me one second. 11 All right. I will pass the 12 witness. 13 ATTORNEY WOOD: Then we are 14 all set. 15 ATTORNEY CRAIN: Okay. 16 THE VIDEOGRAPHER: This 17 marks -- 18 ATTORNEY CRAIN: You're free 19 to go. 20 THE VIDEOGRAPHER: -- this 21 marks the end of the deposition of 22 Melissa Danforth. Going off the Page 596
1 A. That's not work we do. We contract 2 with Johns Hopkins to do that work. 3 Q. Has Johns Hopkins? 4 A. Johns Hopkins is -- have they 5 done -- no, they haven't -- they have -- they're 6 not doing that right now. 7 Q. Okay. And -- and they have not -- 8 A. They did the last one. Sorry. 9 That's why I was pausing. They've done it 10 twice. 11 So what you see on our website is 12 actually an update to a similar white paper 13 that was developed earlier. The upgrade was 14 really adding costs. Employers/purchasers want 15 to know how much things cost. So they did it 16 once in 2015, 2016. They did it again in 2018, 17 2019. They haven't done it again. 18 ATTORNEY CRAIN: Got it? 19 CERTIFIED STENOGRAPHER: Jeez 20 , Louise. 21 ATTORNEY CRAIN: 2015 and 22 2016, and then they get it -- did it Page 595	1 record at 1841. 2 (Witness excused.) 3 4 (Deposition concluded at 6:42 p.m. EDT.) 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 Page 597

C E R T I F I C A T E 1 I, Cindy L. Sebo, Nationally Certified Court 2 Reporter herein, do hereby certify that the 3 foregoing deposition of MELISSA AMEE DANFORTH was 4 taken before me pursuant to notice at the time and 5 place indicated; that said witness duly swore to 6 tell the truth, the whole truth, and nothing but 7 the truth under penalties of perjury; that said 8 testimony of witness was correctly recorded to the 9 best of my abilities in machine shorthand, 10 thereafter transcribed under my supervision with 11 computer-aided transcription; that deposition is a 12 true and accurate record of the testimony given by 13 the witness; that I am neither counsel, nor kin to 14 any party in said action, nor interested in the 15 outcome; and that a copy of this transcript 16 obtained from a source other than the court 17 reporting firm, including an adversary or 18 co-counsel in the matter, is uncertified and may 19 not be used at trial. <i>Cindy L. Sebo</i> 20 CINDY L. SEBO, RMR, CKR, CLR, RPR, CCR, CSR, RSA, 21 CA CSR 14409, NJ Certified CR 30XI0024460, 22 NJ Certified RT 30XR00019500, NM CSR 589, NY Realtime Court Reporter, NY Association Certified Reporter, OR CSR 230105, TN CSR 998, TX CSR 12778, WA CSR 23005926, Notary Public Page 598	CAPTION: Good Samaritan, et al. v. The Leapfrog Group 1 MELISSA AMEE DANFORTH NO. 7574666 2 E R R A T A S H E E T 3 PAGE _____ LINE _____ CHANGE _____ 4 REASON FOR CHANGE: _____ 5 _____ 6 PAGE _____ LINE _____ CHANGE _____ 7 REASON FOR CHANGE: _____ 8 PAGE _____ LINE _____ CHANGE _____ 9 REASON FOR CHANGE: _____ 10 _____ 11 PAGE _____ LINE _____ CHANGE _____ 12 REASON FOR CHANGE: _____ 13 PAGE _____ LINE _____ CHANGE _____ 14 REASON FOR CHANGE: _____ 15 _____ 16 PAGE _____ LINE _____ CHANGE _____ 17 REASON FOR CHANGE: _____ 18 PAGE _____ LINE _____ CHANGE _____ 19 REASON FOR CHANGE: _____ 20 _____ 21 PAGE _____ LINE _____ CHANGE _____ 22 REASON FOR CHANGE: _____ _____ Page 600
I N S T R U C T I O N S T O W I T N E S S 1 Please read your deposition over carefully 2 and make any necessary corrections. You should 3 state the reason in the appropriate space on the 4 errata sheet for any corrections that are made. 5 After doing so, please sign the errata 6 sheet and date it. 7 You are signing same subject to the 8 changes you have noted on the errata sheet, 9 which will be attached to your deposition. 10 It is imperative that you return the 11 original errata sheet to the deposing attorney 12 within thirty (30) days of receipt of the 13 deposition transcript by you. If you fail to do 14 so, the deposition transcript may be deemed to 15 be accurate and may be used in court. 16 17 18 19 20 21 22 Page 599	CAPTION: Good Samaritan, et al. v. The Leapfrog Group 1 MELISSA AMEE DANFORTH NO. 7574666 2 E R R A T A S H E E T 3 PAGE _____ LINE _____ CHANGE _____ 4 REASON FOR CHANGE: _____ 5 _____ 6 PAGE _____ LINE _____ CHANGE _____ 7 REASON FOR CHANGE: _____ 8 PAGE _____ LINE _____ CHANGE _____ 9 REASON FOR CHANGE: _____ 10 _____ 11 PAGE _____ LINE _____ CHANGE _____ 12 REASON FOR CHANGE: _____ 13 PAGE _____ LINE _____ CHANGE _____ 14 REASON FOR CHANGE: _____ 15 _____ 16 PAGE _____ LINE _____ CHANGE _____ 17 REASON FOR CHANGE: _____ 18 PAGE _____ LINE _____ CHANGE _____ 19 REASON FOR CHANGE: _____ 20 _____ 21 PAGE _____ LINE _____ CHANGE _____ 22 REASON FOR CHANGE: _____ _____ Page 601

ACKNOWLEDGMENT OF WITNESS 1 2 I, MELISSA AMEE DANFORTH, do hereby 3 certify that I have read the foregoing pages 4 herein, and that the same is a correct 5 transcription of the answers given by me of the 6 proceedings taken remotely to the questions therein 7 propounded under penalty of perjury, except for the 8 corrections or changes in form or substance, if 9 any, noted in the attached errata sheet. 10 11 _____ 12 DATE SIGNATURE 13 14 15 Subscribed and sworn to before me 16 this ____ day of _____, 20 ____. 17 18 My Commission expires: 19 _____ 20 _____ 21 _____ 22 Notary Public Page 602	
1 Kimberly Blair 2 kimberly.blair@wilsonelser.com 3 September 22, 2025 4 RE: Good Samaritan Medical Center Inc, Et Al. v. The Leapfrog 5 9/18/2025, Melissa Amee Danforth (#7574658) 6 The above-referenced transcript is available for 7 review. 8 Within the applicable timeframe, the witness should 9 read the testimony to verify its accuracy. If there are 10 any changes, the witness should note those with the 11 reason, on the attached Errata Sheet. 12 The witness should sign the Acknowledgment of 13 Deponent and Errata and return to the deposing attorney. 14 Copies should be sent to all counsel, and to Veritext at 15 errata-tx@veritext.com. 16 Return completed errata within 30 days from 17 receipt of testimony. 18 If the witness fails to do so within the time 19 allotted, the transcript may be used as if signed. 20 21 22 Yours, 23 Veritext Legal Solutions 24 25 Page 603	

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Federal Rules of Civil Procedure

Rule 30

(e) Review By the Witness; Changes.

(1) Review; Statement of Changes. On request by the deponent or a party before the deposition is completed, the deponent must be allowed 30 days after being notified by the officer that the transcript or recording is available in which:

(A) to review the transcript or recording; and

(B) if there are changes in form or substance, to sign a statement listing the changes and the reasons for making them.

(2) Changes Indicated in the Officer's Certificate. The officer must note in the certificate prescribed by Rule 30(f)(1) whether a review was requested and, if so, must attach any changes the deponent makes during the 30-day period.

DISCLAIMER: THE FOREGOING FEDERAL PROCEDURE RULES ARE PROVIDED FOR INFORMATIONAL PURPOSES ONLY.

THE ABOVE RULES ARE CURRENT AS OF APRIL 1, 2019. PLEASE REFER TO THE APPLICABLE FEDERAL RULES OF CIVIL PROCEDURE FOR UP-TO-DATE INFORMATION.

VERITEXT LEGAL SOLUTIONS

COMPANY CERTIFICATE AND DISCLOSURE STATEMENT

Veritext Legal Solutions represents that the foregoing transcript is a true, correct and complete transcript of the colloquies, questions and answers as submitted by the court reporter. Veritext Legal Solutions further represents that the attached exhibits, if any, are true, correct and complete documents as submitted by the court reporter and/or attorneys in relation to this deposition and that the documents were processed in accordance with our litigation support and production standards.

Veritext Legal Solutions is committed to maintaining the confidentiality of client and witness information, in accordance with the regulations promulgated under the Health Insurance Portability and Accountability Act (HIPAA), as amended with respect to protected health information and the Gramm-Leach-Bliley Act, as amended, with respect to Personally Identifiable Information (PII). Physical transcripts and exhibits are managed under strict facility and personnel access controls. Electronic files of documents are stored in encrypted form and are transmitted in an encrypted

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EXHIBIT 4

Mission and Vision

Mission and Vision

Our History

What's in a Name



Health care
is big
business.
Employers
and other

purchasers spend billions of dollars on health care every year. But nearly one-third of health care spending is wasteful—think unnecessary procedures, administrative costs, medical errors, and even fraud.

For many years, purchasers have struggled to provide high-quality health care to their employees, simply because they didn't know which providers were safe, or had the best patient outcomes. In no other industry do we encounter this lack of transparency and accountability.

That has to change.

In a country where more than 200,000 lives are lost every year because of preventable medical errors, Leapfrog is fighting to build a movement for transparency. We serve as a voice for health care purchasers, using their collective influence to foster radical, positive change in U.S. health care.

For over 20 years we have collected, analyzed, and published health care data on safety, quality, and resource use. That means purchasers can find high-value care. And it means that real people are empowered with the information they need to make better decisions.

Preventable
medical errors kill
more than
200,000 people
every year.

Our Mission:

To trigger giant leaps forward in the safety, quality and affordability of U.S. health care by using transparency to support informed health care decisions and promote high-value care.

Our Vision:

We envision a future where purchasers will tie health care investment to excellence and educate their employees on choosing the best care. Health plans will support purchasers in their efforts to reward high performance and empower employees. Consumers will fight for the best care for themselves and their families. Providers will be courageous in championing transparency and leading groundbreaking improvements.

By living the vision, all of us will work to give the next generation the safest, highest-quality health care system in the world.

EXHIBIT 5

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

GOOD SAMARITAN MEDICAL)
CENTER, et al.,)
)
Plaintiffs,) CASE NO.
)
v.) 9:25-CV-80526-DMM
)
THE LEAPFROG GROUP,)
)
Defendant.)
_____)

The in-person, video-recorded deposition of Matthew Austin, taken pursuant to Federal Rule of Civil Procedure 45 and Southern District of Florida Local Rule 26.1, at the offices of Zuckerman Spaeder, LLP, 100 E. Pratt Street, Suite 2440, Baltimore, Maryland 21202, by Plaintiffs in the above-referenced action, beginning at 9:09 a.m. The deposition was taken before Marlene Kerr, a Certified Shorthand Reporter, Registered Professional Reporter, Registered Merit Reporter, Certified Realtime Reporter, Federal Certified Realtime Reporter, Notary Public.

Job No. 7616361

1A P P E A R A N C E S: 2Attorneys Representing Plaintiffs: 3GIBSON, DUNN & CRUTCHER, LLP 4BY: LEE R. CRAIN, ESQUIRE 5BY: IASON TOGIAS, ESQUIRE 6200 Park Avenue 7New York, New York 10166-0193 8212.351.2454 9lcrain@gibsondunn.com 10itogias@gibsondunn.com 11 12Attorney Representing Deponent Dr. Matthew Austin and 13The Armstrong Institute: 14ZUCKERMAN SPAEDER 15BY: SARA LAWSON, ESQUIRE 16100 EAST PRATT STREET, SUITE 2440 17BALTIMORE, MARYLAND 21202 18410.949.1181 19slawson@zuckerman.com 20 21 Page 2	1INDEX OF EXAMINATION 2WITNESS: MATTHEW AUSTIN 3Good Samaritan, et al., The Leapfrog Group 4Thursday, September 25, 2025 5 6EXAMINATIONPAGE 7By Mr. Crain11 8By Ms. Wood362 9By Mr. Crain397 10 11Certificate of Reporter417 12Certificate of Deponent418 13Errata419 14 15 16 17 18 19 20 21 Page 4
1A P P E A R A N C E S (continued): 2Attorneys Representing Defendant: 3WILSON ELSE 4BY: COURTNEY L. WOOD, ESQUIRE 5161 North Clark Street, Suite 4500 6Chicago, Illinois 60601 7312.821.6139 8courtney.wood@wilsonelser.com 9 10ALSO PRESENT: 11CURTIS ROGINSKI - Videographer 12 13 14 15 16 17 18 19 20 21 Page 3	1INDEX OF EXHIBITS 2WITNESS: MATTHEW AUSTIN 3Good Samaritan, et al., The Leapfrog Group 4Thursday, September 25, 2025 5EXHIBIT NUMBERDESCRIPTIONPAGE 6Exhibit 1Email from Ms. Binder20 7Exhibit 2from Mr. Austin to23 8Ms. Danforth dated May 1 9Exhibit 3Document that outlines29 10Exhibit 4Grading methodology 11Email from Mr. Austin to30 12Exhibit 5Ms. Danforth, cc'ing 13Ms. Wood 14Exhibit 6Matthew Austin Linked In35 15Profile 16Exhibit 7Contract b/w Johns Hopkins42 17University and The Leapfrog 18Group 19Exhibit 8Document from the Leapfrog71 20Safety Grade website, 21hospitalsafetygrades.org Exhibit 9Printout of a webpage from78 Leapfrog's Hospital Safety Grade website Exhibit 10Hospitalsafetygrades.org102 website page of Frequently asked questions 21 Page 5

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1	PROCEEDINGS		
2	THE VIDEOGRAPHER: Good morning.		
3	We are going on the record at 9:09 a.m., on		
4	September 25th, 2025. This is media unit one of the		
5	video-recorded deposition of Dr. Matthew Austin taken in		
6	the matter of Good Samaritan Medical Center, Inc., et		
7	al., v. The Leapfrog Group, the United States District		
8	Court for the Southern District of Florida, West Palm		
9	Beach Division; Case No. 9:25-CV-08526 [sic.] -DMM.		
10	My name is Curtis Roginski, representing		
11	Veritext. I'm the videographer. The court reporter is		
12	Marlene Kerr, also with Veritext.		
13	Will counsel please identify yourselves and		
14	state whom you represent.		
15	MS. LAWSON: Sara Lawson from Zuckerman Spaeder		
16	on behalf of the witness, Dr. Matthew Austin, and the		
17	Armstrong Institute.		
18	MR. CRAIN: Lee Crain from Gibson Dunn &		
19	Crutcher for Plaintiffs.		
20	MS. WOOD: Courtney Wood, Wilson Elser, on		
21	behalf of the Defendant, The Leapfrog Group.		
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1 MR. TOGIAS: Iason Togias on behalf of 2 Plaintiffs with Gibson Dunn & Crutcher. 3 THE VIDEOGRAPHER: Thank you. 4 Would the court reporter please swear in 5 the witness. 6 THE COURT REPORTER: Sure. 7 Would you please raise your right hand to 8 be sworn. 9 (Witness complied.) 10 THE COURT REPORTER: Do you promise and declare 11 under penalty of perjury the testimony you are about to 12 give will be the truth, the whole truth, and nothing but 13 the truth? 14 THE WITNESS: Yes. 15 THE COURT REPORTER: Thank you. 16 (Witness sworn.) 17 MR. CRAIN: I'm sorry. Could we pause for a 18 second? 19 THE COURT REPORTER: Sure. 20 MR. CRAIN: Do we have the realtime? 21 THE COURT REPORTER: You should. Page 10	1 for the record. 2 A. Yeah, my full legal name is John Matthew 3 Austin, but I go by Matt Austin. 4 Q. And have you gone by any other names besides 5 those two? 6 A. No, I have not. 7 Q. Okay. 8 Have you ever been deposed before? 9 A. I have not. 10 Q. Okay. 11 I want to go through just some ground rules 12 at the start so we're on the same page. A couple of key 13 rules. You understand the court reporter is taking down 14 what you and I say to create a written transcript? 15 A. Uh-huh. 16 Q. And you understand this deposition is being 17 video-recorded? 18 A. Yes, I do. 19 Q. Because of Marlene and to help her out, we want 20 to make sure that we're taking time between the 21 questions and answers. So I'll do my best to let you Page 12
1 MR. CRAIN: Oh, okay. We've got it there. 2 THE COURT REPORTER: Okay. 3 MR. TOGIAS: Is it on, though? 4 THE COURT REPORTER: It's up and running. 5 MR. CRAIN: Actually, can we go off for a 6 second? I'm sorry. 7 (Discussion held off the record regarding 8 the realtime feed.) 9 THE VIDEOGRAPHER: Off the record. The time is 10 9:10 a.m. 11 (Brief pause.) 12 THE VIDEOGRAPHER: This marks the beginning of 13 media unit number two. We're going back on the record. 14 The time is 9:12 a.m. 15 EXAMINATION 16 BY MR. CRAIN: 17 Q. Good morning, Dr. Austin. 18 A. Good morning. 19 Q. My name is Lee Crain. I am counsel for 20 Plaintiffs in this action. 21 Could you please just state your full name Page 11	1 finish, and you do your best to let me finish. Fair 2 enough? 3 A. Sounds good. I'll do my best. 4 Q. It's a little unnatural, but we'll get through 5 it. 6 Answers need to be audible, so no shaking 7 heads or nodding, that sort of thing. Fair enough? 8 A. Fair enough. 9 Q. You understand you're under oath today as if 10 you were testifying in court? 11 A. Yes. 12 Q. Are you under any medications that would impair 13 your ability to testify truthfully today? 14 A. No. 15 Q. Is there any other reason you can't give 16 truthful testimony today? 17 A. No. 18 Q. Okay. 19 Occasionally, it will happen where I will 20 ask a bad question. Don't hesitate to ask if you have 21 questions, if you want me to restate the question, or if Page 13

1 you're confused. If you don't, I'm going to assume you 2 understand the question, but feel free to clarify any 3 time. Fair enough? 4 A. Fair enough. 5 Q. And then the last -- two last things. From 6 time to time, your attorney or Ms. Wood may object. 7 Unless they're instructing you not to answer, we're 8 going to ask you to answer the question. Clear enough? 9 A. That's clear enough. 10 Q. And then the last thing is we can take a break 11 any time, any time you need, any time anybody else 12 needs. The only thing we ask is not while a question is 13 pending. So we'll go through the question and answer 14 and then we can take a break, if that makes sense? 15 A. Yeah, that makes sense. 16 Q. Great. 17 Okay. So I want to just start right at the 18 top. Did you prepare for this deposition? 19 A. I did. 20 Q. Can you tell me what you did to prepare for the 21 deposition? Page 14	1 BY MR. CRAIN: 2 Q. Yes. And none of my questions are getting at 3 that. So I do not want the substance of your 4 communications with counsel. Fair enough? 5 A. Fair enough. 6 MR. TOGIAS: And just to flag, this is -- the 7 Zoom link, I don't see a live feed. 8 MR. CRAIN: We'll do it after. 9 BY MR. CRAIN: 10 Q. So how long did you meet with counsel -- 11 yesterday, you said? 12 A. Yesterday, correct. 13 Q. And how long was that meeting? 14 A. It was approximately three hours. 15 Q. Was anybody else in attendance besides 16 Ms. Lawson -- did I get that right? I'm sorry -- and a 17 paralegal? 18 A. That was it. 19 Q. Okay. And you reviewed documents during that 20 session? 21 A. We reviewed some documents. Page 16
1 A. I met with my attorney and a paralegal 2 yesterday and also reviewed some documents that they had 3 sent me. 4 Q. Did you only meet with counsel one time? 5 A. To prepare for the deposition, yes. 6 Q. Did you meet with counsel other times regarding 7 this case? 8 A. We did have an early sort of exploratory call 9 shortly after Sara was named as my counsel. 10 Q. Okay. 11 MS. LAWSON: And I'm just going to object, just 12 interpose an objection just to make sure that Dr. Austin 13 understands that you can answer with respect to sort of 14 basic details, the who, what, where, when, why, and how 15 of our discussions, but those discussions are protected 16 by the attorney-client privilege. So I would just ask 17 and instruct you not to reveal the substance of any 18 discussions that you've had with me or any other of your 19 counsel from Zuckerman Spaeder, like my partner Marty 20 Himeles as well. So just to make that clear. 21 Page 15	1 Q. Okay. Did you review documents outside of that 2 session with your counsel to prepare today? 3 A. No. 4 Q. Okay. Did you watch any videos? 5 A. No. 6 Q. Did you listen to any audio recordings? 7 A. No. 8 Q. Okay. Did you review any other -- any 9 transcripts from depositions in this case? 10 A. No. 11 Q. Did you review any transcripts of anything 12 else? 13 A. No. 14 Q. Let's see. Who have you talked to about this 15 deposition besides counsel? 16 A. So I've talked to my boss, Allen Kachalia, to 17 let him know that I was being deposed. I spoke to 18 Jordan Derk who at the time of -- or at least at the 19 start of the period was working with me on The Leapfrog 20 Group contract; and with Preeti Joshi, who currently is 21 working with me on the Leapfrog contract, my partner at Page 17

1 home, and my father who is an attorney. 2 Q. And just going down the line, what did you tell 3 Mr. Kachalia about the deposition? 4 A. I had let him know that there was a lawsuit and 5 that I was being deposed for testimony. 6 Q. And what did you talk to Mr. Derk about? 7 A. I let Mr. Derk know that he was going to be 8 receiving a subpoena for documents. We talked a little 9 bit about the lawsuit, as well as some other related 10 items. 11 Q. Did you talk about the methodology, the 12 Leapfrog Hospital Safety Grade methodology with him? 13 A. We didn't talk about that in detail. 14 Q. And what did you talk about with Ms. Joshi? 15 A. I let her know that there was going to be a 16 lawsuit and that she should come to me with any 17 questions or concerns that she had about that. And then 18 when she received notice that she needed to supply 19 documents, we talked about what she needed to supply and 20 how that would go. 21 Q. Okay. And she's a current employee at Page 18	1 Q. Okay. 2 And then did you also speak with counsel at 3 Wilson Elser, Ms. Wood's firm? 4 A. We had a brief conversation the day that I was 5 notified that I was going to be receiving a subpoena. 6 Q. Okay. And have you exchanged emails with 7 Wilson Elser? 8 A. I have not beyond the counsel at Johns Hopkins 9 requested Courtney and Kim's names and emails, and so I 10 supplied them with those. 11 Q. Okay. 12 Now, I want to just start with an exhibit 13 just to mark it. This will be Exhibit 1. 14 (Exhibit No. 1 was marked for 15 identification as of 9/25/2025.) 16 BY MR. CRAIN: 17 Q. Dr. Austin, do you recognize this document? 18 A. I do. 19 Q. And it was produced, if you see the bottom 20 right, by the Armstrong Institute? 21 A. Correct. Page 20
1 Armstrong? 2 A. Correct. 3 Q. Okay. 4 And then with regard to your partner and 5 your father, did you talk about the substance of this 6 case at all? 7 A. I talked about what I was aware of based on the 8 public press releases that both organizations had put 9 out. 10 Q. And what did you say? Just can you give us a 11 general sense? 12 A. Yeah. My general sense is it felt like there 13 was a lot of factual errors in the press release in 14 terms of what tenant was claiming, that those things 15 were just factually wrong. 16 Q. I guess we'll come back to that. 17 And then a couple of other questions. Did 18 you talk to anybody at Leapfrog about this case? 19 A. Not -- so Leapfrog did give me a heads-up that 20 I was going to be receiving a subpoena. So that was the 21 sort of extent of the conversation. Page 19	1 Q. And it's an email from Ms. Binder to a number 2 of folks, including yourself. Do you see that? 3 A. Yes, I do. 4 Q. And Ms. Binder told you, if you look towards 5 the bottom, she asked everybody in the email not to 6 email or talk about the case in writing. Do you see 7 that? 8 A. Can you point me to where that says that? 9 Q. Yes. So it says, number two: "Do not 10 communicate in writing about this matter, such as on 11 slack or email or texting." 12 Do you see that? 13 A. Yes. 14 Q. Did you adhere to that guidance? 15 A. So outside of sort of the need to communicate 16 with, say, my boss or with counsel, I did follow that. 17 Q. Okay. 18 And then she asks -- she says, number 19 one -- do you see that right above? -- "Please refer all 20 questions or concerns, whether you have them personally 21 or you hear them from external sources, to me, Missy, Page 21

1 Lauren, or Karen. Do not put them in writing. Call us 2 or come by my office." 3 Do you see that? 4 A. I do. 5 Q. Did you call any of those folks listed in 6 bullet one? 7 A. I did not. 8 Q. Okay. 9 And then did you come by her office? 10 A. I did not. 11 Q. Okay. 12 Now, did -- I want to talk just for a 13 second about the safety grade expert panel. Do you know 14 what I mean when I say that? 15 A. Yes. 16 Q. I assume you spent a decent bit of time with 17 that group. 18 A. Correct. 19 Q. Did you discuss the lawsuit with the expert, 20 the safety grade expert panel? 21 A. So we did have a meeting with the expert panel Page 22	1 Q. And it's another, if you look at the bottom 2 right, another Armstrong-produced document? 3 A. Correct. 4 Q. And the email at the top, which you'll see as 5 we go through that usually the first email is the last 6 one in the way it's printed out, but you'll see it's 7 from you to Ms. Danforth. Do you see that? 8 A. Yes. 9 Q. And if you go to the next page, there's an 10 email -- actually, it starts on the bottom of page 1 11 from you. Do you see that, that May 1? 12 A. Correct. 13 Q. And then it's an email from you, it looks like, 14 to the Hospital Safety Grade Expert Panelists. Do you 15 see that? 16 A. Correct. 17 Q. And just to get a sense, take a second if you 18 haven't read it. I just want to know was anything 19 discussed on the expert panel that goes beyond what was 20 said in this email? 21 (Witness peruses document.) Page 24
1 already scheduled, and at that meeting, the decision was 2 to share with the expert panel that a lawsuit had been 3 filed. 4 Q. And what was discussed at the meeting? Like, 5 can you give a little more of a play-by-play? 6 A. I don't know if I can give a play-by-play 7 without specific notes in front of me. I don't even 8 remember who shared with the panel that the lawsuit had 9 been filed. I don't know if that was Ms. Binder, 10 Ms. Danforth, if it was counsel for Leapfrog. I really 11 don't remember who shared that information with them. 12 And it was more just to let them know since they had 13 been involved in the safety grade. 14 Q. Okay. 15 I'm going to mark another exhibit. This is 16 Exhibit 2, another Armstrong document. 17 (Exhibit No. 2 was marked for 18 identification as of 9/25/2025.) 19 BY MR. CRAIN: 20 Q. So Dr. Austin, do you recognize this document? 21 A. I do. Page 23	1 THE WITNESS: I don't remember it being much 2 discussion beyond what's in the email. 3 BY MR. CRAIN: 4 Q. Does the email accurately depict what was 5 discussed? 6 A. Yes. 7 Q. Okay. 8 And if you go up in the email, there's an 9 email response from Ms. Danforth to you on May 1 at 10 12:35, p.m. Do you see that? 11 A. Yes. 12 Q. And she says, "Thanks, Matt. I've added Leah 13 Binder and Thomas Duff from Wilson Elser for the first 14 agenda item." Do you see that? 15 A. Correct. 16 Q. Does that refresh your recollection as to 17 whether Ms. Binder was there or whether she spoke at the 18 meeting? 19 A. I know that Ms. Binder was there, and I know 20 counsel was there, but I can't remember exactly who 21 actually led the conversation. Page 25

1 Q. Okay. 2 Do you typically lead the conversations in 3 those meetings? 4 A. We have a formal agenda, and we have sometimes 5 different individuals leading different agenda items 6 depending on the item. But I would say I'm one of the 7 primary folks for doing that. 8 Q. Okay. 9 And then just going to the top email, this 10 is an email from you to Ms. Danforth later that day. Do 11 you see that? 12 A. Yes. 13 Q. And it looks -- you say -- it's three lines 14 down -- "I quickly pulled the breakdown of Spring 2025 15 grades by survey submission status. Will work on adding 16 in percentages." Do you see that? 17 A. Yes. 18 Q. Percentages. I just -- I assume that refers to 19 the percentages that these numbers reflect? 20 A. Correct. 21 Q. Okay. And why did you pull these stats? Page 26	1 THE WITNESS: I would need to see it to 2 confirm. 3 BY MR. CRAIN: 4 Q. Okay. Yeah, let me -- what did you mean when 5 you said the methodology document? 6 A. Leapfrog makes available a public document that 7 explains the Hospital Safety Grade methodology. 8 Q. We'll grab additional documents. 9 And then on Step 1, you said survey cycle. 10 How long is that? 11 A. So if the hospital had completed a survey -- 12 this is where I'm doing this from memory. So this is 13 where -- 14 Q. It's not a memory test. 15 A. -- I want to be -- I believe what we've changed 16 it to is if the hospital had completed a survey in the 17 prior survey cycle, so if you're looking at 2025, if 18 they completed a 2024 survey, we'll use the 2024 survey 19 results. 20 Q. Okay. 21 So each cycle, just so I understand, is Page 28
1 A. To have ready for the expert panel an 2 understanding of how hospital grades break down by the 3 imputation status that Leapfrog uses or did use in the 4 Spring 2025 grades. 5 Q. And just so we're on the same page, can you 6 tell me in your words what's Step 1, what's Step 2? 7 A. Yeah. So Step 1 is that if the hospital has 8 completed a recent Leapfrog Hospital Survey, which I 9 believe is currently defined as within the last survey 10 cycle, that that historical information is used for the 11 hospital. 12 Step 2 is if the hospital does not have a 13 recent survey on record, there is an imputation 14 methodology that is laid out in the methodology document 15 that explains how those scores will be imputed. 16 Q. And just to be clear, the methodology document, 17 is it the one that's linked on the website that's about 18 28, 29 pages? 19 A. I would need to -- 20 MS. LAWSON: Object to form but go ahead. Go 21 ahead. Page 27	1 once a year? 2 A. The survey itself is a once-a-year cycle. 3 Q. And the grades are issued twice a year? 4 A. Correct. 5 Q. I think we have that document for you just to 6 make sure we're on the same page. 7 MR. CRAIN: So we'll mark this as Exhibit 3. 8 I'm taking good notes today. 9 (Exhibit No. 3 was marked for 10 identification as of 9/25/2025.) 11 BY MR. CRAIN: 12 Q. You'll see there are other exhibit markings -- 13 oh, sorry. 14 You'll see there are other deposition 15 stickers on here, but is Exhibit 3 of your deposition 16 the document you're referring to? 17 A. Yes. 18 Q. Okay. 19 Is there another document you're aware of 20 that outlines the methodology besides this? 21 A. There is a second document that explains how Page 29

1 numerical scores are converted into letter grades. 2 Q. What's the name of that document? 3 A. I don't know the official name of it. It is 4 publicly available on Leapfrog's Hospital Safety Grade 5 website. 6 Q. Got it. 7 Does that document includes also the 8 imputation methodology? 9 A. It does not. 10 Q. Okay. 11 All right. Keep on going. 12 MR. CRAIN: And then just for completeness, can 13 we do 64. And then I'm going to mark this Exhibit 4. 14 (Exhibit No. 4 was marked for 15 identification as of 9/25/2025.) 16 BY MR. CRAIN: 17 Q. This is another email produced by the Armstrong 18 Institute. Do you see that on the bottom right? 19 A. Uh-huh. 20 Q. And it's -- the top one is from you to 21 Ms. Danforth, cc'ing our friend Ms. Wood across the Page 30	1 A. We talked about the subpoena coming. 2 Q. Okay. 3 And did you have conversations, either 4 phone or Zoom or in person, with Ms. Wood and Ms. Blair? 5 A. On the 25th of July, I had a call scheduled 6 with The Leapfrog Group to discuss regular work. That 7 was the day that the subpoenas were issued for Jordan 8 and myself. So as I remember, Courtney and Kim joined 9 that call to talk about the subpoenas and that we should 10 contact Johns Hopkins University to let them know we 11 were receiving subpoenas, and also that we shouldn't be 12 chatting with our colleagues at The Leapfrog Group about 13 the lawsuit. 14 Q. Conventional wisdom. 15 A. Yeah. But that we could talk about regular 16 business. 17 Q. Okay. 18 One other question before we shift gears. 19 You came today with a folio. 20 A. Uh-huh. 21 Q. What's in that folio? Page 32
1 table. Is that correct? 2 A. Correct. 3 Q. And you say, "Missy, thanks so much for putting 4 me in touch with Courtney and Kim. I just spoke with 5 Jordan about the lawsuit. I've copied Jordan on the 6 email chain so he has Courtney and Kim's contact 7 information." 8 Do you see that email? 9 A. Yeah, I do. 10 Q. Do this reflect what we discussed earlier, the 11 discussions you had with Mr. Derk and with Wilson Elser? 12 A. Correct. 13 Q. Any other discussions beyond those talked about 14 in this email? 15 MS. LAWSON: Object to form. 16 BY MR. CRAIN: 17 Q. Yeah, let me fix it. 18 About the case? 19 A. I had had a -- yeah, I had had a conversation 20 with Jordan earlier that day. 21 Q. Okay. Page 31	1 A. It's actually the subpoenas. 2 Q. Okay. 3 A. And my pad of paper and a pen. 4 Q. Okay. I have to ask. 5 And when you say "the subpoenas," you mean 6 the document and the deposition subpoenas that led to us 7 being here today? 8 A. Correct. 9 Q. Okay. Anything else? 10 A. No. 11 Q. Okay. 12 I want to shift gears and just talk a 13 little more about your history and your education. 14 A. Uh-huh. 15 Q. So you went to the University of Michigan for 16 undergraduate? 17 A. Correct. 18 Q. Go blue! 19 And you graduated in 1995? 20 A. Correct. 21 Q. You later went to the University of Wisconsin, Page 33

1 Madison, right? 2 A. Correct. 3 Q. Okay. And you graduated with a Masters of 4 Science in Industrial Systems Engineering? 5 A. Correct. 6 Q. And then you went on to do your Ph.D.? 7 A. Correct. 8 Q. And just in a brief nugget, what is your Ph.D. 9 in? 10 A. My Ph.D. is in Industrial and Systems 11 Engineering with a focus on Healthcare Systems. 12 Q. When did you start getting interested in 13 healthcare? 14 A. 2005. 15 Q. Okay. And that was during -- that was at 16 Wisconsin, Madison? 17 A. Prior to Wisconsin, Madison. 18 Q. Got it. 19 What were you doing then? 20 A. I actually was working for Continental 21 Airlines. Page 34	1 BY MR. CRAIN: 2 Q. Dr. Austin, what I've handed you is what -- 3 well, tell me what I've handed you. 4 A. This is what appears to be my LinkedIn profile. 5 Q. Does it look generally accurate to you? 6 A. It does. 7 Q. Great. 8 And just going back, because it's not a 9 memory test, so I figured I'd ground you on the dates, 10 it says you were a director of Leapfrog Hospital Survey 11 from January 2008 to May 2012. Do you see that? 12 A. Correct. 13 Q. Is that -- is that generally right? 14 A. That is -- I actually was employed by the 15 Center for Health Systems Research and Analysis. So my 16 employer was -- 17 Q. Got it. 18 A. -- actually CHSRA. 19 Q. Okay. The one right below? 20 21 Page 36
1 Q. Interesting. How did that convert into a 2 healthcare interest? 3 A. I was interested in transitioning out of the 4 airline industry, and healthcare felt like a prime 5 opportunity for that. 6 Q. Okay. 7 And then you earned your Ph.D. I think in 8 2011. Is that right? 9 A. Correct. Yeah. 10 Q. And then between I think 2008 and 2012, you 11 were a director for The Leapfrog Group. Is that right? 12 A. That was my title -- 13 Q. Okay. 14 A. -- that Leapfrog gave me, but I was not 15 employed by The Leapfrog Group. 16 Q. Okay. 17 Let's, just to ground us, I'm going to give 18 you everybody's favorite. LinkedIn. 19 MR. CRAIN: This will be Exhibit 5. 20 (Exhibit No. 5 was marked for 21 identification as of 9/25/2025.) Page 35	1 (Whereupon, the court reporter seeks 2 clarification, which colloquy will not be 3 captured on the written record.) 4 BY MR. CRAIN: 5 Q. So you said you were employed by CHSRA during 6 that period? 7 A. Correct. 8 Q. Okay. 9 And you said a moment ago you weren't 10 employed by Leapfrog then. Have you ever been employed 11 by Leapfrog? 12 A. No. 13 Q. Okay. 14 Can you tell us the nature of your title as 15 director? 16 A. So in my role as a researcher at the Center for 17 Health Systems Research and Analysis, I was on a 18 contract with a PI who had a contract -- PI, principal 19 investigator -- with The Leapfrog Group, and I was 20 helping support that work. 21 Leapfrog wanted me to have the title Page 37

1 director of Leapfrog Hospital Survey, but that was not 2 my official work title. My official work title at 3 University of Wisconsin was researcher. 4 Q. Was the relationship you had between CHSRA and 5 Leapfrog a contractual relationship? 6 A. Yes. 7 Q. Got it. So Leapfrog had a contract with CHSRA? 8 A. Correct. 9 Q. And who was the PI at the time? 10 A. Barb Rudolph. 11 Q. Okay. And who is she? 12 A. She -- Dr. Barb Rudolph, she has a Ph.D. in 13 social work. She was a senior scientist at the Center 14 for Health Systems Research and Analysis. 15 Q. And what was her role at Leapfrog? 16 A. She helped support them with their measurement 17 and public reporting activities. 18 Q. Was she on the Leapfrog board? 19 A. She was not. 20 Q. Okay. 21 And who was the -- I can't recall if it's Page 38	1 algorithms. Really everything related to putting out a 2 survey around quality and safety of hospitals. 3 Q. And at that time, did Leapfrog assign hospital 4 safety grades? 5 A. No. 6 Q. Approximately, when did that start? 7 A. That started in the Spring of 2012. 8 Q. Okay. We'll come to that a little bit more. 9 Just to round out, after you left 10 Wisconsin, where did you go? 11 A. I came here to Baltimore and to Johns Hopkins 12 University. 13 Q. And you've been here for about 12 years. Is 14 that right? 15 A. Correct. 16 Q. And during that whole time, have you worked 17 with The Leapfrog Group continuously? 18 A. Technically, my contract with The Leapfrog 19 Group didn't start until I think July of 2012, and I had 20 arrived here in May. 21 Q. Got it. Page 40
1 president or CEO, but who was the leader of Leapfrog at 2 the time? 3 A. So Suzanne Delbanco was the CEO at that time. 4 Q. Okay. 5 And when did Ms. Binder take that role? 6 A. I believe it was early 2008. 7 Q. Okay. So approximately at the start of your 8 time working with Leapfrog. Is that right? 9 A. So I actually started working with The Leapfrog 10 Group in March of 2007 as part of a student research 11 assistantship. 12 Q. Okay. Got it. 13 So Ms. Binder came in towards the first 14 year or two of your time? 15 A. Correct. 16 Q. Okay. 17 What were your responsibilities either as a 18 director or researcher at the time? 19 A. Yeah. So I was responsible for developing 20 survey questions, analyses of data, working with experts 21 on developing measures, measure specifications, scoring Page 39	1 A. So just to clarify that. 2 Q. So from July 2012 to the present? 3 A. Correct. 4 Q. I want to shift gears and just talk about your 5 relationship and Armstrong's relationship with Leapfrog. 6 A. Uh-huh. 7 Q. So you said before, I think, there's a 8 contractual relationship between Armstrong and Leapfrog. 9 Is that right? 10 A. Correct. 11 Q. Tell me generally about how that works. 12 A. Yeah. So I serve as the principal investigator 13 on the contract for a portion of my time. So as a 14 research faculty member, I need to cover my effort with 15 grants and contracts, and so Leapfrog is part of that 16 coverage for the work I do. 17 Q. And forgive me. I just don't know. Generally, 18 what is a principal investigator? 19 A. The lead, the lead on a grant or contract. 20 Q. Got it. Okay. 21 And you said it covers a certain portion of Page 41

1 your time. Approximately, what time percentage is that? 2 A. It has ranged between 40 and 70. 3 Q. Forty and seventy. Okay. Forty and 4 seventy percent of your time? 5 A. Correct. 6 Q. And Leapfrog also covers funding for you, 7 correct? 8 A. That is the funding that I'm speaking of. 9 Q. Got it. 10 And does that come to you in the form of 11 compensation? 12 A. That money is paid to Johns Hopkins University 13 -- 14 Q. Okay. 15 A. -- who pays me a salary. 16 Q. Got it. 17 Let's look at a couple of documents. 18 MR. CRAIN: Maybe start with -- let's start 19 with 4. I'm going to mark this Exhibit 6. 20 (Exhibit No. 6 was marked for 21 identification as of 9/25/2025.) Page 42	1 A. Correct. 2 Q. And then if we can keep going to page -- I'm 3 going to refer to these numbers as Bates numbers. Do 4 you know what I mean when I say that? And I can tell 5 you if not. 6 A. Page number? 7 Q. Bates numbers. 8 A. No, I don't know what that is. 9 Q. So Bates numbers are these Armstrong numbers on 10 the bottom right. 11 A. Oh, okay. Okay. 12 Q. They're just a stamp that folks give when they 13 produced. And for some reason, there are two of them on 14 these pages, but I'm going to look at the top little 15 one, which is the page number. 16 So if you could go to Armstrong ending in 17 Bates 006, which also happens to be page 6 of the 18 contract. 19 A. Uh-huh. 20 Q. And do you see there first at the top it's 21 signed by Erica Mobley and Thomas F. Burns? Do you see Page 44
1 BY MR. CRAIN: 2 Q. So Dr. Austin, do you recognize this document? 3 A. I do. 4 Q. And it's another Armstrong-produced document, 5 right? 6 A. Correct. 7 Q. What is it? 8 A. This is the contract between Johns Hopkins 9 University and The Leapfrog Group. 10 Q. And this is a 2018 version. Do you see that? 11 A. Correct. 12 Q. And if you look at Fees and Payment, it's 13 number 4A on the first page. Do you see that? 14 A. Yes. 15 Q. And it says: "Contractor shall be paid a fee 16 not to exceed \$143,898." Do you see that? 17 A. Yes. 18 Q. Does this reflect the funding that you were 19 talking about, the payment to Armstrong? 20 A. The payment goes to Johns Hopkins University. 21 Q. Got it. Not specifically to Armstrong? Page 43	1 that? 2 A. Yes. 3 Q. And Erica Mobley, who is she? 4 A. She was at the time the director of operations 5 for The Leapfrog Group. 6 Q. She's since moved on? 7 A. Correct. 8 Q. Okay. 9 And then there's a budget further down, 10 down there. Do you see that? 11 A. Uh-huh. 12 Q. And it sort of delineates faculty, analysts, 13 and a few other things. Do you see it says faculty 14 \$59,799? 15 A. Correct. 16 Q. And that says: "40 percent of J. Matt Austin's 17 time." Do you see that? 18 A. Uh-huh. 19 Q. And that refers to you, correct? 20 A. Correct. 21 Q. And does that reflect an amount that's Page 45

1 earmarked to you ultimately at the end of the day, or 2 how does that work? 3 A. That is an amount that the university will bill 4 Leapfrog Group for my efforts on the project. 5 Q. Okay. So the university bills Leapfrog for 6 your time, correct? 7 A. Correct. 8 Q. Is it hourly or just a flat fee? 9 A. I don't know for sure. 10 Q. Got it. Okay. 11 And does your compensation rise with this 12 -- or rise -- let me strike that. Bad question. That's 13 the first of many bad questions today. 14 If Leapfrog didn't pay this money, would 15 that affect your compensation? 16 A. Can you clarify that? 17 Q. Yeah. 18 I'm trying to understand -- so this, you 19 said, doesn't get paid to you directly, correct? 20 A. Correct. 21 Q. It gets paid to the university, right? Page 46	1 Q. Yeah, how many -- 2 A. So it's not -- 3 Q. Can you ballpark how many do you have in a 4 year? 5 A. Most contracts or grants last multiple years. 6 In my 12 years at Hopkins, I've probably had 10 to 11 7 different grants and contracts. 8 Q. Okay. All toll. And that includes Leapfrog as 9 one of those 10? 10 A. Correct. 11 Q. Okay. And the reason I clarify is there are 12 multiple contracts, right? 13 A. Yeah, right. 14 Q. Yeah. 15 Okay. And then what -- so I understand 16 this number is not directly paid to you. Can you give a 17 ballpark of what percentage that number is of your total 18 compensation? 19 A. The 40 percent. 20 Q. So this \$59,799 is 40 percent of your salary in 21 that year, correct? Page 48
1 A. Correct. 2 Q. And the university gives you a salary, right? 3 A. Correct. 4 Q. What is the relationship between your salary 5 and grants generally? Let's start with that. 6 A. So as a faculty member, I'm on a three-year 7 contract, and that contract is at risk for nonrenewal if 8 I'm not covering a portion of myself in terms of grants 9 and contracts. 10 Q. Got it. Okay. 11 A. So there would be long-term impact to -- if 12 Leapfrog didn't pay the money to the university, but the 13 short-term is that there isn't an impact. I still 14 receive my salary. 15 Q. Got it. Okay. 16 So it affects your future contract with the 17 university, if any, right? 18 A. Correct. 19 Q. Okay. 20 A. As one of many grants and contracts that I've 21 had. Page 47	1 A. Correct. And then direct costs are added in 2 overhead as well. 3 Q. Yeah. And those are things like -- like what? 4 A. That includes fringe rights, so coverage of 5 health benefits -- 6 Q. Got it. 7 A. -- and that stuff and -- 8 Q. Got it. 9 A. -- then the university tacks on a percentage. 10 Q. Commission. 11 A. Yeah. 12 MS. LAWSON: Objection. 13 MR. CRAIN: Fair enough. 14 BY MR. CRAIN: 15 Q. Okay. So I just want to go through a couple of 16 these. Over -- do you have a general sense of over 17 time -- so this is a 2018 contract, correct? Has the 18 grant amount changed during -- you know, in the 19 preceding -- in the last six years? 20 A. Can you clarify when you say the grant has 21 changed? Page 49

1 Q. Yeah. 2 So I'm trying to get a sense of where the 3 numbers have gone. So there's the total number we saw 4 on the first page that's paid to Johns Hopkins. 5 A. Uh-huh. 6 Q. Has that generally gone up year over year? 7 A. There has been some fluctuation. 8 Q. Okay. 9 A. I'm trying to -- so there have been times where 10 Leapfrog has requested additional researchers at Hopkins 11 be included in the work, and so just by pure numbers, 12 the value, the dollar value of the contract has gone up 13 for that. 14 Q. Okay. 15 A. My salary has changed over time. So it has 16 increased based on just sort of salary changes, and 17 there's been some fluctuation in efforts. 18 Q. So when your salary has changed, the number 19 sort of earmarked to you as a percentage of your salary 20 goes up, correct? 21 MS. LAWSON: Object to form, but you can Page 50	1 I'll say plus or minus, that you performed in your role 2 for Leapfrog? 3 A. Yes. 4 Q. Okay. 5 And I want to focus on particularly page 6 little Bates 9. Do you see that? 7 A. Uh-huh. 8 Q. And there's -- about halfway down the page, it 9 says: "Manage the hospital safety score expert panel 10 process." Do you see that? 11 A. Uh-huh. 12 Q. And it says -- I think it's bullet A -- "Have 13 periodic communications with client-approved national 14 expert panel either via teleconferences and/or written 15 communication, to solicit guidance on: One, which 16 performance measures should be considered for inclusion 17 in future versions of the safety score composite; and, 18 two, suggested adjustments for weighting individual 19 measures within the composite. The polling of panel 20 members of these topics will involve the use of 21 structured communication techniques; e.g., the Delphi Page 52
1 answer. 2 THE WITNESS: Yeah, I mean, right. Leapfrog is 3 paying for a portion of my effort, of my total effort, 4 right. So if my salary goes up, they're paying more for 5 the portion of the effort that they're paying for. 6 BY MR. CRAIN: 7 Q. And when you say a portion of your effort, just 8 so it's clear, that means like your time on the job? 9 A. Correct. 10 Q. Let's take a look just before we move off this. 11 I want to look at Exhibit A, which is page little number 12 7. 13 A. Uh-huh. 14 Q. And this -- it says scope of work. Do you see 15 that? 16 A. Yes. 17 Q. And are you familiar generally with -- it's a 18 couple -- it's a few pages. Are you familiar with the 19 scope? 20 A. Yes, I am. 21 Q. Does this accurately depict the scope of work, Page 51	1 method." 2 Do you see that paragraph? 3 A. Uh-huh. 4 Q. Does this reflect your work with the Hospital 5 Safety Grade expert panel? 6 A. It does generally reflect that work. 7 Q. What -- are there any meaningful differences 8 between this language and what you actually do? 9 A. We've moved away recently from doing formal 10 polling of panel members. 11 Q. Okay. Does that -- is that what the Delphi 12 method refers to? 13 A. Yeah, that would be a -- 14 Q. What is the Delphi method? 15 A. The Delphi method is a -- an approach to gain 16 and understand consensus where you basically go through 17 different rounds of voting where based on the first 18 round, you sort of narrow down to a smaller subset and 19 work towards where there's consensus. 20 Q. And is that -- I see it in here, but is that 21 how it actually worked at the expert -- at the safety Page 53

1 grade expert panel? 2 A. In earlier meetings of the safety grade expert 3 panel, 2011, 2012, 2013, we did put a little more of a 4 focus on having a formal process for that. 5 Q. Okay. 6 And I think you said that you -- I don't 7 have the realtime, so I don't remember exactly what you 8 said, but you said in recent years, you've sort of 9 gotten rid of the polling feature. Is that what you 10 testified to? 11 A. Correct. 12 Q. And approximately, when did that dissipate? 13 A. Probably 2014, 2015. 14 Q. Okay. So a little while ago? 15 A. Yeah. 16 Q. Yeah, okay. 17 And then B says -- if you go back to the 18 document, it says: "Work with the national expert panel 19 to gain consensus on the direction of future versions of 20 the safety score composite and/or understand and 21 document the differences among panel members on their Page 54	1 A. 2011 through 2014. 2 Q. Okay. 3 So is it fair to say in the early days when 4 the safety grade was being created, the Board was more 5 active? 6 A. Yes, that would be a fair statement. 7 Q. And over the years, the Board has been less 8 involved with respect to changes to the safety grade 9 methodology? 10 A. I have become less involved in communicating 11 with Leapfrog's board. So I can't speak to what 12 Ms. Binder or Ms. Danforth have been communicating to 13 the Board but -- 14 Q. Got it. Okay. 15 So let me ask it this way then. This 16 document says one of your services -- if you look at the 17 top, it says: "Contractor will provide client with the 18 following services: Understand the direction set by the 19 client's Board of Directors on the hospital safety 20 score." 21 Do you feel since those early days that Page 56
1 future visions." 2 Do you see that as well? 3 A. Yes. 4 Q. Accurate depiction of what you've done for 5 Leapfrog over the years? 6 A. Yes. 7 Q. Okay. 8 And then C: "Understand the direction set 9 by client's Board of Directors on the hospital safety 10 score and keep the national expert panel conceptually 11 aligned with the board's direction." 12 Do you see that? 13 A. Yes. 14 Q. Is that -- so the first question is, is that an 15 accurate statement of what you've done for Leapfrog, you 16 know, since, let's say, 2018 to the present? 17 A. Yes. My one caveat is I think the Board of 18 Directors has been less hands-on with the safety grade 19 as they were early on. 20 Q. Okay. And when you say "early on," what time 21 period are we talking about? Page 55	1 you've had a sense of the direction set by the Board of 2 Directors? 3 A. I have not received any feedback that the 4 direction we're going is conflicting with what the Board 5 would want to do. 6 Q. Okay. 7 And have you received feedback that it's 8 consistent with what the Board would want to do? 9 A. As mentioned, I don't have as much 10 communication with the Board members. So Leapfrog staff 11 is sort of the filter for that. So I have not heard any 12 feedback that it's one way or another. 13 Q. Okay. So your understanding comes from 14 Leapfrog staff? 15 A. Correct. 16 Q. And it's your understanding of what the 17 organization wants, as opposed to the Board? 18 MS. LAWSON: Object to form. 19 BY MR. CRAIN: 20 Q. Well, what is your understanding? I'm trying 21 to get a sense of do you have an understanding of what Page 57

1 the Board wants, or do you have an understanding of what 2 Leapfrog staff want? 3 A. My direction that I've been given has been from 4 Leapfrog staff. 5 Q. Okay. 6 A. I don't know if that represents their own 7 thoughts or it represents their own thoughts and the 8 Board. I can't speak to that piece. 9 Q. And when you say "staff," who are we talking 10 about? 11 A. Leah Binder, the CEO, and Missy Danforth, the 12 senior vice president of healthcare ratings. 13 Q. Are those folks your primary contacts for 14 Leapfrog? 15 A. Yes. 16 Q. Are there others as well that you interact 17 with? 18 A. A couple of Missy Danforth's direct reports, so 19 Katie Burgraff Stewart and Jean-Luc Tilly. I have quite 20 a bit of contact with them as well. 21 Q. And Ms. Campione? Page 58	1 A. Probably Katie -- 2 Q. Okay. 3 A. -- Stewart. 4 Q. Stewart, yeah. 5 Okay. Let's just keep going. Okay. You 6 can set that -- or wait, actually. Sorry. There's one 7 other thing I want to take a look at. 8 If you go to page 7, just one page back -- 9 A. Uh-huh. 10 Q. -- and there's a list of services called manage 11 the research base. Do you see that? 12 A. Yes. 13 Q. Can you just say generally what that entails? 14 A. Yeah. So this item is related to the Leapfrog 15 annual hospital survey, and it's just sort of being 16 aware of where -- what performance measures have been 17 recently endorsed, which are sort of out there in 18 national programs, doing literature reviews on topics. 19 So basically, ensuring that the measures that Leapfrog 20 is using in its Leapfrog Hospital Survey are valid, 21 reliable, evidence-based measures. Page 60
1 A. Yes, and Alex as well. 2 Q. And what's Ms. Campione's role? 3 A. She -- I don't know her exact title, but she's 4 the one that supports the Hospital Safety Grade program 5 from Leapfrog's side in terms of the analytics and all 6 that goes with that. 7 Q. And does she work with you closely in that 8 regard? 9 A. Yeah. 10 Q. And Mr. Tilly, what's his role? 11 A. Jean-Luc Tilly has a couple of areas of the 12 Leapfrog Hospital Survey that he champions and leads, as 13 well the ambulatory surgery center survey. 14 Q. Okay. 15 And then Ms. Stewart, what's her role? 16 A. Once again, she has certain areas of the 17 Leapfrog Hospital Survey that she champions. 18 Q. Okay. 19 Who do you interact with most at Leapfrog? 20 A. Missy Danforth. 21 Q. Who is the second? Page 59	1 Q. Got it. 2 So stepping back a little bit, Leapfrog has 3 its hospital survey and its safety grades, right? 4 A. Correct. 5 Q. Are those the primary, like, sides of the 6 house, so to speak? 7 A. Those are their two primary reporting 8 initiatives, but there is the Leapfrog Ambulatory 9 Surgery Center Survey as well. 10 Q. Are you involved in any capacity in all three? 11 A. I am in all three. 12 Q. You are what? Sorry. 13 A. I am involved in all three. 14 Q. Okay. I thought you said I am an author. I 15 was going to say an author of what? But I guess I'll 16 ask that question. Do you author any of the hospital 17 survey? Do you draft any of it? 18 A. I do draft some of the survey questions, 19 measure specifications, end notes, FAQs. 20 Q. A lot of work. 21 A. It is a lot of work, yeah. Page 61

1 Q. Do you review each iteration of the hospital 2 survey? 3 A. I do. 4 Q. Top to bottom? 5 A. Not top to bottom. 6 Q. Okay. I would think that would take some time. 7 A. Yeah. 8 Q. Yeah. 9 The survey is about 350 pages. Am I right? 10 A. Correct. 11 Q. Okay. 12 And then with respect to the safety grade, 13 can you just explain your role? 14 A. Yeah. So the role has been to provide Leapfrog 15 with guidance and recommendations on the methodology, 16 and that includes what measures should be included in 17 the safety grade, how we might assign relative weights 18 to each of those measures. 19 Are you asking about currently or sort of 20 historically through the last 11 years? 21 Q. Fair question. I guess I'll start with has it Page 62	1 diminished over the years? 2 A. Not for strategic guidance, no. 3 Q. So what is diminished as compared to strategic 4 guidance? 5 A. So as an example, in the early years of the 6 Hospital Safety Grade, I actually would be the one to 7 put together a histogram of the hospital safety scores 8 from the prior round, the current round, and we would 9 discuss that as a group in terms of what changes we were 10 seeing. That is now something that Alex would do. 11 So there's sort of an analytic piece that 12 has moved more internal to Leapfrog -- 13 Q. Got it. Okay. 14 A. -- but not the strategic guidance part. 15 Q. And just what does strategic guidance mean? 16 A. Yeah. Strategic guidance is thinking about 17 what measures do we currently have in the composite 18 score, what are the changes that are happening like 19 within national programs, CMS, like measures that might 20 be retired, what are new measures that are out there, 21 what are gaps that we would like to try to fill, and are Page 64
1 changed meaningfully in the past 11 years? 2 A. I would assess that my role has actually 3 diminished as Alex, Leapfrog, has gained more sort of 4 independence in what they're doing. 5 Q. Got it. 6 So let me ask you about that. The contract 7 in here says that you're being retained to provide 8 strategic -- let me just find the right word. What does 9 it say? Strategic counseling I think. Is that the -- 10 do you recall that language? 11 A. I don't recall that language. The language I 12 typically use is to say strategic guidance. 13 Q. Guidance. That's it. Yeah, it's on page 7 14 under background, second paragraph, last sentence. You 15 see it says -- 16 A. Uh-huh. 17 Q. -- you were retained to provide client, meaning 18 Leapfrog, with strategic guidance. Do you see that? 19 A. Uh-huh. 20 Q. So to your point of Leapfrog gaining more 21 independence, has the need for strategic guidance Page 63	1 there measures out there that we could use for that. 2 So it's trying to sort of think about 3 what's the right combination of measures to have in a 4 composite score of patient safety and then to also help 5 them think about how we might relatively weight those 6 against each other. 7 Q. So fair to say it's like more holistic as 8 opposed to something more granular that Ms. Campione 9 might do? 10 A. Correct. 11 Q. Okay. 12 I'm not going to put every contract in 13 front of you. You see me flipping. 14 Let me ask a question about just grants 15 before we move on. 16 A. Uh-huh. 17 Q. So you said, for instance -- so we see in the 18 contracts the percentage has changed over time as well, 19 that the grant towards your salary goes to. Do you 20 recall that? 21 A. Correct. Page 65

1 Q. Okay. 2 So we saw in 2018 the number allocated to 3 you was 40 percent, right? Of the remaining 60 percent, 4 does that come from other grants? 5 A. Correct. 6 Q. Okay. And how many grants fill that 60, 7 ballpark? 8 A. Two or three depending on the size of them. 9 Q. Okay. And are any of them as significant in 10 proportion as Leapfrog? 11 Let me -- let me -- that's a sort of 12 unwieldy question. Let me fix that. I saw you 13 thinking. So I'll build it a little more clearly. 14 So in 2018, the amount allocated to your 15 salary was 40 percent. Is that right? 16 A. Correct. 17 Q. Okay. 18 You said of the remaining 60 percent, there 19 were two or three other grants that filled that, 20 essentially, right? 21 A. Correct. Page 66	1 MR. CRAIN: Yeah. 2 MS. LAWSON: -- because I think he testified 3 earlier that he's had like nine or ten other grants. 4 MR. CRAIN: Yeah, I hear you. 5 MS. LAWSON: Yeah. 6 BY MR. CRAIN: 7 Q. So in a given year, let's say between 2018 and 8 2025, the other grants that are not Leapfrog, if you 9 can, approximately what percentage of your compensation 10 do they -- are they? 11 A. It varies from year to year. I'm more trying 12 to just think about what's on my CV and what those 13 efforts are. They might total up to another 50 percent. 14 Q. Total. Okay. Got it. Okay, so -- 15 A. So a typical breakdown might be one that's 20, 16 one that's 20, and one that's 10. 17 Q. Okay. Got it. Okay. And I didn't mean it to 18 be a memory test. 19 A. No, no, no, no, no. I'm trying to answer 20 truthfully, but I don't really remember. 21 Q. Just your best estimate. Page 68
1 Q. Are any of those two to three grants also 2 40 percent? 3 MS. LAWSON: And are you asking just specific 4 to 2018? 5 BY MR. CRAIN: 6 Q. Specific to 2018, yeah, if you recall. 7 A. I don't recall, but I could find that out. 8 Q. Okay. 9 A. I just don't remember offhand. 10 Q. Generally, you know, to the extent you know, do 11 you -- have you had other grants that were the same 12 significance in size as Leapfrog over the years? 13 A. This would be the most significant -- 14 Q. Okay. 15 A. -- ongoing contract. 16 Q. Okay. Got it. 17 And the other two or three grants, as a 18 percentage of your compensation, can you ballpark 19 generally what they are? 20 MS. LAWSON: Object -- objection to form. And 21 maybe if you can clarify over time -- Page 67	1 A. My best estimate, yeah. 2 Q. Okay. 3 MS. LAWSON: And if you're not sure, it's okay 4 to tell him that you're not sure because he wants to 5 know -- 6 MR. CRAIN: Yeah. 7 MS. LAWSON: -- what you know. 8 THE WITNESS: Okay. 9 MR. CRAIN: I'm not asking you to guess. 10 THE WITNESS: Okay. Okay. 11 MS. LAWSON: Yes, he's not asking you to guess. 12 THE WITNESS: Okay. 13 MR. CRAIN: But your best estimate -- 14 THE WITNESS: Okay. 15 MR. CRAIN: -- approximation as the expert of 16 you. 17 THE WITNESS: Right. Okay. 18 BY MR. CRAIN: 19 Q. So let's shift gears a little bit. Are you 20 doing okay on time? 21 A. Yeah. Page 69

1 Q. Okay, good. I mean break. 2 A. Yeah. 3 Q. Okay. 4 So I want to talk a little bit more about 5 the safety grade and what it does and what's it's 6 purpose. So -- 7 MS. LAWSON: Actually, if we're going to 8 totally switch gears -- 9 MR. CRAIN: Yeah. You want to -- 10 MS. LAWSON: -- do you mind if we take a -- 11 MR. CRAIN: Yeah, yeah. No, now is fine. 12 MS. LAWSON: A break? Yeah. 13 MR. CRAIN: Yeah. Good. 14 THE VIDEOGRAPHER: This marks the end of media 15 unit number two. We're going off the record. The time 16 is 10:05 a.m. 17 THE COURT REPORTER: This gives us a chance to 18 get the realtime going, too. 19 MR. CRAIN: Oh, yeah. 20 21 Page 70	1 A. Once in a great while. 2 Q. Okay. 3 So I'm just going to -- I sort of want to 4 walk through what the safety grade is and focus on some 5 of the language in this document if we can. And I -- so 6 starting with paragraph -- the first paragraph, you see 7 there's a sentence "the purpose" -- do you see that -- 8 A. Uh-huh. 9 Q. -- at the bottom? 10 A. Uh-huh. 11 Q. "The purpose of the Leapfrog Hospital Safety 12 Grade is to bring this information to light in a way 13 that's easy for you, the consumer, to use." 14 I realize it says "this information," so I 15 probably need to go back. So I'll start at the top. 16 "One of the most significant problems with 17 today's healthcare system is the failure to make safety 18 and quality information available to the public. But 19 the public deserves this information so they can make 20 informed choices about where to receive care. 21 "The purpose of the Leapfrog Hospital Page 72
1 (Whereupon a short break was had, after 2 which the proceedings continued as 3 follows:) 4 (Exhibit No. 7 was marked for 5 identification as of 9/25/2025.) 6 THE VIDEOGRAPHER: This marks the beginning of 7 media unit number three. We're going back on the 8 record. The time is 10:22 a.m. 9 BY MR. CRAIN: 10 Q. Welcome back, Dr. Austin. 11 A. Thank you. 12 Q. It's like a commercial break on TV. 13 So I've given you what's been marked as 14 Exhibit 7. Do you recognize this document? 15 A. I do not. 16 Q. Okay. So I'll represent to you this is from 17 the Leapfrog Safety Grade website, 18 hospitalsafetygrades.org. Is that familiar to your? 19 A. I'm familiar with that website. 20 Q. Do you know -- like, are you -- do you look at 21 the website periodically or no? Page 71	1 Safety Grade is to bring this information to light in a 2 way that's easy for you, the consumer, to use." 3 Do you see that? 4 A. Yep, I do. 5 Q. Do you agree with that paragraph? 6 MS. LAWSON: So I'll just object to form. 7 And just I want to clarify. I think 8 Dr. Austin, you testified you had not seen this before. 9 THE WITNESS: Correct. 10 I would generally agree. I would maybe 11 reframe the first sentence slightly differently. 12 BY MR. CRAIN: 13 Q. How so? 14 A. I might say that one of the significant 15 problems of today's healthcare system is how to best 16 share safety and quality information with the public. 17 Q. Okay. 18 A. I think information is available. I think 19 we've struggled to help people connect to that. 20 Q. So the difference being the failure language? 21 A. Yeah. I wouldn't say failure to make. Page 73

1 Q. Okay. 2 And then do you agree that the purpose of 3 the Leapfrog Hospital Safety Grade is to bring this 4 information to light in a way that it's easy for you, 5 the consumer, to use? 6 A. Yes. 7 Q. Okay. 8 And then is it right that -- if you go down 9 to the second page -- "Our letter grade scoring system 10 allows consumers to quickly assess the safety of their 11 local hospital and choose the safest hospital to seek 12 care." Do you see that? 13 A. Yes. 14 Q. Do you agree with that statement? 15 A. Yes. 16 Q. And then it says: "As consumers use the 17 Leapfrog Hospital Safety Grade more and more, we hope 18 more hospitals will be compelled to be open about their 19 safety and quality and participate in meaningful public 20 reporting." 21 Do you see that as well? Page 74	1 Q. Okay. How often do they ask you to review the 2 website? 3 MS. LAWSON: Object to form. 4 BY MR. CRAIN: 5 Q. Generally, just over, you know, the last six 6 years. 7 A. Not very often. I mean, I don't know 8 everything that's on their website. You know, so I 9 don't know what the full scope is, so I can't speak 10 to -- 11 Q. No, I hear you. Just so we're on the same 12 page, I'm talking about hospitalsafetygrades.org. 13 A. Right. 14 Q. Are you familiar generally with that website? 15 A. Right. Yeah, yeah, yeah, yeah. Right. 16 Q. And Leapfrog -- I forget the other one but the 17 Leapfrog.org website. 18 A. Uh-huh, right. 19 Q. And one of them refers typically to the survey, 20 right? 21 A. Uh-huh. Page 76
1 A. I do. 2 Q. And do you agree with that sentiment? 3 A. I don't know what the evidence or research 4 supporting the first clause is. I wouldn't necessarily 5 be able to speak to that part, about whether consumers 6 are using the safety grade more and more, but I would 7 agree with the last part. 8 Q. The last part being we hope more hospitals will 9 be compelled to be open about their safety and quality 10 and participate in meaningful public reporting? 11 A. Yes. 12 Q. Okay. 13 And just to be clear, do you have any role 14 in the creation, drafting, revision of Leapfrog's 15 websites? 16 A. If I'm asked to review something, I will review 17 it -- 18 Q. Okay. 19 A. -- and provide back comments and feedback. But 20 they don't ask me to review every single thing on their 21 website. Page 75	1 Q. And the other one is about the safety grades, 2 correct? 3 A. Correct. 4 Q. And do you have any specific recollection 5 sitting here today of any particular page on either of 6 those two websites you were asked to opine on? 7 A. I don't remember exactly. I'm sure through 8 12 years there has been something that I have reviewed, 9 but I couldn't speak to what that is and if it's still 10 up or if it's been taken down. 11 Q. Just asking for your memory today. 12 A. Yeah, yeah. I don't. I don't know. 13 Q. And just to fine-tune it a little bit, do you 14 have any specific recollection of opining on any part of 15 the website regarding the imputation methodology? 16 A. Can you be more specific with what exactly 17 you're referencing there? 18 Q. Yeah. So are you aware of any part of 19 Leapfrog's website that articulates its imputation 20 methodology on the safety grades for nonparticipating 21 hospitals in the survey? Page 77

1 A. I know there's some information in a prior 2 exhibit that we discussed that talks about the 3 imputation. I don't know if there's something on a 4 webpage itself. I just don't know what is actually -- 5 what all the pages are and what's on them. 6 Q. Okay. Just to my question, do you have any 7 specific memory -- 8 A. No, I don't have any specific memory. 9 Q. Let me just finish the question so it's clear. 10 Do you have any specific memory of being 11 asked the opine or otherwise opining on any portion of 12 Leapfrog's website regarding the imputation methodology? 13 A. I don't remember being asked to do that. 14 Q. Okay. 15 MR. CRAIN: Let's go to 67. I'll mark another 16 document. This will be Exhibit 8. 17 (Exhibit No. 8 was marked for 18 identification as of 9/25/2025.) 19 BY MR. CRAIN: 20 Q. Dr. Austin, do you recognize this document? 21 A. I recognize that this is a printout of a Page 78	1 A. Yes. 2 Q. Is that a correct articulation of what the 3 Leapfrog Hospital Safety Grade uses? 4 A. That represents a summary of what has been the 5 formation of the Hospital Safety Grade in sort of its 6 entirety. 7 Q. Okay, fair enough. So let me ask you it this 8 way. Is that correct for the methodology as it exists 9 today? 10 A. Yes, minus that currently the safety grade I do 11 not believe is using information from other supplemental 12 data sources. 13 Q. Okay. What is the safety grade currently using 14 as a data source? 15 A. We're using data from the Centers for Medicare 16 & Medicaid Services and from the Leapfrog Hospital 17 Survey. 18 Q. Okay. So today there's no other supplemental 19 data sources being used with the grade, correct? 20 A. That is my recollection from the current 21 methodology. Page 80
1 webpage from Leapfrog's Hospital Safety Grade website. 2 Q. Do you have any reason to think that it's not 3 an accurate depiction of the website? 4 A. No, I have no reason to think so. 5 Q. Are you familiar generally with the "About the 6 Grade" website? 7 A. I'm familiar with that webpage, yes. 8 Q. I want to ask you a couple of questions about 9 the language on this page, just to your understanding. 10 Did you -- do you recall having any role in drafting 11 this page? 12 A. It is possible but I don't remember exactly 13 today. 14 Q. So page 1 -- and I apologize. There's no page 15 numbers on it but the first page and the second 16 paragraph, it says: "The Leapfrog Hospital Safety Grade 17 uses up to 30 national performance measures from the 18 Centers for Medicare & Medicaid Services, CMS, the 19 Leapfrog Hospital Survey, and information from other 20 sources of supplemental data." 21 Do you see that? Page 79	1 Q. And when did that change? Approximately. 2 MS. LAWSON: So it really is a memory test. 3 THE WITNESS: It is a memory test. 4 BY MR. CRAIN: 5 Q. If he has a memory. 6 A. I don't know the year. 7 Q. Okay. Let me refresh your recollection a 8 little bit. 9 A. Okay. 10 Q. So in 2024, am I right that the imputation 11 methodology changed? 12 A. That is my recollection, yes. 13 Q. And then prior to that, there was a different 14 imputation methodology, right? 15 A. Correct. We've actually used four or five 16 different imputation methodologies over the 11, 12 years 17 of the Hospital Safety Grade. 18 Q. Okay. 19 Can you, at a high level, I'm not asking 20 for a memory test, just generally trace what you recall 21 of those four or five different models? Page 81

1 A. Yeah, yeah, yeah. 2 So when we met with the expert panel early 3 on to talk about the idea of the Hospital Safety Grade, 4 one of the identified issues was that we were likely to 5 encounter missing data, and how did we want to address 6 the issue of missing data. 7 The expert panel laid out five different 8 ideas of sort of generally-accepted approaches of how 9 that has been addressed. 10 The -- if I can remember the five -- 11 Q. I can show you a document. 12 A. Okay. 13 And so we started initially with if we 14 didn't have data for a hospital for our measure, we 15 ignored that measure and put greater weight on the 16 measures for which we did have data. That evolved into 17 using supplementary data sources, specifically the 18 American Hospital Association survey was one of the key 19 data sources for that. 20 That evolved into calculating or assigning 21 the mean performance for hospitals based on cohorts, so Page 82	1 Q. And AHA is American Hospital Association? 2 A. Correct. 3 Q. I always mess that up. That's my aha moment. 4 I've been playing with that one. 5 MS. LAWSON: You delivered it well. 6 MR. CRAIN: Thank you. I'm going to use that 7 one at trial. 8 BY MR. CRAIN: 9 Q. So other forms of supplemental data, is there 10 any -- because CMS is not supplemental data, right? 11 Because it's covered on this page otherwise, correct? 12 A. Correct. 13 Q. Are there any other supplemental data that you 14 can recall Leapfrog using in the Hospital Safety Grade 15 scoring at any time? 16 A. Yes. So the American Hospital Association did 17 a separate survey around health information technology, 18 and we did use that to inform the scores for 19 computerized prescriber order entry. And that's one 20 that comes to my mind. There's none others that 21 immediately come to my mind, but that's not to say there Page 84
1 sort of the national mean based on the cohort that the 2 hospital fell into, and that has since evolved into 3 assigning the hospitals a lower performance score. 4 Q. That's the current methodology? 5 A. That's the current methodology. 6 Q. And when you say "lower performance score," 7 that's limited achievement? 8 A. That is correct, how Leapfrog has 9 operationalized that. 10 Q. And in the current model, am I right that there 11 are two steps, right? The first step is the historical, 12 as you said earlier? 13 A. Correct. 14 Q. The second step is the limited achievement that 15 you were referring to, correct? 16 A. Correct. 17 Q. Okay. 18 So going back to the document, when we talk 19 about supplemental data sources, generally, am I right 20 that the AHA data was a supplemental data source? 21 A. Correct. Page 83	1 weren't others. 2 Q. Okay. 3 A. I just don't recall. 4 Q. Yeah, okay. So that's helpful. 5 I want to keep going down this document. 6 If you go to the bottom of that paragraph: "The 7 Leapfrog Hospital Safety Grade methodology has been peer 8 reviewed and published in the Journal of Patient 9 Safety." 10 Do you see that? 11 A. Yes. 12 Q. Now, does the Journal of Patient Safety -- 13 there's a hyperlink there. Do you see that? 14 A. Uh-huh. 15 Q. And I don't have the document with me, but I'll 16 represent to you it goes to what I think is a 2014 17 article. 18 A. Correct. 19 Q. Does that article, the peer review that this 20 sentence is talking about to your knowledge? 21 A. Yes. Page 85

1 Q. And what does peer review mean, generally? 2 A. Peer reviewed, in at least the medical world, 3 which is really the only world I know, so that's all I 4 can speak to, when you submit to a journal, they 5 actually identify two to three external individuals to 6 actually read the manuscript, provide feedback, provide 7 recommendations of how to improve it. Those go back to 8 the editor of the journal, and the editor makes the 9 decision of what to share back with the authors in terms 10 of requested updates or revisions. 11 The peer reviewers could decide -- could 12 recommend that the article be rejected, right. They 13 don't feel like it's a high enough quality. And so it's 14 a process to sort of have some external review of the 15 work. 16 Q. And the 2014 article was peer reviewed? 17 A. Correct. 18 Q. Do you recall generally by whom? 19 A. I don't -- as an author, you're unaware of who 20 the peer reviewers are. 21 Q. Oh, interesting. Page 86	1 place at the time for the Hospital Safety Grade. 2 Q. In 2014, correct? 3 A. 2014, although -- it got published in 2014. We 4 wrote it in 2013, so this is probably an earlier 5 version. 6 Q. So do you think it's fair to say that the 7 current methodology has been peer reviewed? 8 A. I think it's fair to say that the general 9 approach remains consistent from 2013, 2014. The 10 individual measures that are included in the safety 11 grade has evolved over time. 12 Q. And just to be clear, though, to my question, 13 is it a fair statement to say the Leapfrog Hospital 14 Safety Grade methodology has been peer reviewed and 15 published in the Journal of Patient Safety in 2025? 16 A. I could argue that it does not say the current 17 Leapfrog Hospital Safety Grade methodology. It just 18 says that the methodology has been peer reviewed. 19 Q. If this is on the public consumer-facing 20 website today, do you think the consumer would 21 understand, looking at this, that this is referring to a Page 88
1 A. There's a movement recently toward moving -- 2 making that transparent, but that has not necessarily 3 been the practice. 4 Q. Got it. Okay. 5 Do you remember any feedback they gave on 6 the article? 7 A. You're really testing my memory here. 8 Q. If you don't, that's okay. 9 A. Yeah, I don't. That was 10 years ago, 11 years 10 ago. I don't remember. I'm sure there was feedback 11 from -- almost every article has some degree of 12 feedback, but I don't remember what the feedback was or 13 to the degree. 14 Q. And I don't at all mean to stretch your memory. 15 If you don't remember -- 16 A. Right. I don't. 17 Q. -- that's a perfectly fine answer, yeah, but I 18 have to ask. 19 So now going back, this article, it 20 analyzes an older methodology, right? 21 A. Correct. It was the methodology that was in Page 87	1 2014 methodology, not a 2025 methodology? 2 MS. LAWSON: Object to form. Go ahead. 3 BY MR. CRAIN: 4 Q. You can answer. 5 MS. LAWSON: You can answer. 6 THE WITNESS: I don't know what a consumer 7 would think or not think. Like, I haven't studied that. 8 BY MR. CRAIN: 9 Q. When you first -- this was the first time you 10 recall reading this sentence in a while, at least, 11 right? 12 A. The sentence meaning the one about the patient 13 safety? 14 Q. No, the one I read back to you. The Leapfrog 15 Hospital Safety Grade methodology has been peer reviewed 16 and published in the Journal of Patient Safety. 17 A. Uh-huh. 18 Q. You knew what that referred to, right? 19 A. Yes, I did. 20 Q. Did you think to yourself that's the same for 21 2025 as it was for 2014? Page 89

1 MS. LAWSON: Object to form, but you can 2 answer. 3 THE WITNESS: As I mentioned, I think the 4 general format of what we're doing with a composite 5 score made up of 25 measures that are weighted in two 6 domains remains consistent and solid throughout that 7 time frame. 8 Measures, for whatever -- I mean, measures 9 are going to come and go, right. CMS makes decisions 10 about retiring certain measures. They've added new 11 measures. So the safety grade does continue to evolve, 12 and I would say appropriately, right, like to sort of 13 keep up with the latest information and evidence. 14 BY MR. CRAIN: 15 Q. Has the imputation methodology or the 16 imputation model been peer reviewed? 17 A. That has not. 18 Q. Okay. 19 Okay. Let's keep going. I want to go to 20 -- let's see. Here we go. It's -- and I apologize. 21 There's no page number. If you go to the document, it's Page 90	1 the methodology, so I don't -- I can't speak to -- 2 Q. Fair enough. 3 A. -- how it got implemented. 4 Q. Yeah, let me fix the question. 5 Based on your knowledge of how the 6 methodology works, not whether it's been implemented 7 faithfully or not, but purely based on your 8 understanding of the methodology, is that an accurate 9 explanation or articulation of the methodology? 10 A. Yes. 11 Q. Okay. 12 A. That is what we have set as minimum data 13 thresholds. 14 Q. So I want to talk about some process measures. 15 BCMA, are you familiar with that term? 16 A. Uh-huh. 17 Q. What is BCMA? 18 A. Barcode medication administration. 19 Q. And what is CPOE? 20 A. Computerized physician order entry. 21 Q. And you're familiar with hand hygiene? Page 92
1 the first, second, third, fourth, fifth page to the 2 paragraph starting "A hospital." 3 A. Uh-huh. 4 Q. Do you see that? 5 A. Yep. 6 Q. "A hospital must have enough safety data 7 available for our experts to issue them a letter grade. 8 Hospitals missing more than six process measures, more 9 than five outcome measures, or PSI90 are not graded. 10 All hospitals are encouraged to voluntarily report 11 additional safety data through the Leapfrog Hospital 12 Survey, but they are not required to do so to receive a 13 safety grade." 14 Do you see that language? 15 A. I do. 16 Q. So let's start with process measures. Do you 17 see it says hospitals missing more than six process 18 measures...are not graded? 19 A. Uh-huh. 20 Q. Is that an accurate statement? 21 A. As far as I know. I'm not the one implementing Page 91	1 A. Correct. 2 Q. As a measure, not generally. 3 And are you familiar with IC -- IPS? 4 A. Yes, ICU physician staffing. 5 Q. And those I'm going to generally talk about now 6 as we move forward as the four imputed measures. 7 A. Uh-huh. 8 Q. Do you understand what I'm talking about? 9 A. Uh-huh. Yes, I do. 10 Q. When a hospital does not report to Leapfrog's 11 survey, does Leapfrog have any data about the hospital's 12 performance on any of those four measures? 13 A. In the imputation method for Step 1, if a 14 hospital submitted a survey in the prior year, there may 15 be data on one or more of those four measures. 16 Q. Fair enough. What about for Step 2? 17 A. For Step 2, there wouldn't be recent data, 18 right. So there wouldn't be either a survey that was 19 submitted the prior year or a survey submitted this 20 year. 21 Q. Yeah. So if a hospital has never reported to Page 93

1 Leapfrog's survey, is it fair to say that Leapfrog has 2 no data on the actual performance of that hospital on 3 those four imputed measures? 4 A. We do not have any data that's been reported 5 through the survey, correct. 6 Q. So why is that not missing data? 7 A. Some I guess it could be one's definition of 8 missing. Those missing data thresholds were really 9 intended to not assign grades to small hospitals that 10 may not have enough data from CMS. So, as an example, 11 there are smaller hospitals that may not have had enough 12 central lines inserted during the reporting period to 13 actually have a central line associated blood stream 14 infection rate. 15 And so the intent of those missing data 16 thresholds was really to make sure we weren't assigning 17 grades to hospitals for which we had unreliable 18 information. It was not necessarily intended to allow 19 hospitals not to report. 20 Q. So is missing data really supposed to be absent 21 data? Like, you mentioned folks that don't have enough Page 94	1 gave Delray a limited achievement for hand hygiene, 2 right? 3 A. That would be my understanding of how that 4 would get applied. 5 Q. And but -- so there's -- to your point a minute 6 ago, which I've now lost but I will find, you said 7 missing data would refer to a measure for which we don't 8 have a value. Isn't it right that Leapfrog has no value 9 for hand hygiene for Delray? 10 A. That would be correct. 11 Q. Okay. 12 So this paragraph is not correct, right, 13 the one we looked at on the document? 14 A. I think the distinction I would make is whether 15 an imputed score is considered missing or if it's 16 considered a value. 17 Q. You're going to have to say more about that 18 one. What do you mean by that? 19 A. Right. So Leapfrog imputed a score for Delray 20 for hand hygiene of 15 points out of 100. 21 Q. Yes. Page 96
1 central lines. 2 A. Missing data would refer to a measure for which 3 we don't have a value. 4 Q. And so just to put it concretely, when you say 5 "we don't have a value," who do you mean? 6 A. Meaning The Leapfrog Group doesn't have a 7 value. 8 Q. So how is that different -- so one of my 9 clients is Delray Medical Center in Florida, right. And 10 we always use Delray as the example. I don't know why, 11 but Delray is the example. We can pick any of them. 12 Leapfrog gave Delray a limited achievement 13 for hand hygiene. Are you generally aware of that? 14 A. I have not reviewed Delray's results but I -- 15 Q. But you understand, as the plaintiff in this 16 case, it's a nonparticipating hospital, right? 17 A. Yes, that's my understanding. 18 Q. And it's -- one of the core elements of the 19 case is the Step 2 methodology, right, for imputation? 20 A. Correct. 21 Q. So based on that, you understand that Leapfrog Page 95	1 A. So to me it sort of comes down to is that -- we 2 have a score for Delray for that measure. So it's not 3 missing. 4 Q. And how did Leapfrog pick that score? 5 A. Leapfrog -- so the reason Leapfrog chose 6 limited achievement is that has always been the bottom 7 performance category and it -- basically, given the lack 8 of information that we have about the hospital's 9 performance in hand hygiene, it felt like that was the 10 appropriate score to give, given the absence of 11 information that would tell us something otherwise, that 12 they were performing on a higher level. 13 Q. So is the assumption that Delray is performing 14 at the lowest level for hand wipe -- hand hygiene? 15 A. Given the lack of other information from them, 16 that is our assumption. 17 Q. One of the things that hand hygiene evaluates 18 is whether a hospital has a handwashing policy, right? 19 Let me strike that. 20 One of the things that the survey asks 21 about handwashing is about handwashing training. Are Page 97

1 you aware -- 2 A. Correct. Yes. 3 Q. Do you have any knowledge of any hospital that 4 does not train doctors and nurses on hand hygiene? 5 MS. LAWSON: Object to form. You can answer. 6 BY MR. CRAIN: 7 Q. Your knowledge. 8 A. There are -- to be clear, what's asked in this 9 survey isn't just about training. It's the way that the 10 training is done, who is trained, and that was not 11 necessarily universally done across all hospitals. So 12 it extends just beyond training employees. 13 Q. Okay. Fair enough. 14 So coming back to this document again, so 15 the four imputed measures, do you agree that they are 16 process measures? 17 A. They are considered either process or 18 structural measures. 19 Q. But in terms of -- I understand that Leapfrog 20 puts its measures into two buckets, process or 21 structural or outcome. Is that right? Page 98	1 grade, correct? 2 A. Those are not imputed, correct. 3 Q. Those are not imputed. They're just discarded, 4 right? 5 A. They are ignored, and their relative weights 6 are assigned proportionately to the others. 7 Q. Redistributed, right? 8 A. Redistributed. 9 Q. Yeah. I don't mean to put words in your mouth, 10 but I think it's the word I've seen. 11 So then those are process and structural 12 measures, too, right? 13 A. Correct. 14 Q. So that's seven, right? 15 A. Correct. 16 Q. Okay. 17 And just to be clear, this document doesn't 18 say -- this is the Leapfrog website. I'm looking at it 19 again. Hospitals missing more than six process measures 20 are not graded. That's what it says. It doesn't say 21 hospitals -- strike that. Page 100
1 A. Correct. 2 Q. They all fit the process or structural, right? 3 A. Correct. 4 Q. There are also three others, three other 5 process measures that when a nonreporting hospital is 6 graded are left out of the scoring methodology, right? 7 A. Can you clarify that? 8 Q. Yeah. 9 Are you familiar with safe practice one? 10 A. Yes. 11 Q. And can you remind me what it is? If you 12 don't, I can pull it out. 13 A. Yeah, it's like leadership. 14 Q. Yeah. And are you familiar with safe practice 15 two? 16 A. Yes, which is culture measurement. 17 Q. And are you familiar with total nursing care 18 per patient hour? 19 A. Yes. 20 Q. Those are the three measures that -- for 21 nonparticipating hospitals that do not go into the Page 99	1 We just walked through Leapfrog does not 2 have data for seven process measures, right? 3 MS. LAWSON: Object to form. You can answer. 4 THE WITNESS: Okay. 5 BY MR. CRAIN: 6 Q. If you're confused, I can rephrase. Let me 7 build it up. 8 So we talked about the four imputed 9 measures, right? 10 A. Correct. 11 Q. We talked about the three what I'll call 12 discarded measures, correct? Do you understand what I'm 13 saying when I say that? 14 A. Yeah, I know the three you're referring to. 15 Q. And they're all process or structural measures, 16 right? 17 A. Correct. 18 Q. And there are seven of them? 19 A. Correct. 20 Q. And yet this document tells consumers that 21 hospitals missing more than six process measures are not Page 101

1 graded. Do you see that? 2 A. That is what the document says. 3 Q. And can you tell me again why that's accurate? 4 A. For me, it comes back to the question of is it 5 an imputed score, a score, or is it missing. And I 6 would argue it's a score. So for those four imputed 7 measures, those hospitals have scores. They aren't 8 missing data. 9 Q. Aren't missing data even though Leapfrog has no 10 data for those scores? 11 A. Even though Leapfrog does not have any 12 information that was reported by the hospital through 13 the Leapfrog Hospital Survey. 14 Q. Okay. 15 Okay. All right. Let's keep going. I 16 want to also talk about -- let's see if it's on this 17 page. 18 MR. CRAIN: Can we go to tab 65. This will be 19 Exhibit 9. 20 (Exhibit No. 9 was marked for 21 identification as of 9/25/2025.) Page 102	1 And I want to talk through a few things on 2 this document. First I want to start with there is a 3 "why." "Why should people" -- yeah. "Why should people 4 worry about a hospital's patient safety. Aren't all 5 hospitals the same?" 6 Do you see that on page 2? 7 A. Yes. 8 Q. And if you go down to about midway down the 9 paragraph, it says "and all." Do you see that? 10 A. Uh-huh. 11 Q. And it says: "And all hospitals are not the 12 same. Some hospitals are much safer than others. Johns 13 Hopkins Medicine researchers estimate that patients are 14 twice as likely to die of a preventable problem at a 15 "C," "D," or "F" hospital than an "A" hospital, and over 16 50,000 lives would be saved if all hospitals performed 17 the way "A" hospitals did." 18 Do you see that? 19 A. Yes. 20 Q. And I know you didn't write this, but do you 21 have any reason to think you are not the Johns Hopkins Page 104
1 BY MR. CRAIN: 2 Q. So Dr. Austin, I've been giving you a document. 3 This one has, fortunately, a URL at the bottom. Do you 4 see that? 5 A. Uh-huh. 6 Q. And has page numbers, fortunately, too. 7 Do you recognize this document? 8 A. I do not. 9 Q. Okay. Do you have a general sense just from 10 looking at it what it purports to be at least? 11 A. Yeah, I do. 12 Q. Okay. 13 So I'll represent to you -- and you can see 14 on the URL at the bottom we pulled this off of 15 hospitalsafetygrades.org, which we talked about earlier 16 that's one of Leapfrog's websites, right? 17 A. Uh-huh. 18 Q. And this is a frequently asked questions page. 19 Do you see that? 20 A. Yes. 21 Q. Okay. Page 103	1 researcher? 2 A. No, that is me. 3 Q. And do you have any reason to think that's not 4 referring to your white paper? 5 A. I have no reason to believe that it does not 6 refer to the white paper. 7 Q. And tell me, just so we're on the same page, 8 what is the white paper to which this is referring? 9 A. The white paper that -- so we, in 2016, did a 10 white paper that was referred to as "lives lost, lives 11 saved." And in 2019, we did an update to that. So I 12 don't know -- I believe this is referring to the 2019 13 updated white paper. 14 Q. And the 2019 updated white paper did not 15 analyze "A," "B," "C," "D," and "F" hospitals under the 16 current methodology, right? 17 A. No. They were -- that was done through -- I 18 would have to go back and look at the document but 19 probably based on like the Fall 2018 safety grades. I 20 don't -- yeah. I think we put it out in 2019, but I 21 think it may have been Fall of 2018 that we actually Page 105

1 used. 2 Q. And have you published any estimates of that 3 patients are twice as likely to die of a preventable 4 problem at a "C," "D," or "F" hospital than an "A" 5 hospital based on the 2025 methodology? 6 A. No, we have not. 7 Q. Do you have any understanding as to whether 8 that is correct today, or you just don't know? 9 A. We have done some early analysis around this 10 based on 2025, and these statements would remain true. 11 Q. Okay. Based on that early analysis? 12 A. Correct. 13 Q. Okay. And when did you conduct that analysis? 14 A. We started that back in March, April, somewhere 15 in that time frame. 16 Q. Okay. And so even though this is referencing 17 the 2019 white paper and the prior methodology, you're 18 saying based on the current imputed methodology the 19 twice as likely to die language is still correct? 20 A. Yes, I would stand by that. 21 Q. You would stand by it or you do? Page 106	1 Q. Okay. Do you have any sense of when you're 2 going to publish that? 3 A. I don't have a sense of it. 4 Q. How far into the drafting are you? 5 A. I don't know how to estimate that. I mean, 6 it's actually updating the 2019 white paper. So I've 7 gone through at this point and made notes on which 8 values need to be updated, where we need to update 9 tables, but all that work would still need to be done. 10 Q. And is your analysis, would you say, an apples 11 to apples analysis between what you're doing today and 12 what was done in 2019? 13 A. It mirrors the spirit of what we did in 2019 in 14 that the measures themselves have changed between 2019 15 and now, but the approach of how we've estimated lives 16 lost and lives saved has remained consistent. 17 Q. And can you explain generally what that 18 approach is? 19 A. Yes. So what we've done is we have -- to 20 estimate the lives lost for looking at "A" hospital as 21 an aggregate, "B" hospital as an aggregate, "C" an Page 108
1 A. I do. 2 Q. Okay. 3 And how did that analysis transpire? 4 A. Transpire? Can you clarify? 5 Q. How did it come to -- how did you -- why did 6 you conduct that analysis? 7 A. Yeah. So The Leapfrog Group asked that we look 8 at doing an update from the 2019 in 2025. So it was an 9 effort to follow through on that request and to provide 10 an updated analysis of where we're at. 11 Q. And have those analyses been released publicly 12 yet? 13 A. No. 14 Q. Okay, and why is that? 15 A. We -- you would have to ask The Leapfrog Group 16 on their decision and timing on that. 17 Q. Okay. 18 And you've not -- have you drafted a new 19 white paper? 20 A. I have started working on drafting a new white 21 paper. I have not finished that. Page 107	1 aggregate, and "D" and "F" hospitals an aggregate, we 2 look at the mean incidence rates of each of the patient 3 safety events that are included in the Hospital Safety 4 Grade. And from the literature, we've identified an 5 attributable mortality rate to each of those events. 6 So as an example, for central line 7 associated blood stream infections, one in every seven 8 patients who acquires one in the hospital passes away 9 from that. So if you are in a hospital that has a 10 higher rate of those, your risk of dying from one of 11 those increases. 12 And so we apply that against the admissions 13 that are in each of those buckets, so "A" hospitals, 14 "Bs", "Cs", "Ds", and "Fs" to estimate the number of 15 lives lost due to the preventable medical mistakes that 16 are included in the Hospital Safety Grade. 17 And we estimate. Let me put that word out 18 there very clearly. It's an estimate of the number of 19 lives that are lost. 20 Q. And why do you emphasize estimate? 21 A. Because we're -- for example, one assumption Page 109

1 that we have to make is the attributable mortality rate, 2 right. We're using that same rate in all four buckets, 3 "As," "Bs," "Cs," "Ds," and "Fs." The reality is we 4 might actually see that "A" hospitals have a lower 5 mortality rate when a patient develops a CLABSI than, 6 say, like a "D" and "F." But we're assuming that that 7 mortality rate is similar across all hospitals. 8 Q. Got it. Okay. Okay, we'll come back to that a 9 little bit more. 10 Okay. So then I want to go back to this 11 FAQ just before we go into other topics. 12 A. Sure. 13 Q. I want to talk about -- let's see. I lost the 14 question. Oh, here it is, page 3. It says: "Does a 15 hospital get a better safety grade if it reports to the 16 Leapfrog Hospital Survey?" Do you see that? 17 A. Uh-huh. 18 Q. And it says: "The Hospital Safety Grade 19 reflects how well a hospital does on safety, not whether 20 they complete the Leapfrog Hospital Survey." Do you see 21 that? Page 110	1 Q. Have you conducted any analysis to assess 2 whether hospitals that do not participate in the 3 Leapfrog survey are actually less safe than hospitals 4 that do? 5 A. Not that I can think of. 6 Q. Okay. 7 MR. CRAIN: I'm going to shift gears. 8 Everybody good on time? I'm going to switch topics. 9 You good? 10 BY MR. CRAIN: 11 Q. So I want to talk about the development of the 12 imputation models. So I'm going to focus you on the 13 2024 period. Is that fair enough? 14 A. Yep. 15 Q. Okay. 16 So in April 2024, the expert panel met to 17 discuss, among other things, imputation model. Do you 18 recall that meeting? 19 A. That sounds correct. I know we had a meeting 20 with them, and I think that was the timing of when we 21 talked about that topic. Page 112
1 A. Uh-huh. 2 Q. And just one question on this line. Do you 3 believe, as, you know, familiar as you were with the 4 methodology, is that accurate with respect to 5 nonparticipating hospitals? 6 A. There are nonparticipating hospitals that have 7 received "As," "Bs," "Cs," "Ds," and "Fs." 8 Q. And do you think that is -- the Hospital Safety 9 Grade reflects how well a hospital does on safety, not 10 whether they complete the hospital survey. Do you agree 11 with that statement? 12 A. I do agree with that statement. I think 13 transparency is an important component of safety. 14 Q. Okay. Why do you say that? 15 A. Yeah. So hospitals that are choosing to share 16 their data through the Leapfrog Hospital Survey are 17 making that information transparent, and I think that 18 does tie to a safety culture of one where we want to 19 make information publicly available, hold ourselves 20 accountable. So I do think there is a link between 21 transparency and safety. Page 111	1 Q. Yeah. And I'll get you a document. 2 MR. CRAIN: Can we get 32A, just to ground the 3 discussion. This will be Exhibit 10. 4 (Exhibit No. 10 was marked for 5 identification as of 9/25/2025.) 6 BY MR. CRAIN: 7 Q. Dr. Austin, do you recognize this document? 8 A. Yes. 9 Q. Okay. And this is an email thread leading up 10 to before and after I think the April 12th, 2024, expert 11 panel meeting. Do you see that? 12 A. Yes. 13 Q. Okay. And I want to just start at the -- where 14 is the attachment? 15 MR. CRAIN: Do we have the slide deck? 32 I 16 need also. Sorry. We have them separately. 17 So let's look at the deck, which was 18 attached to this email, but I think it's separate. 19 This will be Exhibit 11. 20 (Exhibit No. 11 was marked for 21 identification as of 9/25/2025.) Page 113

1 BY MR. CRAIN: 2 Q. Okay. So now this is the deck. Do you see 3 that, Dr. Austin? 4 A. I do, yeah. 5 Q. Okay. And it's attached to a Zoom invite -- or 6 to a meeting invite you sent on -- at some point but for 7 a meeting at April 12th at 4 to 5 p.m. Do you see that? 8 A. Yes. 9 Q. Okay. 10 And this was for the safety grade expert 11 panel's meeting for I think that year, right? 12 A. I believe that was the only meeting we held 13 with them in 2024. 14 Q. Okay. 15 And so going to the deck, I'm just going to 16 walk through it with you. And if you go to slide two, 17 which is Bates ending 437364 -- do you see that? 18 A. Uh-huh. 19 Q. And you lay out three topics, right? 20 A. Uh-huh. 21 Q. The first topic is update on swearing DHA Page 114	1 A. I believe I actually am the one who probably 2 drafted this. 3 Q. Yeah. So if you look at the prior exhibit -- 4 A. Uh-huh. 5 Q. -- this is Exhibit 10. 6 A. Uh-huh. 7 Q. On page 74782, do you see that? 8 A. 782, yes. 9 Q. And there's an email at the bottom from you to 10 Ms. Campione, Ms. Danforth, and Ms. Joshi. Do you see 11 that? 12 A. Yes. 13 Q. And it goes to the next page. And you say, 14 "Attached is an updated version of the slides. Alex, 15 these are looking good. I added in a slide at the start 16 of the imputation section that outlines the problems we 17 are trying to solve." Do you see that? 18 A. Yep. 19 Q. Does that refresh your recollection as to 20 whether you drafted -- 21 A. Yep -- Page 116
1 military treatment facilities. 2 (Whereupon, the court reporter seeks 3 clarification, which colloquy will not be 4 captured on the written record.) 5 BY MR. CRAIN: 6 Q. The second is feedback on reevaluating 7 imputation model, and the third is feedback on two 8 possible new outcome measures. 9 Do you see that? 10 A. Yes, I do. 11 Q. Okay. 12 And I want to focus on the middle one. So 13 if we can skip to what is page 7366 [sic]. 14 A. Uh-huh. 15 Q. Now, do you see this slide is entitled "Problem 16 that We are Working to Solve?" 17 A. Uh-huh. 18 Q. And I want to just go back to the prior 19 exhibit. Well, I'll ask before we go there. Do you 20 recall who drafted this slide? If you don't, I can 21 refresh you. Page 115	1 Q. -- this slide? 2 A. -- it does. 3 Q. Okay. 4 Just remember to let me finish before -- 5 A. I'm sorry. 6 Q. -- and vice versa, just for Marlene. 7 So going back to the slide, why did you 8 draft this slide? 9 A. I thought it was helpful to remind the expert 10 panel of what are some of the challenges we are facing 11 with the current Hospital Safety Grade methodology and 12 why we might want to consider moving in a different 13 direction for imputation. 14 Q. Okay. And the challenges you're talking about 15 are the two bottom bullets, right? 16 A. Correct. 17 Q. Okay. And so the first one is imputed scores 18 have crept up, making imputation a more favorable choice 19 for lots of hospitals and has de incentivized true 20 transparency of performance, right? 21 A. Correct. Page 117

1 Q. Now, when you say imputation scores have crept 2 up, what's that based on? 3 A. So the imputation methodology at the time was 4 that it involved -- there was still the historic element 5 of Step 1. 6 Q. And I'll help you. I don't mean to interrupt, 7 but there's a slide that lays it out if it's helpful to 8 you. 9 A. Okay. 10 Q. It's 7369. 11 A. Uh-huh. 12 Q. Do you see that? 13 A. Yep, I do. 14 Q. Okay. Just in case it's helpful. But go on. 15 A. So the Step 1 was assigning the most recent 16 scores from the four past rounds of the safety grade, 17 and then Step 2 was actually looking at two different 18 mean performances. And what we had seen was a trend 19 with those scores were creeping up, which incentivized 20 hospitals to not report to the survey and, instead, to 21 take the imputed score. Page 118	1 A. Correct. 2 Q. But not necessarily empirical evidence of 3 nonparticipating hospitals making the decision not to 4 participate because the scores were going up? 5 A. I don't remember any evidence in that way. 6 Q. Okay. 7 Then the second -- just going back to slide 8 I think it's five, which is 7367 on the Bates number, 9 you see -- so the first bullet we just talked about is 10 primarily a problem with Step 2 in this old methodology. 11 Is that right? 12 A. Correct. 13 Q. And the second bullet is about Step 1, right? 14 A. Correct. 15 Q. And it says: "Hospitals are using Step 1 16 imputation, using their individual hospital's historical 17 data as a reason to not report on the current year 18 survey." Right? 19 A. Correct. 20 Q. Okay. So tell me a little bit about that 21 issue. Page 120
1 Q. And how did you know it was driving that 2 incentive, that was the reason they were not reporting? 3 A. That feedback was clear from hospitals. They 4 had verbally shared that with Leapfrog. 5 Q. With you? 6 A. Not with me, with Leapfrog. 7 Q. Did you talk to any hospital that shared that 8 with you personally? 9 A. No. 10 Q. Okay. 11 And who did they share it with at Leapfrog? 12 A. From what I remember, Missy Danforth. 13 Q. Any sense of how many hospitals? 14 A. I don't have a sense of that. 15 Q. And do you have any other basis of knowledge to 16 support that statement besides what you said about 17 Ms. Danforth? 18 A. We have -- we numerically had been tracking the 19 mean score. So we did have empirical evidence of that 20 going up. 21 Q. Empirical evidence of scores going up? Page 119	1 A. Yeah. Leapfrog had seen patterns where 2 hospitals were choosing to report one year, not report 3 the next year, report the next year as a way to sort of 4 keep their scores sort of used in the Hospital Safety 5 Grade without having to report to the survey every year. 6 Q. And what was your understanding of why those 7 hospitals weren't reporting every year? 8 A. I can't speak to why the hospitals were 9 choosing not to report. 10 Q. You have no understanding? 11 A. I have theories but I don't -- I haven't had 12 conversations with hospitals specifically about their 13 decision not to report. 14 Q. So same thing with respect to Step 1 -- 2 that 15 we just talked about, right? You said you -- 16 MS. LAWSON: Object to form. 17 BY MR. CRAIN: 18 Q. Yeah, let me fix it. 19 So you said I have theories but I haven't 20 had conversations with hospitals specifically about 21 their decision not to report. That goes for either Page 121

1 decision not to report about Step 1 or Step 2, right? 2 A. That is for me personally I never had 3 conversations with hospitals about that. 4 Q. And did you ever have conversations with 5 Ms. Danforth about the hospitals that are deciding not 6 to report in the Step 1 context? 7 A. Yes. 8 Q. Okay. Tell me about those conversations. 9 A. So that was a similar point of feedback, that 10 she had had conversations with hospitals who had 11 indicated -- Leapfrog also has regional leaders, which 12 you may be familiar with. I think the regional leaders 13 were also hearing from hospitals that, oh, yeah, we're 14 not going to report this year because our scores still 15 get used in the Hospital Safety Grade. 16 So there had been sort of a current of 17 we're choosing to bypass transparency. 18 Q. And was that in relation to the burden of 19 completing the survey? 20 A. That's what I can't speak to. 21 Q. So you have no knowledge about the why? Page 122	1 A. I have had conversations with hospitals -- 2 well, I guess I have had conversations with hospitals 3 about their decision to pause reporting. 4 Q. Okay. How many conversations, approximately? 5 A. Five to ten through ten years. 6 Q. Okay. 7 And have you had conversations with 8 hospitals about this imputation methodology at all at 9 any time? 10 MS. LAWSON: Well, I just want to object to 11 form. 12 Just to clarify, the imputation -- this 13 imputation methodology, are you asking about the current 14 2024? 15 MR. CRAIN: Yes. 16 MS. LAWSON: Yes. So just to clarify that. 17 THE WITNESS: I do not believe I've had any 18 conversations with hospitals about that. 19 BY MR. CRAIN: 20 Q. Okay. 21 So your knowledge today about hospitals' Page 124
1 A. I don't have any firsthand knowledge of the 2 why. 3 Q. Do you have any secondhand knowledge about the 4 why? 5 A. My secondhand knowledge would be burden would 6 be a consideration. 7 Q. Okay. And when you say "burden would be a 8 consideration," what do you mean by that? 9 A. So what I hear from hospitals generally, not 10 specific to this, is that at times, they feel like they 11 need to prioritize other quality improvement efforts and 12 may make a decision on where those priorities exist from 13 year to year. 14 Q. And when you say what you hear from hospitals, 15 that's not firsthand, right? 16 A. That has been firsthand, yes. 17 Q. So you do talk to hospitals? 18 A. I do talk to hospitals, not specifically about 19 whether they are reporting every year or every other 20 year. 21 Q. Okay. Page 123	1 decision-making with respect to reporting onto the 2 survey primarily comes from Ms. Danforth? 3 A. That would be a fair statement. 4 Q. Okay. 5 Okay. So going back to the deck, there's a 6 number of tables, and I want to go to slide -- it's the 7 slide with your proposal. Oh, here we go. Slide 13, 8 which is 7375. 9 A. Uh-huh. 10 Q. And this is the proposed future imputation 11 methodology. Do you see that? 12 A. Yes. 13 Q. Okay. This is not the methodology that 14 Leapfrog ultimately adopted, right? 15 A. Correct. 16 Q. Okay. Was this the methodology discussed at 17 the meeting? 18 A. Yes. This is what we put forward to the expert 19 panel. 20 Q. Okay. And you received feedback about this 21 proposal? Page 125

1 A. Correct. 2 Q. Right. 3 Okay. And just generally, can you explain 4 what the proposal was? 5 A. The proposal was that we would basically move 6 to a single form of imputation which would be the -- 7 that we would use Step 2b imputation for all hospitals. 8 Q. And you would -- to your point, a single form 9 of imputation, that's the retire Step 1 bullet? 10 A. Correct. We would retire Step 1, and we would 11 move all hospitals to Step 2b. 12 Q. Okay. And which is 2b? 13 A. 2b, as it's described here, is that hospitals 14 would be assigned to cohorts and then the means of 15 scores from the first year of reporting would be used to 16 calculate the means. 17 Q. Okay. 18 A. And then the hospital would be assigned that 19 mean. 20 Q. Got it. Okay. 21 And then I just want to go -- so that was Page 126	1 A. I don't know whether that is -- yeah, correct. 2 Q. Okay. 3 So I want to talk a little bit about the 4 meeting itself. Do you recall whether other expert 5 panelists proposed alternative imputation methodologies? 6 A. I really don't remember the details of that 7 call. 8 Q. Okay. 9 Do you remember who was on it? 10 A. We have meeting notes of -- from that meeting, 11 but I don't recall who exactly was on that call. 12 Q. Okay. 13 So I want to go to tab 33. This is a 14 document I don't think you've seen before, so I'll just 15 preface that so you know. 16 A. Okay. 17 MR. CRAIN: And this will be Exhibit 12. 18 (Exhibit No. 12 was marked for 19 identification as of 9/25/2025.) 20 BY MR. CRAIN: 21 Q. It's huge. I'll walk you through it. So are Page 128
1 the proposal you put out, correct? 2 A. Correct. 3 Q. And it was not the one that was adopted? 4 A. Correct. 5 Q. And we'll get to the why, but before we do 6 that, if you could go one slide back, slide 12. 7 A. Uh-huh. 8 Q. You see it says: "A slight dip in survey 9 participation occurred this past year as hospitals opted 10 to use past survey results in Step 1 imputation." Do 11 you see that? 12 A. Correct. 13 Q. So what is that based on? How did you know 14 that the slight dip was caused by hospitals using past 15 survey results in Step 1 imputation? 16 A. That is probably more just a -- based on 17 conversations that Ms. Danforth had had with hospitals. 18 I don't know if that's -- if we have anything 19 empirically to back up that statement. 20 Q. Okay. So you don't know whether that's 21 accurate or not? Page 127	1 we good? 2 A. We're good. 3 Q. Okay. 4 So if you look back at exhibit -- the 5 exhibit with the email, which I think is Exhibit 10. 6 A. Uh-huh. 7 Q. Okay? 8 Do you see at the top there'd an email from 9 Ms. Campione to you? 10 A. Uh-huh. 11 Q. And it says, "Here is the link to the recording 12 if you need it for notes. Please let me know if you 13 have any issues with it." 14 A. Uh-huh. 15 Q. And it gives a URL and password, right? 16 A. Uh-huh. 17 Q. So the expert panel meeting was recorded? 18 A. Correct. 19 Q. Was that typically how it was done? 20 A. Yes. 21 Q. Okay. Page 129

1 And do you recall watching the video of the 2 recording at any point? 3 A. I did not. 4 Q. Okay. Do you recall reviewing a Zoom 5 transcript at any point? 6 A. I do not. 7 Q. Okay. 8 So I will represent to you this, what you 9 have in front of you, is a certified transcript of that 10 recording -- 11 A. Okay. 12 Q. -- just for discussion purposes. And so I want 13 to just walk through a couple of things with you. So -- 14 and I know you haven't seen this before, so I'll walk 15 you through it. 16 So if you go to the back of the document, 17 there's an index. Do you see that? 18 A. Uh-huh -- yes. 19 Q. Sorry. Yes? 20 A. Yes. 21 Q. Okay. Page 130	1 scores to nonparticipating hospitals? 2 A. I don't remember what was exactly said. I 3 would not be surprised if the Hospital Safety Grade 4 expert panelists weren't familiar with the term "limited 5 achievement." 6 Q. Sorry. Say that again. I think that was a 7 double negative. 8 A. I would not be surprised if the Hospital Safety 9 Grade expert panelists were not familiar with the term 10 limited achievement. 11 Q. Got it. Okay. 12 Is there another term they might use? 13 A. They might have used lowest performance score. 14 Q. Okay. What about zero? 15 A. It's possible that zero could have been 16 mentioned. 17 Q. Okay. 18 So I want to go to zero, too, in the index, 19 just to close that loop. 20 MS. WOOD: And Lee, I do just want to object to 21 form. I've never seen this document before either. Has Page 132
1 So the index, I want to just focus on a few 2 things. If you go to page 9 and you go to "L," do you 3 see the word "limited" appear on the index? 4 A. I do not. 5 Q. And I want to go to the word A -- excuse me, to 6 the portion of the index for "A." Do you see the word 7 "achievement"? 8 A. I see achieving but not achievement. 9 Q. Okay. And where is achieving? There it is. 10 Do you want to -- let's flip to 36.3. So page 36, line 11 3. Tell me when you're there. 12 A. I am there. 13 Q. And it says: "But achieving consensus is 14 difficult." Do you see that? 15 A. Yes. 16 Q. So that doesn't refer to limited achievement, 17 right? 18 A. It does not use that phrase. 19 Q. So based on this index, and to the best of your 20 recollection, did anybody at any time during the meeting 21 raise the idea that you could impute limited achievement Page 131	1 this been produced in discovery? 2 MR. CRAIN: It is being produced today. 3 MS. WOOD: Okay. And when was it -- was it 4 prepared on September 11th? 5 MR. CRAIN: I do not know the date, but we can 6 talk off the record. So your objection is noted. 7 BY MR. CRAIN: 8 Q. So do you see zero, Dr. Austin, in the index? 9 A. Uh-huh. 10 Q. Okay. 11 If you go to 40, it said -- in the index, 12 it said line 7, 7 to 11. Do you see that? 13 A. Yes. 14 Q. And I just want you to look at this page from, 15 say, line 6 to 11. Does this reflect anybody proposing 16 to impose a zero score for nonparticipating hospitals? 17 A. No, it doesn't. 18 Q. Okay. 19 Okay. So is it accurate to say that no one 20 suggested, based on the index, based on your memory, 21 that imposing a zero score for nonparticipating Page 133

1 hospitals? 2 MS. LAWSON: Object to form. 3 THE WITNESS: I honestly don't remember the 4 conversation. 5 BY MR. CRAIN: 6 Q. Okay. 7 A. I will clarify that what has been assigned is 8 not zero to hospitals. 9 Q. I understand. 10 So do you remember any other proposal made 11 during the expert panel meeting besides the one that you 12 proposed in the slides that we looked at? 13 A. I don't remember. 14 Q. Okay. 15 So I'll take you to one other that is in 16 here. Do you recall -- who is Dr. Pronovost, Peter 17 Pronovost? 18 A. He is one of the Hospital Safety Grade expert 19 panelists. 20 Q. Okay. And you worked with him previously at 21 Armstrong, right? Page 134	1 lowest quartile? 2 A. I would need to go back further up in the 3 document -- 4 Q. If you want to take a look and -- 5 A. -- to understand what the context was -- 6 Q. Yeah, why don't you go back to page -- 7 A. -- because I don't know what the discussion was 8 at that point. 9 Q. Go back to page 24 and start with 10 Dr. Srinivasan. 11 Who is Dr. Srinivasan? 12 A. He's at the Centers for Disease Control and 13 Prevention. 14 Q. Okay. And take a second. 15 (Witness peruses document.) 16 THE WITNESS: So I've read it. And can you 17 repeat your question? 18 BY MR. CRAIN: 19 Q. Yeah. I wanted to know if you have an 20 understanding of what Dr. Pronovost was referring to 21 when he's talking about the bottom quartile. And I Page 136
1 A. Correct. 2 Q. Okay. 3 Now, he proposes -- if you go to pages -- 4 if you go to page 25 -- 5 A. Uh-huh. 6 Q. -- oh, wait. Sorry. Page 26. 7 A. Uh-huh. 8 Q. And you see at line 18 it says Peter Pronovost 9 and colon? 10 A. Uh-huh. 11 Q. And he says, "Peter Pronovost: Missy, though, 12 to Arjun's point, I wonder in our model do we include 13 that if they're in the lowest quartile, that they stay 14 in that? You know what I mean? At least to reduce the 15 gaming." 16 Do you recall him saying that? 17 A. That's what it says here. 18 Q. Yeah. Do you have any independent -- 19 A. I don't remember. 20 Q. Okay. 21 Do you know generally what that means, the Page 135	1 think Dr. Srinivasan talks about the bottom quartile, 2 too. And I will also preface, if you don't remember, I 3 can show you an email subsequently about the bottom 4 quartile, but I wanted to know if you have an 5 independent recollection. 6 A. I don't have a recollection of that. 7 Q. Okay. That's fine. It's not a memory test. 8 Again, we'll get to another document. I'm just going 9 through this. 10 I want to look at one other quick thing in 11 the index. If you go to "W," do you see the word 12 "willing"? 13 A. I do. 14 Q. Let's see. Where is it? 15 A. Oh, no. I don't see it. 16 Q. Yeah, I didn't see it. 17 Just to confirm, do you see the word 18 "willing" in the index? 19 A. I do not. 20 Q. Okay. 21 Do you know what the phrase "willing to Page 137

1 report" means? 2 A. That is the term that Leapfrog used prior to 3 limited achievement. 4 Q. Okay. So that was the lowest performing score, 5 right? 6 A. That was the phrase that was used for that in 7 the past. 8 Q. Okay. Do you recall when it was retired? 9 A. I could estimate 2018, 2019, somewhere around 10 there. 11 Q. And just -- I'm representing to you that the 12 index is from a certified court reporter. Based on this 13 index, the phrase "willing to report" or even just the 14 word "willing" was not discussed at this meeting, 15 correct? 16 A. I do not see the word "willing" in the index. 17 Q. Okay. 18 And you have no independent recollection of 19 a discussion of the phrase "willing to report" at the 20 meeting, right? 21 A. I do not. Page 138	1 A. And I recognize the email. 2 Q. Yeah. Okay. So you have no reason to think 3 this wasn't sent and received? 4 A. Correct. Yes. 5 Q. Okay. 6 And you'll note in the bottom it's an 7 Armstrong-produced document, right? 8 A. Correct. 9 Q. So it's an email originally from the 16th from 10 Preeti Joshi. And remind us, who is she again? 11 A. Preeti is an analyst that works for me. 12 Q. Okay. And she works on the Leapfrog account? 13 A. Correct. 14 Q. Okay. 15 And she says first in that email, "Matt, 16 please review the attached Leapfrog Hospital Safety 17 Grade HSG" -- is that Hospital Safety Grade? 18 A. Uh-huh. Correct. 19 Q. -- "expert panel meeting notes, and let me know 20 your suggestions." 21 Then she follows up, right? Page 140
1 Q. Okay. 2 Okay. I'm going to set this aside, and 3 we'll come back to it, so don't lose it. 4 (Whereupon, a discussion was held between 5 counsel regarding lunch schedule, which 6 portion was not included in the written 7 record.) 8 BY MR. CRAIN: 9 Q. Okay. So let's keep going. 10 So you mentioned there were minutes after 11 the meeting, right? 12 A. Correct. 13 Q. I want to start with tab 33A, which will be 14 Exhibit 13. 15 (Exhibit No. 13 was marked for 16 identification as of 9/25/2025.) 17 BY MR. CRAIN: 18 Q. So Dr. Austin, do you recognize this document? 19 A. I recognize the meeting notes that are behind 20 it. 21 Q. Behind it. Okay. Page 139	1 A. Correct. 2 Q. And she says -- it looks like it's a few hours 3 later that same day, April 16th -- "Matt, please 4 disregard the attachment of previous email and consider 5 the attached document for review. I accidentally attached 6 a different file with previous email." 7 Do you see that? 8 A. Yes. 9 Q. Okay. 10 And then going on to the notes, this is, 11 fair to say, her draft of the notes, right? 12 A. Correct. 13 Q. Okay. 14 And then just stepping back, does every 15 expert panel, safety grade expert panel have meeting 16 notes like these? 17 A. Yes. Could there be one or two for which we 18 just somehow didn't do them? Possibly. But the intent 19 is, yes, to have meeting notes like this. 20 Q. And is this the normal process where the person 21 who is reporting to you starts the first draft and you Page 141

1 revise? 2 A. Correct. 3 Q. Okay. And do you generally try to be accurate 4 with the meeting minutes? 5 A. Yes. 6 Q. Okay. What do you look for when you revise? 7 A. I look for accuracy. I try to highlight 8 broader themes. So as an example, often when the 9 analyst first starts working with me, the notes will be 10 incredibly, like, detailed. Sara said this. Bob said 11 this, right. So I try to sort of move it up a level, 12 right, and I try to be clear with sort of action items 13 of what we need to do next and to be clear with decision 14 points. 15 Q. Okay. And you still try to be faithful to the 16 discussion, right? 17 A. Correct. 18 Q. Okay. 19 So I'm going to set this one aside, and I 20 want to go to your version of the notes. Let's see. 21 Oh, wait. Come back. Sorry. Sorry. Let's start with Page 142	1 Q. I've been trying to understand it, too, so I 2 get it. 3 Does this seem like a fair articulation of 4 what he was saying in the call? 5 A. If it's in the notes, I would say it's probably 6 a fair articulation, but I don't remember that myself. 7 Q. Okay. 8 Now, just to be clear, looking at this, 9 there is no indication -- and you can read the bullets. 10 They're pretty short -- that anyone was proposing giving 11 hospitals a zero or limited achievement or willing to 12 report, right? 13 A. Can you repeat your question, please? 14 Q. Yeah. 15 Is there any indication in these notes that 16 someone raised the idea during the meeting of giving 17 nonparticipating hospitals a zero or limited achievement 18 or willing to report for the imputed measures? 19 MS. LAWSON: Object to form, but you can 20 answer. 21 THE WITNESS: It doesn't necessarily explicitly Page 144
1 this. I'm all out of order. 2 Okay. So if we go down to Preeti's version 3 of the notes, do you see number two? 4 A. Uh-huh. 5 Q. Proposed changes to the imputation model, 6 right? 7 A. Uh-huh. 8 Q. And if you go, it looks like one, two, three 9 bullets down, it says "Peter asked." 10 A. Uh-huh. 11 Q. "Peter asked whether Leapfrog has a way to keep 12 the low-performing hospitals in the lowest quartile 13 using this Step 2 imputation model." Do you see that? 14 A. Uh-huh. 15 Q. Okay. Was that what we looked at in the 16 transcript a little while ago? 17 A. I don't know because I actually didn't fully 18 follow what Peter was trying to ask there. 19 Q. Okay. Got it. 20 A. To be really, really honest, I -- it didn't 21 make much sense to me. Page 143	1 say that in these notes. 2 BY MR. CRAIN: 3 Q. Okay. 4 You say "explicitly." Do you have a reason 5 to believe those topics were discussed? 6 A. There was concerns about -- that Arjun raised 7 about a hospital that was performing very poorly and 8 that they would actually get an imputed score, so a 9 better score than what they would actually be -- so to 10 me that seems to be raising the question of whether the 11 current imputation model was rewarding poor performing 12 hospitals. 13 So, I mean, there could be an 14 interpretation of that. 15 Q. So you said the question was raised. My 16 question is was the answer provided, proposed answer? 17 A. I don't remember. 18 Q. Okay. 19 And do you see anything on this page from 20 what you read a few minutes ago from the transcript to 21 suggest that those solutions were proposed that I just Page 145

1 mentioned? 2 A. I don't see anything here that would indicate 3 that the actual solution that we landed on is what was 4 explicitly proposed by the expert panel. 5 Q. Okay. Let me ask you this question. Who 6 proposed the solution that you landed on? 7 A. I don't recall with certainty. 8 Q. Okay. Do you think it was Leapfrog, or do you 9 think it was the expert panel? 10 A. I'm guessing it was Leapfrog that proposed that 11 solution based on the concerns that the expert panel was 12 raising. 13 Q. Got it. 14 So to your framing before, the question was 15 raised and Leapfrog was supplying an answer? 16 A. Is your question during this call? 17 Q. During this period. April 2024 -- 18 A. I don't remember with certainty how the 19 solution that is currently in use was developed. 20 Q. Okay. 21 I want to also take a look a couple bullets Page 146	1 document and what's your understanding of this sentence, 2 and I'll try to find a line. 3 A. It's unclear to me what "them" is referring to 4 in this sentence. Like, I don't have the context to 5 remember what "them" is. To me, I was suggesting that, 6 perhaps, we needed to look at difference in performance 7 between -- yeah, I don't have a great sense just from -- 8 Q. I can take you where the -- if you go back to 9 the transcript, page 27 is where you talk about bias. 10 MS. LAWSON: And you might want to just start 11 from the page preceding, which is the page we reviewed 12 previously, and just keep going on the discussion. I 13 think that might help. 14 (Witness peruses document.) 15 THE WITNESS: The context from the transcript 16 is such that we were talking about safety net hospitals 17 and some sort of concerns about bias in measurement for 18 those safety net hospitals. 19 BY MR. CRAIN: 20 Q. Only for them? 21 A. That is the context that Kathy McDonald had Page 148
1 down. It says, "Matt mentioned." Do you see that? 2 A. Uh-huh. 3 Q. And Matt, I take it, is you? 4 A. Correct. 5 Q. "Matt mentioned it is important to see whether 6 there is an actual difference in hospitals' performance 7 and whether there is some sort of bias in the 8 measurement against them. He said to minimize the 9 second, and if there are differences in hospitals' 10 performance, we can address the structural issues to fix 11 them." 12 Do you see that? 13 A. I do. 14 Q. So taking that one by one, what does the first 15 sentence mean? 16 MS. LAWSON: Might it be helpful for him to 17 just review the transcript of what he said? 18 MR. CRAIN: Yeah. I'm pulling that out now. 19 THE WITNESS: That would be helpful. 20 BY MR. CRAIN: 21 Q. But you know what, let's start with this Page 147	1 brought up was the safety net hospitals. 2 Q. Fair enough. I get that she says that from 3 lines 3 to 11 on page 27, but you follow up, and you 4 say, "I think where I struggle is what is a true -- 5 well, where is there a true difference in performance, 6 right, and where is there some sort of bias in the 7 measurement against them. Right?" And then Kathy says, 8 "Right." And then you say, "And I think we want to 9 minimize the second." 10 And so I guess the question I have out of 11 that is what does bias mean in that context? 12 A. Bias would refer to that there is some sort 13 of -- that there is some sort of structural -- I'm 14 trying to think of the right words for this. That there 15 is some sort of structural sort of -- there's something 16 structural about safety net hospitals that disadvantages 17 them. 18 Q. So you're talking about bias about the 19 hospitals or bias about the scoring methodology? 20 A. The bias in the hospitals. And I say that 21 because I think on the next page I talk about that Page 149

1 marginalized communities tend to receive care at less 2 safe hospitals. So I think the concern is that there is 3 a bias against safety net hospitals in terms of quality 4 and safety. 5 Q. So this doesn't refer to bias in the survey -- 6 in the scoring methodology -- excuse me -- against 7 safety net hospitals? 8 A. I believe what this is referring to is actually 9 the bias in the challenges that safety net hospitals 10 face to prioritize quality and safety of care. 11 Q. And how does that factor into the imputation 12 methodology? 13 A. So safety -- well, to be clear, safety net, 14 there is no formal definition of that. If they are a 15 critical access hospital, they don't receive a Hospital 16 Safety Grade. 17 Q. What is a critical access hospital? 18 A. Critical access hospital, there is about 1,400 19 of them in the United States. They're small hospitals 20 that have 25 beds or less -- 21 Q. Got it. Page 150	1 looking at some of the safety net hospitals and just 2 making sure that they were going to be treated fairly. 3 Q. Okay. And is that -- is a difference in the 4 safety net hospitals, as compared to non-safety net 5 hospitals, their capacity to complete the survey? 6 A. I couldn't speak to that. 7 Q. Do they have fewer resources than non-safety 8 net hospitals? 9 A. They typically are more resource constrained 10 hospitals than larger hospitals -- or not larger 11 hospitals, than hospitals that are better funded. 12 Q. So did you understand Kathy to be saying that 13 she wanted to recognize the burden that they were 14 experiencing as compared to non-safety net hospitals? 15 A. I don't know if that was what she was implying 16 there. 17 Q. Okay. 18 So and then going back to your point about 19 bias, how would the imputation methodology -- strike 20 that. Sorry. 21 Going back to your point about bias, how Page 152
1 A. -- that are generally in rural areas and for 2 which the funding from the government is different, 3 basically to keep their doors open, and they are 4 generally in small, rural communities. 5 Q. And so I get there is no definition of safety 6 net hospital. What's your general understanding of what 7 that means? 8 A. One definition that I commonly use is it's 9 hospitals that care for greater proportions of patients 10 who have Medicaid as their primary insurance. 11 Q. Got it. And they can be for-profit or 12 nonprofit hospitals? 13 A. Correct. 14 Q. Okay. And so what type of -- so how does the 15 safety -- how does the imputation -- like, how does that 16 fact -- let me state the question in a real way rather 17 than stuttering way. 18 How does the safety net bias that you're 19 talking about here relate to the imputation methodology 20 that was the topic of the agenda here? 21 A. I believe what Kathy is looking at is -- was Page 151	1 could the imputation methodology take that into account? 2 A. Which imputation methodology are we discussing? 3 Q. Any one, whether -- well, how could any 4 imputation methodology take into account the bias that 5 you're identifying here apparently as to safety net 6 hospitals? 7 A. Well, there's the concern that -- I mean, one 8 potential bias is that if other safety net hospitals are 9 performing less well and you choose to not complete the 10 survey, you're going to maybe get assigned the same 11 value as your average safety net hospital. So that 12 would be one way that a safety net hospital might face a 13 bias. 14 Q. Okay. But you need the definition of what 15 qualifies as a safety net hospital, right? 16 A. Correct. And Leapfrog has its own definition 17 that it uses for that. 18 Q. Is it different from yours? 19 A. I don't know. 20 Q. Okay. You have no knowledge of what that 21 definition is? Page 153

1 A. I couldn't say with exact certainty what their 2 definition is. 3 Q. Do you know in what context they have that 4 definition? 5 A. They have it in some of their data files 6 because a lot of their data licensees like to be able to 7 drill down on that type of detail, but I don't know what 8 -- how they get that source or what they are using for 9 them. 10 Q. Okay. Okay. 11 So going back to the notes, which I believe 12 is Exhibit 13, I want to go back to the bullet. Preeti 13 said, "Matt mentioned it is important to see whether 14 there is an actual difference in hospitals' performance 15 and whether there is some sort of bias in the measures 16 against them. He said to minimize the second, and if 17 there are differences in hospitals' performance, we can 18 address the structural issues to fix them." 19 Do you see that? 20 A. I do. 21 Q. Now, she doesn't mention safety net hospitals Page 154	1 before we broke. Do you recall that? 2 A. Yes. 3 Q. I want to go back in time just a little bit. 4 The April 12th meeting, if you recall correctly from the 5 notes we saw, was between 4 and 5 o'clock. 6 A. Correct. 7 Q. And if you keep the notes out, if you look at 8 the portion where it says the attendees, do you see 9 that? 10 A. Yes. 11 Q. Dr. Romano is not on that list, right? 12 A. Correct. 13 Q. Okay. And do you recall that -- whether you 14 met with Dr. Romano earlier that day with regard to the 15 safety grade expert panel? 16 A. I can't say with certainty. 17 Q. Okay. 18 A. But I believe we met with him at some point 19 around that meeting. 20 Q. Okay. And that was -- do you recall who 21 attended that meeting? Page 156
1 there, right? 2 A. She does not. 3 Q. Okay. So -- okay. I'll leave it there. 4 MR. CRAIN: I think maybe we'll take a break 5 now. Do you want to do the lunch break now? 6 MS. LAWSON: We're off the record. 7 THE VIDEOGRAPHER: This marks the end of media 8 unit number three. We're going off the record. The 9 time is 11:49 a.m. 10 (Whereupon a lunch break was had, after 11 which the proceedings continued as 12 follows:) 13 THE VIDEOGRAPHER: This marks the beginning of 14 media unit number four. We're back on the record. The 15 time is 12:56 p.m. 16 BY MR. CRAIN: 17 Q. Okay. Welcome back. 18 A. Thank you. 19 Q. I hope you had a nice lunch. 20 A. Yeah. Thank you. 21 Q. So we were talking about the April 12th meeting Page 155	1 A. I don't recall with certainty. I could 2 estimate who I think would be there, but I can't say 3 with certainty. 4 Q. That's okay. That's okay. 5 And before we go to -- I'll refresh you 6 with a document, but before we go there, who is 7 Dr. Patrick Romano? 8 A. So Dr. Patrick Romano is one of the Hospital 9 Safety Grade expert panelists. 10 Q. And what's his background? 11 A. He is a physician and health services 12 researcher at the University of California, Davis. 13 Q. And fair to say he's an expert in something? 14 A. He is. 15 MS. LAWSON: Object to form but go ahead. 16 THE WITNESS: Yeah. He would be perceived as 17 being an expert in quality measurements in healthcare. 18 BY MR. CRAIN: 19 Q. And have you worked with him for a long time? 20 A. Yes, I have. 21 Q. Did you work with him in the early days when Page 157

1 the safety grade was being developed? 2 A. Yes. 3 Q. And was he involved in the development of the 4 first imputation model around 2020, 2021? 5 A. We worked with Dr. Romano in thinking through 6 different options for the imputation. 7 Q. Okay. And do you know how long Dr. Romano has 8 been involved in any capacity with Leapfrog? 9 THE COURT REPORTER: I'm sorry. We just lost 10 connection. 11 MR. CRAIN: Should we go off? 12 THE COURT REPORTER: Could we? 13 MR. CRAIN: Can we go off the record. 14 THE COURT REPORTER: Just one quick second. 15 THE VIDEOGRAPHER: This marks the end of media 16 unit number four. We're going off the record. The time 17 is 12:58 p.m. 18 (Whereupon, the proceedings paused due to 19 technical difficulty, after which the 20 proceedings continued as follows:) 21 THE VIDEOGRAPHER: This marks the beginning of Page 158	1 glitch, so I'll make sure we get it, how long has 2 Dr. Romano been involved with Leapfrog? 3 A. Since 2011. 4 Q. Okay. So he came on after you joined or after 5 you got involved with Leapfrog, let's say? 6 A. He was part of the Hospital Safety Grade expert 7 panel that was formed in 2011. 8 Q. When the safety grade was originally being 9 developed? 10 A. Correct. 11 Q. Okay. 12 MR. CRAIN: Okay. So I'm going to mark as 13 Exhibit 14... 14 (Exhibit No. 14 was marked for 15 identification as of 9/25/2025.) 16 BY MR. CRAIN: 17 Q. Dr. Austin, do you see this is an 18 Armstrong-produced document? 19 A. Yes. 20 Q. And it's an email from you to you. Do you see 21 that? Page 160
1 media unit number five. We're going back on the record. 2 The time is 1 o'clock p.m. 3 BY MR. CRAIN: 4 Q. Great. Okay. We're back after a technical 5 glitch, and I'm going to ask the question that we 6 started before. 7 So was Dr. Romano involved in the 8 development of the first imputation model around 9 2020/21? 10 A. He was. To clarify, that wasn't -- it depends 11 on your definition of what is an imputation model. We 12 had had other imputation approaches prior to '20 to '21. 13 Q. Fair enough. 14 Was he involved in the development of that 15 model in -- 16 A. Yes. He helped provide input and guidance. 17 Q. Okay. 18 MS. LAWSON: And just make sure that Mr. Crain 19 has finished his question, yes. 20 BY MR. CRAIN: 21 Q. And I think I had asked during the technical Page 159	1 A. Correct. 2 Q. Does this reflect notes that you took on 3 April 12th, 2024? 4 A. It reflects -- 5 Q. I'll direct you to the subject matter, the 6 subject of the email. 7 A. Yes. It was my notes from the Hospital Safety 8 Grade expert panel meeting. 9 Q. And do you have a practice of sending yourself 10 notes over email? 11 A. I do. 12 Q. Okay. So this is a true and accurate, to the 13 best of your knowledge, copy of your notes from that 14 day? 15 A. Yes. 16 Q. Okay. 17 And on the top, it says: "Patrick 18 recommend keep Step 1." Do you see that? 19 A. Yes. 20 Q. Does that refresh your recollection of whether 21 you had a meeting with Dr. Romano on April 12th? Page 161

1 A. As I mentioned, I know we met with Dr. Romano 2 around that time because he was unable to make the 3 primary call, but I don't remember the exact timing of 4 when that was. 5 Q. Okay. 6 Do you -- is it correct that these bullets 7 one, two, and three below, "Patrick recommend keep Step 8 1," reflect your notes from the discussion with 9 Dr. Romano? 10 A. That would be likely to be true, yes. 11 Q. Okay. You don't have a specific memory, but 12 that's what the document -- 13 A. Correct. 14 Q. -- indicates? 15 A. Yes. 16 Q. Okay. Again, just let's try not to talk over 17 each other. 18 Okay. And then the remainder of this 19 email, just going down, do those reflect your notes from 20 the subsequent expert safety grade panel meeting later 21 that day? Page 162	1 the last page to orient. Good? Are you there? 2 A. Can you repeat that, please? 3 Q. Sorry. 4 Can you go to page 8331, the second to the 5 last page. 6 A. Yes. 7 Q. Okay. 8 And there's an email from Ms. Campione to, 9 among others, you at 12:17 p.m.? 10 A. Yes. 11 Q. And the subject is imputation changes. Do you 12 see that? 13 A. Yes. 14 Q. So Ms. Campione writes to you and others, "Hi 15 all, please find the table we discussed below. I also 16 included the underlying issues. Please feel free to 17 edit the response to this email." Do you see that? 18 A. Yes. 19 Q. Okay. 20 Do you have a recollection of her sending 21 this email? Page 164
1 A. Yes. 2 Q. Okay. 3 That's all we need to talk about with this 4 document. You can set it aside. 5 MR. CRAIN: Now, I want to go to another 6 document. This will be 15, tab 34. 7 (Exhibit No. 15 was marked for 8 identification as of 9/25/2025.) 9 BY MR. CRAIN: 10 Q. And you will see on the bottom this was a 11 deposition exhibit from Ms. Campione as well. Do you 12 see that blue sticker? 13 A. Yes. 14 Q. Okay. 15 So the top email is from you to 16 Ms. Campione, Ms. Danforth, and Ms. Joshi. Do you see 17 that? 18 A. Yes. 19 Q. And I want to just go through -- if we could 20 start at the bottom, which is the first email, this will 21 be page -- if you could go to page 8331, the second to Page 163	1 A. I do remember seeing that table at the bottom 2 of the email, but I didn't remember the context of the 3 email. 4 Q. Do you remember seeing it from back then? Do 5 you remember from seeing it more recently? 6 A. I -- in showing this to me today, I very 7 distinctly remember her sending an email with this 8 table. 9 Q. Okay. Do you remember -- and you said you 10 don't remember the context. Do you remember anything 11 about why she sent it? 12 A. I would guess, based on what's here, it was to 13 sort of further refine a potential direction that we 14 would go for the imputation models. 15 Q. And this was about 10 days after the expert 16 panel meeting, right? 17 A. Correct. 18 Q. Okay. 19 So I want to just go through this chart a 20 little bit just to make sure we're on the same page. 21 Are you looking at the chart on 8332? Page 165

1 A. Uh-huh. 2 Q. Okay. So "no change" is the left-most column. 3 Do you see that? 4 A. Yes. 5 Q. And that's -- is it right that's basically the 6 model you had, right, at the time? 7 A. Correct. 8 Q. "Small change" says: "Shorten imputation to 9 past two rounds for Step 1." Do you see that? 10 A. Yes. 11 Q. Is that what you ultimately did, or is it 12 "moderate change" that Leapfrog ultimately imposed? 13 A. Are you asking about recent survey 14 participants? 15 Q. I'm asking -- yeah, I'm asking about Step 1 for 16 recent survey participants. I'll walk you through it. 17 I'll build it a little more clearly. 18 Under "small change" for Step 1, it says: 19 Shorten imputation to two past rounds. Do you see that? 20 A. Uh-huh. 21 Q. Does that reflect, to the best of your Page 166	1 every year, is that a more apt understanding of what the 2 Step 1 is? 3 A. I would frame it as hospitals that have not 4 submitted the most recent hospital survey. 5 Q. Got it. But for which there exists a 6 historical survey response? 7 A. Correct. 8 Q. Okay. 9 So on the top in Step 1, small change, you 10 go back to the two past rounds of the survey, right? 11 A. That is what's being proposed under small 12 change. 13 Q. Then moderate change is you shorten imputation 14 to one past round, right? 15 A. Correct. 16 Q. And is that what you testified earlier -- is 17 that what ultimately Leapfrog did for Step 1? 18 A. I would have to defer to the methodology -- 19 Q. Okay. 20 A. -- document on how that gets phrased or framed. 21 Q. Okay. Page 168
1 understanding, an imputation of a historical score in 2 the past two rounds of the hospital survey? 3 A. Can you repeat that again, please? 4 Q. Yeah. 5 To the best of your understanding, does 6 this column, does this "small change" box in Step 1 7 reflect that you would propose to impute the historical 8 score for a nonparticipating hospital for the past two 9 rounds of the hospital survey? Am I reading that right? 10 A. That is not exactly my understanding. 11 Q. Okay. Can you give me your understanding? 12 A. Yeah. My understanding is what's being 13 proposed is for hospitals that have recently completed 14 the survey, how far of a lookback would we do to see if 15 there was a recent survey. 16 Q. Got it. And was that different from what I 17 said because I said nonparticipating hospitals? 18 A. Correct. 19 Q. Yeah, okay. Let me fix that. That's a fair 20 point. 21 For hospitals that are not participating Page 167	1 What do you think is the difference? 2 A. Difference from what? 3 Q. What's your hesitation as to why this is not 4 the same thing as you understand Leapfrog is doing today 5 for Step 1? 6 A. I guess I'm a little unclear on what moderate 7 change would actually be. So that's where I'm now sort 8 of second-guessing like, well, did we implement moderate 9 or did we implement small change? 10 Q. Okay. 11 A. My understanding, putting the words aside, is 12 that what we moved to was the ability for a hospital -- 13 we would look back and see if a hospital submitted a 14 survey last year -- 15 Q. Got it. 16 A. -- and if we did, we would use that. 17 Q. Okay. 18 A. But we wouldn't go any further back than that. 19 Q. Okay. 20 A. So I don't know how that translates into these 21 exact words. Page 169

1 Q. Okay. 2 I mean, I would read one past round to be 3 last year, but I don't know if that's right. You're not 4 sure about that either? 5 A. I'm not sure about that either. 6 Q. Okay. 7 Okay. And then "drastic change" is 8 eliminate Step 1. Do you see that? 9 A. Yes. 10 Q. And that you did not do, right? 11 A. Correct. 12 Q. But that was the proposal at the April 12th 13 meeting, to retire Step 1? 14 MS. LAWSON: Object to form. 15 THE WITNESS: The proposal that we introduced 16 at the Hospital Safety Grade expert panel meeting was to 17 eliminate Step 1. 18 BY MR. CRAIN: 19 Q. Yeah. Okay. 20 Now, in Step 2, if you could just go -- I 21 don't know if you feel more comfortable walking me Page 170	1 deviations below the mean." Do you see that? 2 A. Yes. 3 Q. Now, we saw in the transcript that we looked at 4 in the notes the discussion of the lowest quartile. Is 5 this what that's referring to, to the best of your 6 understanding? 7 MS. LAWSON: Object to form. 8 THE WITNESS: I would need to re-review the 9 transcript to refresh myself on what exactly the 10 conversation was about lowest quartile. 11 BY MR. CRAIN: 12 Q. Okay. I'm trying to think should we do that. 13 Would you like to do that? I'm happy to take you back 14 to it unless you have an understanding. 15 A. I don't have -- I mean, I saw in the 16 transcript there was conversation about lowest quartile. 17 Q. Yeah. 18 A. And there's, obviously, conversation here about 19 bottom quartile. I don't know if those two 20 conversations are the same thing. That's what I don't 21 know. Page 172
1 through it, or I could walk you through it, but Step 2, 2 the no change, it says: "Impute with the mean of first 3 time scores for their cohort." Do you see that? 4 A. Yes. 5 Q. And is that a no change, or is that sort of an 6 adaptation? I had understood the Step 2 to be the mean 7 of first time versus the mean of the cohort generally, 8 right? 9 A. At the time, the nonsurvey -- so Step 2 was -- 10 yes, it was the lower of the mean of either first time 11 respondents or the mean of the cohort. 12 Q. Yeah, okay. So slightly different from what 13 the no change says here, right? 14 A. Correct. 15 Q. Okay. 16 And that small change -- there's a no 17 change, which is interesting. Do you see that? 18 A. Correct. 19 Q. Okay. 20 And then moderate change says: "Assign 21 hospitals to the bottom quartile or several standard Page 171	1 Q. Okay. So you don't have an independent 2 recollection of whether this column comes from the 3 discussion of the expert panel meeting or not? 4 A. Correct. I do not have an independent 5 recollection. 6 Q. Okay. 7 And then on the last one, the drastic 8 change, it says: "Impute with limited achievement 9 scores," right? 10 A. Correct. 11 Q. Okay. 12 And, again, we looked at the index, and 13 there was no discussion of limited achievement, right, 14 at least based -- 15 MS. LAWSON: Object to form. 16 BY MR. CRAIN: 17 Q. At least based on the index? 18 MS. LAWSON: Object to form. 19 THE WITNESS: Correct. There was no use of 20 that explicit term. 21 BY MR. CRAIN: Page 173

1 Q. Yeah. 2 And there was no use of the term 3 willingness, as in willingness to report, right? 4 MS. LAWSON: Object to form. 5 THE WITNESS: Correct. 6 BY MR. CRAIN: 7 Q. Okay. 8 And in the index at least, when we looked 9 at the word "zero," there was no discussion of anybody 10 proposing that nonparticipating hospitals should get 11 zero in Step 2, right? 12 MS. LAWSON: Object to form. Go ahead. 13 THE WITNESS: Correct. 14 BY MR. CRAIN: 15 Q. Okay. 16 So let's go up a little bit on this box. 17 And you respond, do you see that, 12:27 p.m.? 18 A. I -- 19 Q. I can give you a page number if you need it. 20 A. I do -- yep. 21 Q. Got it? Page 174	1 information to the Leapfrog Hospital Survey about their 2 staffing, we were coming to the conclusion that they 3 didn't meet the staffing model that Leapfrog requires. 4 Q. Got it. 5 So you made the assumption based on the 6 existence of an ICU that they were performing at a level 7 of limited achievement? 8 A. To clarify, I'm not sure we were making an 9 assumption. We were -- we had a lack of information 10 about their staffing models. That would be the 11 equivalent of assigning limited achievement. 12 Q. Got it. 13 And is that, to your knowledge, 14 communicated anywhere on the Leapfrog website to 15 consumers? 16 A. I don't know. 17 Q. Okay. 18 Is that communicated in the methodology 19 document, that that's why Leapfrog assigns limited 20 achievement for IPS for nonparticipating hospitals? 21 A. I don't know for certainty. Page 176
1 A. Yep. I do, yes. 2 Q. And you said, "Alex, this looks great. I'm 3 wondering do we, one, want to reflect that we're 4 already" -- doing -- "using" -- sorry -- "drastic change 5 for Step 2 for IPS? And, two, do we want to use a 6 different term for drastic change, like large change?" 7 Do you see that? 8 A. Yes. 9 Q. So just breaking that down, number one, can you 10 tell me what you understood yourself to mean when you 11 said: Do we want to reflect that we're already using 12 drastic change for Step 2 for IPS? 13 A. So as I remember it, we had already moved 14 imputation for IPS to be limited achievement. 15 Q. And when did that come about? 16 A. I don't remember exactly. 17 Q. Okay. And do you remember the basis? 18 A. The basis is we actually had information from 19 CMS, Centers for Medicare and Medicaid Services, that 20 could tell us whether a hospital operated an ICU. And 21 if they operated an ICU, and they had not submitted Page 175	1 Q. Okay. Do you want to take a look? 2 A. I can. 3 Q. I'm happy to take you there. That's Exhibit 3. 4 A. That sounds correct. 5 Q. I wrote them down today. 6 A. If my memory serves me right. 7 Q. Do you have it, Dr. Austin? 8 A. I do. 9 Q. And if you go to page 10, it talks about the 10 IPS model -- or the measure. 11 MS. LAWSON: This is for Spring 2025? 12 MR. CRAIN: Correct. 13 BY MR. CRAIN: 14 Q. The IPS, as you testified a minute ago, I 15 think, did not change, right, the imputation 16 methodology? 17 A. That was my comment back to Alex. 18 Q. Okay. Yeah. 19 But to the best of your recollection today, 20 between 2024 and 2025, Step 2 for IPS was always limited 21 achievement, right? Page 177

1 A. Correct. 2 Q. Okay. 3 So are you on page 10? 4 A. I am. 5 Q. Okay. So just take a look and read the IPS 6 block. 7 A. Yep. I have, yes. 8 Q. And does it provide any explanation, the 9 explanation you just gave for why hospitals receive 10 limited achievement if they don't participate in the 11 survey? 12 A. You would need to follow the last line that 13 says if a hospital didn't submit a survey, you need to 14 look at using secondary data sources. 15 Q. Okay. Let's go to that page. That's page 15? 16 Take a look. And it's on 15 and 16? 17 A. Yes. 18 Q. Yeah. Is there an explanation there? 19 A. On page 16 there is. 20 Q. Let's see. Where is it? 21 A. Note about IPS: Only hospitals that operate an Page 178	1 hospital is assigned a point value that is equivalent to 2 receiving limited achievement for this measure on the 3 Leapfrog Hospital Survey. 4 Q. And so what you testified a minute ago, though, 5 was that the -- tell me if I'm misunderstanding -- that 6 the assumption is if a hospital has an ICU and is not 7 reporting, it's not meeting Leapfrog's standards, right? 8 A. We have assigned a score to hospitals. If we 9 know they operate an ICU based on the CMS cost report, 10 and they don't report to the Leapfrog Hospital Survey, 11 we are assigning them a score of limited achievement. 12 Q. Yes, but that was not directly responsive to my 13 question which was -- and I'll go back just to make sure 14 I say it the right way. 15 What you said a minute ago was that the 16 assumption is that if a hospital has an ICU, and they 17 are not reporting, that they are not meeting Leapfrog's 18 standards, right? That's what you said. 19 A. Correct. And then I corrected myself and did 20 not use the word "assumption." That was a poor choice 21 of word there. Page 180
1 adult or pediatric medical and/or surgical or neuro ICU 2 are eligible for Step 2 imputation of the IPS measure. 3 A hospital's ICU designation is determined from the 4 number of beds reported on Worksheet 5-3 Part 1 of the 5 hospital's most recent CMS cost report. If your 6 hospital does not operate an ICU but shares a CMS 7 certification number, please contact the help desk. 8 Q. Sorry. I see that on page 15. You see it on 9 16? 10 A. I see it on 16. 11 MS. LAWSON: I also see it on 16. 12 THE WITNESS: Under Step 2. 13 BY MR. CRAIN: 14 Q. Step 2. Okay. 15 And your testimony is that language 16 communicates that if a hospital has an ICU and doesn't 17 participate, it automatically gets limited achievement? 18 A. That is the first sentence under Step 2. 19 Q. Okay. 20 A. If the hospital does not have historical data 21 from the last two rounds of the safety grade, the Page 179	1 Q. Okay. That's what I'm trying to understand. 2 A. Correct. 3 Q. Okay. 4 So maybe you tell me in your words then, 5 because now I'm a little confused by the change, why 6 does a hospital get assigned limited achievement if it 7 has an ICU and does not participate? 8 A. They receive a score of limited achievement 9 because we know they have an ICU, and we don't have any 10 information that would tell us whether or not they are 11 meeting the staffing models that Leapfrog asks hospitals 12 to have in the ICU. 13 Q. So why not impose some achievement and not 14 limited achievement? 15 A. Because the way Leapfrog's standards are set in 16 the survey is there are clear criteria of what needs to 17 be met for some achievement, considerable achievement, 18 and achieved the standard. And if you don't meet the 19 criteria for some achievement, you're in the limited 20 achievement bucket. 21 Q. But, again, you don't know either way whether a Page 181

1 given hospital is meeting some versus limited or -- I 2 forgot -- the top one, right? 3 A. Correct. 4 Q. Okay. 5 Okay. So let's go back to this document. 6 So that covers IPS Step 2. 7 The second part says, "Do we want to use a 8 different term for drastic change like large change?" 9 Why did you not like the phrase "drastic change"? 10 MS. LAWSON: Object to form. 11 BY MR. CRAIN: 12 Q. Did you not like the word "drastic change"? 13 A. I did not like the word "drastic change." 14 Q. With that now established, why did you not like 15 the phrase "drastic change"? 16 A. I'm trying to think. It felt -- it felt 17 sensational. 18 Q. Okay. What do you mean by sensational? 19 A. I personally think of the word "drastic" as 20 having sort of a sensational connotation, right. It's 21 extreme. Page 182	1 chart is revised on page 8330? 2 A. Yes. 3 Q. And that, as best I can tell, is just changing 4 to reflect the limited achievement, you know, for IPS, 5 right? 6 MS. LAWSON: And Dr. Austin, you can read -- 7 feel free to read through the whole email chain if you 8 need that to refresh your recollection. 9 (Witness peruses document.) 10 THE WITNESS: Can you repeat your question, 11 please? 12 BY MR. CRAIN: 13 Q. Yeah. I'm just looking at 8330, and it looks 14 like the change on the chart is just as you noted 15 before, that IPS was already doing the impute limited 16 achievement. 17 A. Correct. 18 Q. So there's no change there, right? 19 A. That is the only change from the prior chart. 20 Q. Yeah. Sorry. There's no change to IPS under 21 this chart? Page 184
1 Q. Got it. Dramatic? 2 A. Dramatic. That would be a better word. 3 Q. We work with words for a living. 4 MS. LAWSON: I struggled not to interpose my 5 own. 6 BY MR. CRAIN: 7 Q. So did you feel dramatic was inaccurate or it 8 was a problem with the messaging and how it might be 9 received? 10 A. My concern was the messaging and how it would 11 be received. 12 Q. Okay. 13 MR. CRAIN: Oh, I'm sorry. Iason tells me I 14 said dramatic. No, I meant dramatic. 15 MR. TOGIAS: Oh, you meant it? 16 MR. CRAIN: Yeah. 17 MR. TOGIAS: Okay. Sorry. 18 MR. CRAIN: I meant dramatic. 19 BY MR. CRAIN: 20 Q. Let's see. Okay. So let's keep going up. Let 21 me see if there's anything else here. So you see the Page 183	1 A. Correct. 2 Q. Yeah. 3 Okay. Let's set this aside. Keep it at 4 the ready. 5 MR. CRAIN: Can I get 36. I'll mark this as 6 Exhibit 16. 7 (Exhibit No. 16 was marked for 8 identification as of 9/25/2025.) 9 BY MR. CRAIN: 10 Q. So Dr. Austin, do you recognize this document? 11 A. Yes. It's an email between myself and Leapfrog 12 staff. 13 Q. You get the hang of it now, these documents. 14 And you see on the bottom right it's an 15 Armstrong-produced document, right? 16 A. Correct. 17 Q. Okay. I want to start -- just go to the bottom 18 again to the first email in the chain, and if you need a 19 minute, take it. Whenever you're ready. 20 (Witness peruses document.) 21 THE WITNESS: Yes. Page 185

1 BY MR. CRAIN: 2 Q. Okay. 3 So the first email on the bottom is from 4 Ms. Campione, and it's to Ms. Danforth, you, and 5 Ms. Joshi. Do you see that at 5:41 p.m.? 6 A. Yes. 7 Q. And the subject is Step 2 imputation scores. 8 Do you see that? 9 A. Yes. 10 Q. And she says, "Hi all. I have some bad/good 11 news. The Step 2 scores aren't what we would like. 12 Turns out the hospitals that do the survey perform very 13 well. The BCMA scores below will likely drop with the 14 methodology changes, though." 15 Do you see that? 16 A. Yes. 17 Q. Do you have any understanding today of what she 18 meant by the Step 2 scores aren't what we would like? 19 MS. LAWSON: Object to form. Go ahead. 20 (Witness peruses documents.) 21 THE WITNESS: Where I'm hesitating is my sense Page 186	1 (Whereupon, the court reporter seeks 2 clarification, which colloquy will not be 3 captured on the written record.) 4 BY MR. CRAIN: 5 Q. Let's go up. You respond. Do you see that? 6 A. Yes. 7 Q. And you say, "Alex, would it be easy to look at 8 the same for first time reporters? We may have to 9 consider the option of just assigning the score for 10 limited achievement, which is actually consistent with 11 how we are approaching IPS." 12 Do you see that? 13 A. Yes. 14 Q. Okay. 15 Does this refresh your recollection as to 16 what she was running and why she was doing this? 17 A. Not really. 18 Q. Okay. It doesn't have to. That's okay. 19 A. Okay. 20 Q. Okay. So she responds it looks like five 21 minutes later. She says, "Not too difficult. I would Page 188
1 is she was looking at a subset of hospitals, and I don't 2 remember what that subset of hospitals was. 3 BY MR. CRAIN: 4 Q. Okay. 5 Do you remember the purpose of her running 6 that subset? 7 A. My recollection is it's somehow connected back 8 to conversations with the expert panel about imputation 9 and one of the scenarios that maybe someone suggested we 10 look at, but I couldn't explicitly say which scenario 11 that was. 12 Q. So we talked a little bit about quartile, 13 right? Do you remember that discussion? 14 A. Uh-huh. 15 Q. If you look at the chart right below her text, 16 do you see it says Mean of Bottom Quartile? 17 A. Yes. 18 Q. Okay. And it says the CPOE, hand hygiene, and 19 BCMA scores. Do you see that? 20 A. Yes. 21 Q. And I'll work you up the email now. Page 187	1 predict they're just slightly lower." And then you 2 respond at the top, "Thanks. Then maybe not worth the 3 effort." 4 Do you see all of that? 5 A. Yes. 6 Q. Okay. 7 Do you have any recollection today about 8 why you would say it's not worth the effort? 9 A. What I interpreted from Alex's statement was 10 that the results wouldn't be much different than what 11 she had originally produced. 12 Q. And the -- go ahead. Sorry. 13 A. So it didn't seem worth the analytical effort 14 to update it for something that wasn't meaningful 15 different -- meaningfully different in terms of Leapfrog 16 deciding how it wanted to move forward. 17 Q. And meaningfully different in this case meaning 18 lower, right? 19 A. Correct. She indicated that they would be 20 slightly lower. 21 Q. And you all wanted the numbers to be lower, Page 189

1 right? 2 MS. LAWSON: Object to form. 3 BY MR. CRAIN: 4 Q. You can answer. 5 A. There were concerns that the mean scores that 6 we had been using for imputation had been going up 7 considerably which created a disincentive for hospitals 8 to actually complete the survey. 9 Q. Yes. We saw that in the safety grade meeting, 10 right, that there were concerns that imputation scores 11 were creeping up? 12 A. That was one of the noted -- yeah. 13 Q. Right. On the slide that you drafted. 14 A. Correct. 15 Q. That was one of the bullets, right? 16 A. Correct. 17 Q. And in response to that, we saw that 18 Dr. Pronovost suggested a quartile approach, right? 19 MS. LAWSON: Object to form. 20 THE WITNESS: Once again, I -- in reading the 21 transcript, it wasn't super clear what Peter was exactly Page 190	1 9:11 p.m. This is on page 2128. Do you see it? 2 A. Uh-huh. 3 Q. She said, "This is sort of what I was afraid of 4 but somehow more stark seeing the actual numbers. I do 5 think that we need to at least go wider" -- which I 6 understand to mean consider -- "going to limited 7 achievement." Do you see that? 8 A. Yes. 9 Q. Okay. 10 Do you understand what she is saying in 11 this email? 12 A. My understanding is she was indicating that the 13 numbers aligned with what she thought might be the case 14 and was recommending that we need to consider going to 15 limited achievement. 16 Q. Okay. 17 So just to build this out a little bit, at 18 this time, under the methodology that was governing, the 19 imputation under Step 2 was a straight mean, not a 20 lowest quartile mean but a straight mean, right? Do you 21 understand what I mean? Page 192
1 discussing or suggesting. 2 BY MR. CRAIN: 3 Q. Let me phrase it a little bit differently that 4 I hope will be easier. 5 At the expert panel meeting, in the 6 transcript we saw him say the word "quartile." Fair? 7 A. Fair. 8 Q. Okay. 9 And then 10 days later -- let me just 10 double check. More than 10 days later we have 11 Ms. Campione sending around a chart that lays out, among 12 other things, the mean of bottom quartile. Do you see 13 that? That's on the last page. 14 A. Yes. 15 Q. Okay. 16 But the numbers are too high there, right? 17 MS. LAWSON: Object to form. 18 THE WITNESS: I don't know how to respond to 19 that. I mean, all of the data are here. 20 BY MR. CRAIN: 21 Q. So let's go to Ms. Danforth's email of Page 191	1 A. It was a -- there were two values that were 2 calculated for each hospital. There was the overall 3 mean and I believe that of -- the first time reporters 4 in the hospital got the lower of those two values. 5 Q. And the concern was those means were too high, 6 right? 7 A. The concern was that those means 8 disincentivized hospitals to report into the survey. 9 Q. Yes. Okay. Because they were too high, right? 10 A. Because they would give hospitals a lot of 11 credit when they wouldn't have to necessarily 12 demonstrate anything for that. 13 Q. Okay. 14 And you say when they wouldn't have to 15 demonstrate anything for that, but do you have any 16 empirical knowledge of whether that credit, so to speak, 17 would have been due as a matter of performance? 18 A. We don't have any empirical evidence on what a 19 hospital's performance would be when they don't report 20 because we don't actually have those data. 21 Q. On the measures for which you don't have data, Page 193

1 right? What I mean is you have other data, like CMS 2 data for those hospitals? 3 A. Correct. 4 Q. That's all I meant. 5 So then Ms. Campione runs a different mean, 6 right? The mean in this email is not the mean that you 7 all had been imputing as a part of Step 2 in the prior 8 methodology. Is that right? 9 A. My understanding is the very bottom table -- 10 Q. Uh-huh. 11 A. -- where it says current Step 2 means for 12 reference are what the means had been that we were using 13 at the time. 14 Q. Okay. 15 And so but the mean in the top part where 16 it says the Mean of Bottom Quartile, am I understanding 17 right that that's taking the bottom quartile of 18 hospitals and calculating the mean of those hospitals? 19 A. That's what I don't know was what sample of 20 hospitals she was using for that calculation. I don't 21 know if it was all hospitals or if it was a subset of Page 194	1 A. Yes. 2 Q. And this is an email thread between you and 3 Ms. Joshi, right? 4 A. Yes. 5 Q. And this, if you look at the bottom two emails 6 on the first page, that's the emails we saw at a prior 7 exhibit where she's sending you her draft of the notes, 8 right? 9 A. Yes. 10 Q. Okay. And you say -- this is on May 14th. Do 11 you see that date? 12 A. Yes. 13 Q. So it's a few days after the email we just 14 looked at, which was dated April 22nd. Do you see that? 15 A. Yes. 16 Q. Okay. So this is after you've gone through the 17 analysis of the bottom quartile mean. It's after you've 18 gone through that email thread we just saw, right? 19 A. Yes. 20 Q. Okay. 21 In between that period of April 12th and Page 196
1 hospitals. 2 Q. Okay. 3 So how would it work to calculate the mean 4 of bottom quartile for all hospitals? 5 A. I would take the full dataset of hospitals for 6 which we have data, identify the bottom 25 percent, and 7 calculate the mean of that sample. 8 Q. Okay. And do you have any reason to think 9 that's not what she did? 10 A. I don't have any reason to think it's not what 11 she did, but I also don't know that is what she did. 12 Q. Okay. Okay. 13 Okay. So we can set that aside. 14 MR. CRAIN: Okay. Let's go to tab 38. This 15 will be Exhibit 17. 16 (Exhibit No. 17 was marked for 17 identification as of 9/25/2025.) 18 BY MR. CRAIN: 19 Q. Okay. Dr. Austin, you have Exhibit 17, and you 20 see on the bottom it's an Armstrong document ending 21 16473? Page 195	1 now May 14th, do you recall any other discussions you 2 had with members of the expert panel about the 3 imputation model? 4 A. I don't remember. 5 Q. Okay. You don't -- just to be clear, you don't 6 remember either way? 7 A. I don't remember either way. 8 Q. Okay. 9 So I want to go to the Word document here 10 of the attachment. And do you see -- is it -- these are 11 your revisions to the notes, correct? 12 A. Yes. 13 Q. And I want to walk through a few of these. You 14 start by at the top adding Tim Vogus to the attendees? 15 A. Yes. 16 Q. Any idea how you remembered he was there a 17 month later? 18 A. To be clear, I sent the edits back to Preeti a 19 month later. 20 Q. That's what the email suggests. If you look -- 21 look on page 1. Page 197

1 A. But that doesn't mean I made the edits a month 2 later. 3 Q. Oh, so I'll represent to you that the metadata 4 shows that these are your changes. 5 A. Okay. 6 Q. I'm trying to see if there is a comment, too. 7 No. But I'll represent to you that the attachment shows 8 that you -- like you inserted the track changes. 9 Do you have any reason to think you didn't? 10 A. No. I'm wondering about the timing of when I 11 made the edits. 12 Q. Got it. Okay. That I don't know as well. So 13 you're saying you could have made these edits earlier? 14 A. Correct. 15 Q. Got it. Okay. 16 Do you recall, to do these edits, did you 17 watch the video of the meeting? 18 A. No. 19 Q. Okay. So you were going from memory, you 20 think? 21 A. Yes, and my own notes. Page 198	1 A. Yes. 2 Q. And I won't read them because we've been 3 through them, but just looking yourself at Step 1 and 4 Step 2, consistent with the slide deck that we saw? 5 A. Yes. 6 Q. And then you say, "Leapfrog's proposal was to 7 retire Step 1 of the model and use only Step 2, 8 assigning hospitals the mean score for their cohort." 9 Do you see that? 10 A. Yes. 11 Q. And then I want to skip down a bullet that you 12 delete. Do you see that? 13 A. Yes. 14 Q. And it says, "Missy gave an example of Stewart 15 Health System and said that Leapfrog's purpose by 16 implementing the Step 2 imputation model is not to 17 penalize hospitals or to motivate them to submit a 18 survey, but they don't want to report hospitals with the 19 highest scores when hospitals are not submitting the 20 hospital survey." 21 Do you recall why you deleted that bullet? Page 200
1 Q. And your own notes. And your own notes, would 2 they have been different from the email we saw earlier 3 where you sent it to and from yourself? 4 A. No. That was the extent. 5 Q. So I'm going to skip bullet one, which is on 6 the military treatment facilities again, and I want to 7 focus on your edits to bullet two. Do you see those? 8 A. Yes. 9 Q. Okay. And you say, "Matt provided the expert 10 panel with a quick overview of the current imputation 11 model approaches Leapfrog has been using and some of the 12 challenges those approaches have created for issuing 13 accurate grades." Do you see that? 14 A. Yes. 15 Q. Okay. And to the best of your recollection, 16 that is an accurate statement of what occurred at the 17 meeting, right? 18 A. Yes. 19 Q. Okay. 20 Then you say, "The current imputation model 21 has two steps when data are missing." Do you see that? Page 199	1 A. I believe I deleted that bullet because it felt 2 like a little too micro of a note to include in a 3 meeting summary. 4 Q. Got it. So it was not an edit for substance? 5 A. Can you define that? 6 Q. Yeah. Fair enough. 7 Did you delete it because you disagreed 8 that anything -- with anything in that bullet? 9 A. No, that was not my reason for deleting it. 10 Q. Okay. 11 Then let's keep going. So you then go -- 12 there's a bullet we looked at before. "Matt mentioned 13 it's important to see whether there is an actual 14 difference in hospitals' performance and whether there 15 is some sort of bias in the measurement against them. 16 He said to minimize the second, and if there are 17 differences in hospitals' performance, we can address 18 the structural issues to fix them." 19 Do you see that? 20 A. Yes. 21 Q. And you deleted that one as well, right? Page 201

1 A. Yes. 2 Q. And similar, not to be so granular in the 3 meetings? 4 A. Yes. 5 Q. And then you added a bullet and you say, "The 6 experts' panel were in support of having hospitals share 7 their current performance, so liked the idea of imputing 8 the equivalent of willing to report to hospitals that do 9 not submit a survey." 10 Do you see that? 11 A. Yes. 12 Q. Now, you recall looking at the index of the 13 transcript, right? 14 A. Yes. 15 Q. And we saw the phrase "willing" did not appear 16 at least in the index, correct? 17 A. Yes. 18 Q. Where did this line come from? 19 A. So as mentioned, I'm not sure the expert panel 20 would have necessarily used the term "willing to report" 21 in their conversation. I would need to go back to the Page 202	1 Q. Okay. 2 And then just to go back, do you remember 3 the chart we looked at, the drastic change chart? 4 A. Yes. 5 Q. You want to look at it again just so we're 6 not -- and that is exhibit -- 7 A. Fifteen. 8 Q. Fifteen. Let's look at 15. And we can go to 9 the last page, 18332. Do you see that? 10 A. Yes. 11 Q. Okay. 12 And is it your testimony that the bottom 13 right box is the same as this willing to report? 14 A. Yes. 15 Q. Okay. And the bottom right box says impute 16 with limited achievement scores, right? 17 A. Yes. 18 Q. So your testimony is that at the meeting at 19 least somebody discussed the notion of imputing limited 20 achievement scores, maybe not by that word, and that 21 others agreed, right? Page 204
1 transcript, but my guess is that there was communication 2 about putting them in the lowest performance category. 3 Q. Okay. So the phrase you would be looking for 4 is lowest performance category? 5 A. Or some context of that. 6 Q. Okay. And presumably you would want to review 7 the whole thing before committing one way or another? 8 A. Correct. 9 Q. Fair enough. 10 Okay. So to the best of your 11 recollection -- so strike that. 12 When creating the notes, you would have 13 wanted to be accurate, right? 14 A. Correct. 15 Q. Okay. And so just looking at these notes and 16 your edits, your best understanding of these edits is 17 that at some point somebody discussed the concept of 18 giving them the willing to report grade, right? 19 A. Correct. 20 Q. Okay. 21 A. And that others agreed with that point of view. Page 203	1 MS. LAWSON: Object to form. 2 THE WITNESS: From my notes here, it indicates 3 that the expert panel supported the idea of assigning 4 the bottom performance category. 5 BY MR. CRAIN: 6 Q. Okay. And do you recall -- strike that. 7 Okay. You can set that aside. 8 MR. CRAIN: Let's go to tab 43. This is going 9 to be Exhibit 18. 10 (Exhibit No. 18 was marked for 11 identification as of 9/25/2025.) 12 BY MR. CRAIN: 13 Q. All right. This is an email. The top one is 14 from Ms. Binder to Ms. Campione, cc'ing you and 15 Ms. Danforth. Do you see that? 16 A. Yes. 17 Q. Okay. And do you recognize this document? 18 MS. LAWSON: You can take a minute to read 19 through it all. 20 THE WITNESS: The email or the -- 21 BY MR. CRAIN: Page 205

1 Q. Let's start with the email. Do you recognize 2 the email? 3 A. Yes. 4 Q. Okay. You recall it today? 5 A. Can you clarify that? 6 Q. Yeah. Do you recall receiving it? 7 A. I do recall Alex putting together a document 8 with the proposed changes to the methodology that would 9 go out for public comment. 10 Q. And is that the document, at least in edited 11 form, on page 9813? 12 A. Yes. 13 Q. Okay. And do you recall did any members of the 14 expert panel review and revise the document? 15 A. I don't remember explicitly if we shared this 16 document with them. 17 Q. Yeah. Okay. I mean -- I'll move on from that. 18 I'll move on from that. 19 So the attachment, do you see it says 20 Request for Public Comment? 21 A. Yes. Page 206	1 But go down to the third line. The 2 original text said: "The panel recognized that the 3 current imputation method, which is used to fill in 4 missing data among hospitals that did not complete the 5 most recent Leapfrog survey, have influenced hospital 6 survey participation and may no longer be valid." 7 Do you see that? 8 A. Yes. 9 Q. Okay. She changed it to: "The panel advised 10 that Leapfrog modify the current imputation method, 11 which is used to fill in missing data among hospitals 12 that did not complete the most recent Leapfrog survey." 13 Is that consistent with your recollection 14 of who was advising? Did the panel actually advise 15 Leapfrog to change the methodology? 16 MS. LAWSON: Object to form but go ahead. 17 THE WITNESS: The Leapfrog Group has full 18 decision-making authority around its ratings and rating 19 systems and methodologies. So myself and all of the 20 expert panels are acting in an advisory capacity to 21 Leapfrog for that. Page 208
1 Q. Do you recall reviewing the document? 2 A. I don't recall. 3 Q. Okay. Just your best answer. That's all we 4 ask. 5 So I want to go -- I'll represent to you on 6 page 9814 these are Ms. Binder's tracked change edits to 7 the documents, and I want to just note a few things that 8 she tweaked. So if you go to the second -- tell me when 9 you're ready. No worries. 10 MS. LAWSON: The font is so small. 11 MR. CRAIN: Yeah, it is small. Sorry about 12 that. 13 BY MR. CRAIN: 14 Q. Are you good, Dr. Austin? 15 A. Yes. 16 Q. Okay. 17 So if you go to the second paragraph, to 18 ensure, do you see that? 19 A. Yes. 20 Q. And I apologize. It's in black and white, too, 21 which makes it harder. Page 207	1 BY MR. CRAIN: 2 Q. Okay. 3 So is this accurate, this change? 4 A. Yeah, that change would be accurate. 5 Q. Okay. 6 And then if we go down, I want you to look 7 at -- can you read what she cut in the next paragraph? 8 A. Yes. 9 Q. Okay. "Note that Step 1 imputation will be 10 temporarily paused" -- oh, sorry. That's not the one I 11 wanted. 12 Go back up, excuse me, to the prior 13 paragraph. She cut a sentence: "The collective 14 recommendation was for Leapfrog to modify its current 15 imputation approach to encourage survey participation 16 and to improve user's confidence in the data that are 17 used to calculate scores." 18 Do you see that? 19 A. Yes. 20 Q. Okay. Was that accurate? 21 MS. LAWSON: Just to be clear, you're asking Page 209

1 was the sentence that she struck, that the collective 2 recommendation, was that sentence accurate? 3 MR. CRAIN: Correct. Not the strike. I don't 4 want to know if the strike was accurate. I want to know 5 if the sentence as written was accurate. 6 THE WITNESS: Okay. 7 (Witness peruses document.) 8 THE WITNESS: Yes. 9 BY MR. CRAIN: 10 Q. Okay. 11 Now, I want to go to her email. And what 12 she says is -- are you at the top? 13 A. Yes. 14 Q. The second paragraph: "I don't think we need 15 the sentence about influencing survey participation and 16 giving people confidence in validity. It sounds 17 defensive, like nobody participates in the survey and 18 our own TEP questions our validity. Actually, this 19 change affects a minority of hospitals and optimizes the 20 grade's already strong validity. Anyway, it's not 21 necessary to get into the why. It's enough that the Page 210	1 sounds like nobody participates in the survey and our on 2 TEP questions our validity. Did you have that same 3 reaction reading it? 4 A. That wasn't my own read of that sentence. 5 Q. What was your read of the sentence? 6 A. That we wanted to improve confidence in the 7 data that we were using and the score. 8 Q. And to encourage participation? 9 A. That would be a byproduct of that change. 10 Q. How would that be a byproduct? 11 A. If we're no longer imputing the mean scores, it 12 might encourage some hospitals, specifically those that 13 are performing better than the mean, to actually come in 14 and share their performance. I take that back. They 15 would have been already incentivized to do that. 16 It would incentivize hospitals that didn't 17 report and were below the mean to come in and report. 18 Q. Because the new score would be lower than their 19 performance? 20 A. Correct. 21 Q. Okay. And the new score would not necessarily Page 212
1 expert panel advised us to do the imputation in a 2 different way and not treat older, better data in an 3 equivalent way to new data." 4 Do you see that? 5 A. Yes. 6 Q. Okay. 7 And then did you agree that it sounded 8 defensive -- that's my first question -- the changes 9 that she cut? 10 MS. LAWSON: Object to form. 11 I think, just to clarify, do you agree that 12 the sentence she cut sounded defensive? 13 MR. CRAIN: Correct. 14 (Witness peruses document). 15 THE WITNESS: That wouldn't be the word I would 16 use to describe that sentence. 17 BY MR. CRAIN: 18 Q. What word would you use? 19 A. Explanatory. 20 Q. Okay. 21 And do you agree -- I mean, she says it Page 211	1 reflect their actual performance? 2 A. It's undetermined whether it would reflect 3 their performance or not. 4 Q. Because you don't know either way? 5 A. Because we don't know, exactly, where each 6 hospital is at. 7 Q. Yes. Okay. 8 And then I want to go back to her email. 9 And she says, "I think when we respond to the public 10 comments, we can be more pointed and specific about the 11 survey and imputation reasoning, if necessary. The 12 comments will give us a good gauge on the extent to 13 which we need to reveal all our reasoning and whether 14 the expert panelists will truly stand up for it when 15 push comes to shove." 16 Do you see that paragraph? 17 A. Yes. 18 Q. What's your understanding of what she meant 19 here? 20 A. That the -- putting out the proposed changes 21 wasn't the time to share all of the logic which led to Page 213

1 the decision to propose this, that that could come out 2 during the responses to the comments. 3 Q. And do you have any understanding by what she 4 means of whether the expert panelists will truly stand 5 up for it when push comes to shove? 6 A. I believe she meant that there could be some 7 pushback from hospitals about this proposed change and 8 would the expert panel stand with Leapfrog in this -- in 9 moving forward in this direction. 10 Q. Had the expert panel ever not stood with 11 Leapfrog in a change to the methodology? 12 A. No. 13 Q. Okay. So any understanding as to why this 14 might be different? 15 A. This change was the most direct in confronting 16 hospitals about their lack of participation in the 17 survey. 18 Q. What do you mean by direct? 19 A. In the past, all the imputation models, from 20 ignoring the measure to using secondary data sources to 21 calculating, assigning you the national mean didn't Page 214	1 transparent but didn't meet the standards that Leapfrog 2 had set. 3 So we don't have -- can you repeat your 4 question again, please? 5 Q. Sure. Sure. 6 I said -- you said -- so you talked about 7 one goal was the confidence of the data, right, and what 8 I asked was how does it improve the confidence of the 9 data to automatically assign nonparticipating hospitals 10 limited achievement on the four imputed metrics? 11 A. So when we were calculating the national mean 12 for hospitals, we don't necessarily have any information 13 that that hospital is an average performer in that area. 14 We are assuming they are average, and in a normal 15 distribution, half of hospitals are below the average. 16 So because we don't know anything about the 17 hospital and their performance in that way, in some ways 18 this idea of willing to report actually better reflects 19 what we do know. 20 Q. Better -- okay. 21 So I want to go and look at -- let's get Page 216
1 necessarily direct -- confront a hospital to say you're 2 not submitting data and that's a problem with us. 3 We gave them sort of a pass. We found 4 another way to give them a score. So this was the most 5 direct confrontation on that. 6 Q. Was that the goal of the change? 7 A. I think the goal was multifold. 8 Q. Okay. 9 A. I think one, as mentioned, was to improve the 10 confidence of the data in terms of what data we were 11 using to calculate the scores. A secondary goal was to 12 increase or incentivize survey participation. 13 Q. Okay. 14 And then the confidence of the data, how 15 does it improve the confidence of the data to 16 automatically assign nonparticipating hospitals limited 17 achievement on the four imputed measures? 18 A. In the framework of the idea being that if we 19 don't have any information about your hospital -- so the 20 historical use of willing to report, the idea was that 21 was to acknowledge hospitals who were willing to be Page 215	1 concrete with this. 2 MR. CRAIN: So this is Exhibit 19. 3 (Exhibit No. 19 was marked for 4 identification as of 9/25/2025.) 5 BY MR. CRAIN: 6 Q. So Dr. Austin, do you recognize this page, at 7 least generally? 8 A. Yes. 9 Q. Okay. This is the Delray Medical Center 10 Hospital Safety Grade page, right? 11 A. Yes. 12 Q. Have you ever seen Delray in particular? 13 A. No. 14 Q. Okay. But you know generally the format of how 15 these pages work, right? 16 A. Yes. 17 Q. Okay. So it's not necessarily the best because 18 it's a paper, and you can see it on a website instead, 19 but you get the gist, right? 20 A. Yes. 21 Q. So I want to go down the page. You see at the Page 217

1 top it says big "F," right, for Delray? 2 A. Yes. 3 Q. Okay. 4 And I want to go to page 2. And so this is 5 specifically on the handwashing measure, right? 6 A. Yes. 7 Q. And if you go just back to page 1, and it's a 8 little hard to tell because -- but if you line up the 9 handwashing at the top of page 2 with the gas gauge, do 10 you see that? 11 A. Yes. 12 Q. And there's a red gas gauge above handwashing, 13 right? And then it says: The hospital's score is 15, 14 right? 15 A. Yes. 16 Q. And it says: Worst hospital's score is 15, 17 correct? 18 A. Yes. 19 Q. And then it says: What safer hospitals do. 20 And before I go into that, I just want to 21 clarify again. Did you have any role in editing this Page 218	1 meeting Leapfrog's standard for hand hygiene, and, 2 therefore, in the absence of information, we're going to 3 assign the equivalent of willing to report, which is now 4 limited achievement. 5 Q. Even though they're not willing to report, 6 right? Correct? 7 A. Correct. 8 Q. Yeah. 9 So how does a consumer looking at this 10 page, though, feel confidence that the grade is 11 accurate? 12 A. I haven't studied how consumers review and 13 interpret this information, so I don't know if I can 14 speak to how they would interpret this. 15 Q. You buy things, right? 16 A. I do. 17 Q. And do you look at consumer reports, other 18 ratings types for products? 19 A. Yes. 20 Q. Do you trust that the rating is accurate that 21 those reports provide? Page 220
1 website, not specific to Delray but the safety grade 2 pages, generally? 3 A. I did review and help edit the descriptions 4 that are -- the handwashing and what safer hospitals do. 5 Q. Okay. So you're familiar with this language? 6 A. Yes. 7 Q. Okay. 8 And it says: "What safer hospitals do. 9 Hospitals provide training and implement policies to 10 make sure all hospital staff cleans their hands before 11 touching a patient." Do you see that? 12 A. Yes. 13 Q. Okay. 14 Now, you said a goal of the new 15 methodology, the first goal was -- let me just go back 16 to what it was. It's confidence in the data, right? 17 A. Correct. 18 Q. How does putting Delray at a 15 for handwashing 19 give confidence in the data? 20 A. Once again, we don't have any information from 21 Delray Medical Center about how they are doing toward Page 219	1 MS. LAWSON: Object to form. Go ahead. 2 THE WITNESS: I think it depends on the source. 3 BY MR. CRAIN: 4 Q. Fair enough. Give me one that you trust. 5 A. I can't think of one offhand, but I'd be more 6 inclined to trust something that was an individual 7 reviewing products against similar products. 8 Q. Okay. I'm not sure I understood that, but can 9 you clarify? Sorry. 10 A. Yeah. Meaning like if I wanted to buy a new 11 coffee maker -- 12 Q. Yeah. 13 A. -- I would be more inclined to trust someone 14 who has reviewed coffee maker A against B, C, and D -- 15 Q. Okay. Got it. 16 A. -- than someone just chiming in about coffee 17 maker A and what their experience was. 18 Q. Okay. That's -- okay. We can work with that 19 one. 20 So my question is if you have coffee maker 21 -- in your first analogy, right, coffee maker A, B, C, Page 221

1 and D, he's reviewing them all. If you find out that 2 for a subset of the coffee makers he's giving you 3 information about the quality of the product without 4 actually having reviewed it, does that instill 5 confidence in you or no? 6 A. It might give me pause. 7 Q. And how is that different from what we see 8 here? 9 A. Can you clarify that question? 10 Q. Yeah. So you said it might give you pause if 11 for certain of the coffee makers the ultimate rating 12 included measures for which the reviewer didn't have any 13 information, right? How is that different from 14 handwashing for Delray? 15 A. So I think what's notable is that the score has 16 an asterisk, which explains, I believe, how that score 17 was arrived at. 18 Q. So we'll come to the asterisk in a second. I'm 19 trying to get a sense of you said one of the goals of 20 the new model was to instill confidence in the data. 21 And you said another goal was to encourage Page 222	1 A. That's what we're representing here is that we 2 have no information. That's what the asterisk is 3 telling you is we have no information. 4 Q. Okay. So the asterisk, you're saying -- so 5 does the asterisk undermine the score? 6 A. No. The asterisk is saying the hospital 7 declined to report their performance, so the score 8 reflects the lack of information available. 9 Q. So then how can the consumer feel confident 10 that the ultimate grade is accurate? 11 A. So Leapfrog is fully transparent with the 12 information it presents. A patient can review each of 13 the measures, decides what's important to them, what's 14 not important to them, and make decisions based on that 15 and other pieces of information that they may look for 16 and acquire. 17 Q. So I take the talking point. Do -- when you 18 say they're fully transparent, is that referring to the 19 methodology document that we looked at as Exhibit 3? 20 A. That is the methodology document. That is how 21 each of the individual scores on each of the individual Page 224
1 participation, right? How does it instill confidence in 2 data to represent that a hospital got the lowest score 3 on hand hygiene when you have no information about their 4 performance otherwise? Doesn't that undermine 5 confidence in the data? 6 MS. LAWSON: Object to form. 7 MR. CRAIN: Two questions. 8 MS. LAWSON: Two questions. 9 BY MR. CRAIN: 10 Q. You can pick either one or I can restart, 11 either or. 12 A. Can you restart? 13 Q. Sure. So -- that's a fair ask. 14 So I want to understand how does it instill 15 confidence in data to represent that a hospital got the 16 lowest score in hand hygiene where this page says 17 hospitals that are safer provide training and implement 18 policies to make sure all hospital staff cleans their 19 hands before touching a patient. How does it instill 20 confidence in data to give a hospital the lowest score 21 on that metric with no information? Page 223	1 measures make up the composite. 2 Q. So let's take a different hospital. Delray, 3 you understand, got Step 2 imputation, right? 4 A. Yes. 5 Q. If I showed you a hospital for Step 1 6 imputation, is the website any different? 7 A. I don't know the answer to that. 8 Q. Okay. I will represent to you it's the same 9 asterisk. How does a consumer know whether a 10 nonparticipating hospital got Step 1 or Step 2 11 imputation? 12 A. I don't know enough about what those different 13 scenarios are on the website, so I can't. 14 Q. Do you have any reason to believe that Leapfrog 15 actually communicates to the consumer that Wood hospital 16 or Austin hospital got Step 1, as opposed to Crain 17 hospital Step 2? 18 MS. LAWSON: Object to form. Go ahead. 19 THE WITNESS: To answer that, I would need to 20 see an example of a hospital that had Step 1 imputation. 21 BY MR. CRAIN: Page 225

1 Q. Okay. But you have no reason today to think 2 that there is any difference in the presentation? 3 A. I don't know whether there is or is not. 4 Q. Okay. 5 Where on the page in front of you does it 6 say how the score was assigned? 7 A. Can you clarify that question? 8 Q. Yes. 9 So you pointed to the asterisk on this 10 package, right, and it says a score was assigned, right? 11 A. Correct. 12 Q. And you said you had a role in at least 13 reviewing that asterisk, right? 14 A. I don't know that that's true or not true. 15 Q. Okay. You said you had a role in reviewing 16 something on this page. 17 A. I reviewed the descriptions underneath 18 handwashing and what safer hospitals do. 19 Q. Got it. But you don't recall whether you 20 reviewed the asterisk? 21 A. Correct. Page 226	1 Q. Is that what you're saying? 2 A. I don't know how people read and interpret 3 things. 4 Q. Okay. 5 Do you think this is a clear explication of 6 how the score was assigned? 7 A. I think it puts in words what Leapfrog did. It 8 puts Step 2 into words. 9 Q. How does it put Step 2 into words? 10 A. There was a lack of information available -- 11 Q. Uh-huh. 12 A. -- so a score was assigned to reflect the lack 13 of information. 14 Q. But a score could be assigned in any way, 15 right? How would a consumer know that it was assigned 16 with an automatic limited achievement? 17 MS. LAWSON: Object to form. 18 THE WITNESS: From the text that's there and 19 the asterisk, I'm not sure they would know how that was 20 assigned. 21 BY MR. CRAIN: Page 228
1 Q. Okay. 2 So it says a score was assigned, right? 3 Where does it say how the score was assigned? 4 A. Can you clarify the "how"? 5 Q. Sure. I'll give you an example. This was -- 6 let's say a hospital is assigned a score through Step 1. 7 Where would it say that on this page? 8 A. I don't know where Leapfrog chose to put that. 9 Q. Okay. 10 Where does it say that Delray received a 11 score under Step 2? 12 A. That's what the asterisk is noting is that it 13 was -- they declined to report their performance, so a 14 score was assigned to reflect the lack of information 15 available. 16 Q. So you're saying that somebody reading that 17 will understand that the assignment of the score was 18 under Step 2? 19 MS. LAWSON: Object to form. 20 21 BY MR. CRAIN: Page 227	1 Q. Okay. Thank you. 2 And are you aware of any other page on 3 Leapfrog's website where that's explained besides 4 Exhibit 3, the methodology document? 5 A. I don't know if it is or not. 6 Q. Okay. 7 MR. CRAIN: Okay. Let's -- let's see. How 8 long have we been going? About an hour. Are you good 9 to keep going, or do you want a break? 10 THE WITNESS: Yep. I'm good. 11 MS. LAWSON: I was going to say can we take a 12 quick break? 13 MR. CRAIN: Yeah, that's fine. It's been about 14 an hour. It's not an endurance test. 15 THE VIDEOGRAPHER: This marks the end of media 16 unit number five. We're off the record. The time is 17 2:13 p.m. 18 (Whereupon a short break was had, after 19 which the proceedings continued as 20 follows:) 21 THE VIDEOGRAPHER: This marks the beginning of Page 229

1 media unit number six. We're going back on record. The 2 time is 2:38 p.m. 3 BY MR. CRAIN: 4 Q. So Dr. Austin, we were talking about the 5 website, and I think that's what you have in your hand. 6 You can put that aside for now. We're going to go back 7 to what we were talking about before we went down the 8 website rabbit hole. 9 You recall we were looking at Ms. Binder's 10 edits to the -- the public comment document. Do you 11 recall that? 12 A. Yes. 13 Q. Okay. 14 I just want to show you another email. 15 MR. CRAIN: This will be Exhibit 20. 16 (Exhibit No. 20 was marked for 17 identification as of 9/25/2025.) 18 BY MR. CRAIN: 19 Q. All right. Dr. Austin, you see the document, 20 the email at the top is from you? 21 A. Yes. Page 230	1 Q. And Patrick refers to Dr. Romano? 2 A. Correct. 3 Q. Okay. Both of whom have been involved with 4 Leapfrog for many years, right? 5 A. Correct. 6 Q. And you respond at 4:25. Do you see that? 7 A. Yes. 8 Q. And you say, "My only note is the "why" has 9 been edited out the explanation. So you don't really 10 explain why this change is being done. But it reads 11 fine. No concerns." Do you see that? 12 A. Yes. 13 Q. So you noted that the "why" was edited out, 14 right? 15 A. Yes. 16 Q. Would you have preferred to keep it in? 17 A. Prefer is, perhaps, a strong term. The 18 communication is coming from The Leapfrog Group, so they 19 get the final call on what it says. I thought it was -- 20 it would be stronger to sort of explain why we were 21 doing this. Page 232
1 Q. Okay. Do you recognize this email thread? 2 A. Yeah. It's a continuation of the prior one. 3 Q. Yeah, the one -- the prior one being where 4 Ms. Binder gave her comments, right? 5 A. Correct. 6 Q. And do you see Ms. Danforth forwards you 7 Ms. Binder's email that we were looking at before, and 8 she says, "Hi, Matt. Since she mostly updated the parts 9 Peter and Patrick helped with, you can take a look and 10 let us know if you have any concerns? We'd love to get 11 this out Monday or Tuesday next week." 12 Do you see that? 13 A. Yes. 14 Q. First of all, does this refresh your 15 recollection as to whether Peter and Patrick helped with 16 this document? 17 A. Yeah. I will take it at its value or face 18 value. That's what it says, so that's what they had 19 done. 20 Q. And Peter refers to Dr. Pronovost? 21 A. Correct. Page 231	1 Q. So you thought -- okay. Got it. 2 And why did you think it would be stronger 3 to explain why you were doing it? 4 A. I think generally people like a context to why 5 something is being done. 6 Q. Would it have been more transparent to explain 7 the reasoning? 8 A. I don't know if transparent is the word I would 9 use for that. It would have been more complete. 10 Q. Okay. 11 Okay. You can set that one aside. 12 Let's see. So just going back to the 13 comment document, right, that we saw. You're aware that 14 it was issued to the public, right? 15 A. Yes. 16 Q. And you're aware that the public commented on 17 the proposal, right? 18 A. Yes. 19 Q. Did you have any role in reviewing the 20 comments? 21 A. I don't remember. Page 233

1 Q. Okay. Do you remember anything about the 2 comments generally? 3 A. I don't. 4 Q. Okay. Let's take a look at some and just see 5 if it jogs your memory. 6 MR. CRAIN: Iason, can you give me 45. 7 This will be Exhibit 21. 8 (Exhibit No. 21 was marked for 9 identification as of 9/25/2025.) 10 BY MR. CRAIN: 11 Q. Okay. Exhibit 21. So take a look at this 12 document, Dr. Austin. Do you recognize it at all? 13 A. I do not. 14 Q. Okay. I'm just going to read -- this is an 15 email from the Leapfrog help desk to Ms. Campione. I'm 16 just going to read -- do you see down the page it says 17 Becky Wenthold? 18 A. Yes. 19 Q. And she said, "I was [sic.] disappointed with 20 the 2024 proposed changes. These changes will penalize 21 hospitals that do not submit a Leapfrog survey. The Page 234	1 produced something and said I had reviewed it, it's 2 probably true, but I don't remember reviewing the 3 comments. 4 Q. Okay. It's possible but you just don't have a 5 recollection? 6 A. Correct. 7 Q. Okay. 8 And fair to say you disagree with what I 9 read, with her comment, or no? 10 MS. LAWSON: Object to form but go ahead. 11 BY MR. CRAIN: 12 Q. I can rephrase if it's helpful. 13 A. Could you rephrase? 14 Q. Yeah. 15 Is there any portion of what I read to you 16 from her comment that you agree with? 17 A. Of the sentences you've read or the ones that 18 go beyond that? 19 Q. Will your answer change? 20 A. It will. 21 Q. Okay. Start with the sentences I've read. Page 236
1 public will not understand nor dig into the methodology 2 of these grades, and hospitals will be falsely 3 represented with a lower grade because they choose not 4 to complete a survey. The survey is extremely time 5 intensive and, in a time when hospitals are barely 6 breaking even financially, they do not have the 7 resources to commit to this survey." 8 Do you see that? 9 A. Yes. 10 Q. You don't recall comments to this effect? 11 A. I do not remember reviewing Ms. Wenthold's 12 comments. 13 Q. Do you recall any other comments? 14 A. I don't remember reviewing the comments. 15 Q. Do you recall comments in favor of the change? 16 A. I don't remember seeing the comments that came 17 in from the public comment period. 18 Q. Okay. So just to close the loop, you have no 19 memory either way? 20 A. I have no memory of seeing them, but I see a 21 lot of information and a lot of -- so if someone Page 235	1 A. The sentences you have read, obviously, the 2 first sentence is her own opinion of what she sort of 3 sees the situation as. I don't disagree that the 4 changes will penalize hospitals that don't submit a 5 Leapfrog survey. 6 Q. Okay. 7 A. Her statement about the public won't understand 8 or dig into the methodology of these grades, I'm not 9 sure her nor I really know that to be the truth. 10 Q. Okay. 11 A. Hospitals will be falsely represented with a 12 lower grade I don't think is necessarily a truthful 13 statement. 14 Q. Is it possible because you don't know the 15 actual performance of nonrepresenting hospitals -- 16 nonparticipating hospitals, excuse me? 17 A. Correct. So if she said possibly represented 18 with a lower grade. 19 Q. So let me ask it this way. Is it possible that 20 at least some hospitals will be falsely represented with 21 a lower grade than they otherwise would achieve based on Page 237

1 performance? 2 A. Right. So imputation by definition is trying 3 to estimate performance, and there is almost, by 4 definition, going to be some error, and that error may 5 be in the measured entity's favorite. It may be in the 6 measured entity's unfavor or disfavor. 7 But, I mean, it's imputation, right. So we 8 don't know the answer. So, therefore, we're trying to 9 estimate or guess an answer. So by definition, 10 imputation is going to have an error associated with it. 11 So when we were imputing higher scores with 12 a means for many hospitals, there was an error 13 associated with that as well. 14 Q. So it's your testimony that imputation is an 15 estimation of actual performance? 16 A. Correct. 17 Q. And is that true with regard to the automatic 18 assignment of limited achievement? 19 A. If we're imputing a score like we were doing 20 with limited achievement, there is the possibility for 21 error. Page 238	1 A. Correct. 2 Q. So you are saying that's an estimation of their 3 actual performance on handwashing? 4 A. Yes. 5 Q. Okay. And that, again, is based on no data to 6 support it, right? 7 A. That is based on a lack of data. 8 Q. Yes. Okay. But it's an estimate, right? 9 A. It's an estimate. 10 Q. Okay. 11 Okay. Let's go back to the comment. 12 A. Okay. This extremely time intensive, once 13 again, extremely is a relative term, so I don't know how 14 Ms. Wenthold would define extremely. 15 Q. How would you characterize the burden? 16 A. What I hear from hospitals or I've heard from 17 hospitals is that it takes about 40-person hours to 18 complete it the first time but that in future years, as 19 hospitals refine their internal processes for reporting, 20 that that burden decreases. 21 Q. Okay. And which hospitals have you heard that Page 240
1 Q. So my question is a little bit different. So 2 let's break it down a little bit. 3 A. Okay. 4 Q. In the prior model for imputation, prior to 5 2024, let's go prior to 2021, you used American Hospital 6 Association data -- we had our aha moment -- to impute a 7 score for the hospitals, right? 8 A. Correct. 9 Q. Okay. And was that an estimation based on the 10 AHA data? 11 A. Yes. 12 Q. Okay. 13 Then when you get to 2024, you impute 14 limited achievement, correct? 15 A. Correct. 16 Q. Is that an estimation of performance or no? 17 A. That is an estimation of performance. 18 Q. Okay. 19 So going back to the website we looked at, 20 again for Delray you impute limited achievement on 21 handwashing, right? Page 239	1 from? 2 A. I've heard that from Johns Hopkins Hospital 3 when I queried them on that question. I've heard that 4 from other hospitals that I couldn't necessarily name, 5 but that's just from poor memory. 6 Q. Fair enough. 7 Ballpark, how many did you ask? 8 A. I've maybe have heard that from three or four. 9 Q. Okay. 10 So going back to the comment. 11 A. Yeah. So what I would -- she is correct that 12 there is no option for the submission for a survey for a 13 health system; that Leapfrog's policy, since its 14 inception, has been for each individual brick and mortar 15 hospital to complete its own survey. 16 And her statement about excellent outcomes 17 will no longer be able to receive an A is actually 18 incorrect because there were two hospitals that actually 19 did get an A that did not complete a survey. 20 Q. Nationwide, right? 21 A. Nationwide. Page 241

1 Q. And that was on that first email we looked at 2 where you were pulling information -- 3 A. Yes. 4 Q. -- for the lawsuit, right? 5 A. Yes. 6 Q. Just to make sure, I think that was Exhibit 1. 7 Okay. That's helpful. 8 MR. CRAIN: Okay. Let's go to tab 47. This 9 will be Exhibit 22. 10 (Exhibit No. 22 was marked for 11 identification as of 9/25/2025.) 12 BY MR. CRAIN: 13 Q. I'm sorry. This one is very small. 14 Dr. Austin, this is another comment, which 15 I think was submitted through what I believe is 16 Leapfrog's Zendesk platform. Do you see that? 17 A. Yes. 18 Q. My guess is -- have you not -- have you seen 19 this document before? 20 A. No, I haven't. 21 Q. Okay. So I want to just take you to the Page 242	1 Q. To your understanding. 2 MS. LAWSON: I mean to your understanding. 3 BY MR. CRAIN: 4 Q. It's always to your understanding. 5 A. Right. 6 So the impetus for the Hospital Safety 7 Grade -- let me take us back a little bit in time. 8 So since 2001, Leapfrog has been doing a 9 voluntary survey of hospitals around quality and safety 10 practices. It has collected those data and made those 11 publicly available. One of the concerns for that model 12 is Leapfrog was collecting a lot of different data 13 points and reporting those out as individual data 14 points. 15 And what we know from conversations with 16 consumers and patients is that they strongly prefer 17 composite scores, star ratings, letter grades, that they 18 find that much more digestible. 19 Q. Easier to understand? 20 A. Easier to understand. 21 In addition to wanting to move towards a Page 244
1 bottom, and I think that's the comment. Do you see it's 2 from it looks like Alana Noble? 3 A. Yes. 4 Q. And she says, "We strongly disagree with the 5 proposed Fall 2024 Step 2 imputation. If Leapfrog is 6 going to implement this change, they need to offer 7 hospitals an option to opt out of being graded rather 8 than penalize a hospital for not submitting the resource 9 intensive survey. The survey is very resource intensive 10 outside of existing regulatory, quality operations and 11 quality improvement efforts. Hospitals that do not have 12 the resources to do the survey annually should not be so 13 adversely punished, especially in the post-COVID era 14 when resources are increasingly hard to come by and 15 retain." 16 And my question to you is: Why can't 17 Leapfrog give hospitals an option to opt out of being 18 graded? 19 MS. LAWSON: Object to form. 20 You can answer. 21 BY MR. CRAIN: Page 243	1 letter grade, Leapfrog also wanted to -- the model that 2 Leapfrog was working from was the restaurant ratings in 3 like New York City, Los Angeles, right, where the health 4 department comes in. They do an assessment of the 5 restaurant, and the hospital has to post a letter grade 6 in their window with an A, a B, or a C. 7 And one of Leapfrog's board members 8 supposedly thought, oh, wouldn't it be great if we could 9 ask hospitals to do the same thing around the idea of 10 patient safety. 11 The concern with making it voluntary is 12 that it is a relative score, right. So the methodology 13 is such that hospitals are being compared to the 14 national mean, the standard deviation of the national 15 sample. And so it would be difficult to issue grades if 16 we were pulling from a selected subset of hospitals. 17 Q. Is that still true today where 80 percent of 18 inpatient beds are I think represented on the Leapfrog 19 survey? 20 A. So I see that as a little bit of a chicken and 21 egg situation. Page 245

1 Q. Okay. Tell me why. 2 A. That if Leapfrog made it voluntary, one 3 potential consequence of that would be fewer hospitals 4 would report to the survey, and, therefore, you would 5 lose that 80 percent capture that is currently there. 6 Q. Is it fair to characterize that as a slippery 7 slope problem? 8 A. I don't know how to characterize a slippery 9 slope. 10 Q. Okay. 11 I guess what I mean by that is you're 12 suggesting that if you make it voluntary, the number 13 20 percent of inpatient beds that were not responding 14 would increase, right? 15 A. That could be a potential consequence. 16 Q. Okay. 17 So to encourage greater participation, it 18 cannot be voluntary. Is that right? Take your time. 19 A. So one of the challenges Leapfrog was trying to 20 address with the Hospital Safety Grade was that there 21 had been a plateauing of hospital participation in the Page 246	1 Q. Yeah. 2 A. Or not rephrase but repeat the question. 3 Q. Oh, repeat? Yeah, repeat I can do because I 4 have the realtime. 5 We've talked a lot about how there are 6 errors with any imputation methodology, correct? 7 A. Correct. 8 Q. Isn't the most accurate way to get safety 9 information out there to not impute? 10 A. Are we discussing the scores, or are we 11 discussing the grades? 12 Q. Let's do both. Start with the score. 13 A. So for the score, I think that would have a 14 little more of an influence -- let me say that again. 15 The decision to impute a score would impact the overall 16 score. 17 Q. The overall grade? 18 A. The overall -- so just to clarify, when we 19 calculate the grade, what we're actually calculating is 20 a score, a numerical score. So each hospital has a 21 numerical score that's calculated. Those numerical Page 248
1 survey. 2 Q. Okay. 3 A. And, therefore, we only had quality and safety 4 information for a -- not a small, a fraction of the 5 hospitals in the United States. And so by making it 6 nonvoluntary was an opportunity to have safety 7 information out there about as many hospitals in the 8 U.S. as possible. 9 And so if you make it voluntary, you sort 10 of defeat that goal of trying to have safety information 11 for as many as possible. 12 Q. Has that goal overtaken any goal to report 13 accurately on safety? 14 A. No. 15 Q. Okay. And why is that? Because -- strike 16 that. 17 We've talked a lot about how there are 18 errors, right, with any imputation methodology. Isn't 19 the most accurate way to get safety information out 20 there to not impute? 21 A. Can you rephrase the question? Page 247	1 scores then get converted into letter grades. 2 Q. Yes. Got it. 3 A. So the letter grade, by definition, is a range 4 of scores, right. So it's less sensitive to the 5 decision to impute one measure or not to impute a 6 measure. 7 If we're talking about the actual numerical 8 score, the accuracy would be improved without 9 imputation. 10 Q. Okay. 11 So is it right that Leapfrog has 12 prioritized as a goal increasing participation as 13 compared to the accuracy of the score? 14 A. So when you say participation, what are you 15 referring to? 16 Q. Participation in the survey. Let me rephrase 17 it so it's clear. 18 Is it fair to say that Leapfrog has 19 prioritized encouraging greater participation in the 20 survey as compared to greater accuracy in the scoring of 21 a safety grade? Page 249

1 A. I don't see it as an absolute tradeoff in that 2 way. 3 Q. Okay. Is it -- why is that? 4 A. Because I think you can work towards both 5 goals. I don't think you necessarily have to completely 6 have one goal be worked towards at the detriment of the 7 other goal. 8 Q. You don't think that's what's happening with 9 imputation? 10 A. So to be clear, the decision to impute scores 11 is primarily driven by the desire to have more accuracy 12 in what we are issuing as a score grade. A potential 13 benefit of that is that hospitals may choose to come in 14 and report to the survey. 15 So that's why I don't see them as 16 necessarily diametrically opposed goals. 17 Q. Is the most accurate way to score excluding 18 imputation altogether? 19 A. Yes. As previously stated, you would have a 20 more accurate score without imputation. 21 Q. Okay. Page 250	1 Leapfrog feel it can't allow an opt out? 2 A. This is my own speculation because I have not 3 discussed with Leapfrog this scenario. One might be 4 concerned that if you allow hospitals to opt out, most 5 of them will, and now what is your rating program if you 6 don't have many participates. 7 Q. And it's also -- what is your rating program, 8 meaning the grade, the survey, or both? 9 A. Potentially both. 10 Q. And going back to the restaurant analogy. You 11 mentioned the L.A. restaurant grades. Do you think 12 that's a fair analogy to what Leapfrog is able to do? 13 MS. LAWSON: Object to form. 14 BY MR. CRAIN: 15 Q. To your knowledge. 16 A. So Leapfrog can't require hospitals to post a 17 letter grade in their window. 18 Q. It also, unlike a regulatory agency, can't 19 compel participation, right? As a legal matter, right? 20 A. I will defer to lawyers on that. 21 Q. Fair enough. Okay. Page 252
1 And so going -- I don't know if I got an 2 answer to this question, though, but let me just be 3 really clear. So this comment says if Leapfrog is going 4 to implement this change, they need to offer hospitals 5 an option to opt out, right? 6 First, I guess stepping back, do you recall 7 any discussion of an opt out internally to either the 8 expert panel or Leapfrog? 9 A. No. That's never been the conversation. 10 Q. Okay. And why can an opt out not be provided? 11 A. If -- is your question is it possible for 12 Leapfrog to implement an opt out? 13 Q. Well, so -- 14 A. Or -- 15 Q. Yeah, fair question. 16 So there's the question of whether it's 17 physically possible. I assume it's physically possible 18 to implement an opt out, right? 19 A. Yes. 20 Q. Yeah. 21 Why does -- to your knowledge, why does Page 251	1 Let me ask -- 2 A. Leapfrog, what it's doing is it's using 3 publicly available data to make an assessment of a 4 hospital's patient safety performance. 5 Q. And it's also using the lack of data, right, to 6 make an assessment of performance? 7 A. That's using what data are available. 8 Q. Yeah. 9 A. And in some situations, that is data that's not 10 available. 11 Q. Yeah. Okay. 12 Okay. You can set that one aside. 13 I want to talk a little bit about the 14 imputed measures themselves so -- and we talked about 15 earlier in the day, it feels like hours ago, BCMA, CPOE, 16 IPS, and hand hygiene, right? 17 A. Correct. 18 Q. So I've been trying to understand why are those 19 the four that are imputed as compared to the three what 20 I called earlier in the day discarded measures. You may 21 feel free to call them something else, but why are those Page 253

1 different? 2 A. It is somewhat a function of historical 3 artifact and when the measure was introduced to the 4 Leapfrog Hospital Survey. So within those three 5 measures, we put the two safe practices into one bucket 6 and hand hygiene in the other bucket. 7 Q. Okay. 8 A. The safe practices I put in the sort of 9 historical artifact bucket in that when the decision was 10 to move towards secondary data sources, like the aha, 11 AHA hospital survey -- 12 Q. That's my favorite. 13 A. There wasn't any data within that AHA survey 14 that matched up with those safe practices. Like, there 15 was nothing about leadership. There was nothing about 16 culture measurement. 17 So at that time, the decision was, okay, 18 we're going to continue to hold those in the 19 we're-just-going-to-ignore-the-measure-if-you-don't-have 20 -it bucket, which was the original imputation. 21 That historical sort of artifact has just Page 254	1 Q. And it's one of your notes to yourself. Do you 2 see that? 3 A. Yes. 4 Q. And it says: "Notes for today's call with 5 Dr. Romano." [sic] Right? 6 A. Yes. 7 Q. Okay. 8 April 12th, coincidentally, 2019. Do you 9 see that? I say coincidentally because the expert panel 10 meeting was also April 12th. 11 A. Okay. 12 MS. LAWSON: Of 2024. 13 MR. CRAIN: Yeah, of 2024. Sorry. It was my 14 own aha moment. 15 BY MR. CRAIN: 16 Q. So going down, you say, "Patrick, to guide 17 today's call, I put together some quick notes." Do you 18 see that? 19 A. Yes. 20 Q. And I can't tell if you sent this to him or 21 they were just talking points. Any sense? Page 256
1 sort of rolled forward. 2 Q. Okay. Fair to say it was grandfathered in? 3 A. Yeah. It's a historical artifact of where we 4 started and where we're at. 5 The nursing workforce -- 6 Q. Yep. 7 A. -- was just recently introduced to the Leapfrog 8 Hospital Survey, and the collective wisdom was perhaps 9 we don't have enough experience in data with that to 10 impute scores. 11 Q. So very helpful on the three. 12 I want to ask you also about the four, why 13 they are imputed, and I have a document that I think 14 might help us in what I've been trying to figure out. 15 MR. CRAIN: So this will be Exhibit 23. 16 (Exhibit No. 23 was marked for 17 identification as of 9/25/2025.) 18 BY MR. CRAIN: 19 Q. So this is another Armstrong-produced document. 20 You see that on the bottom, right? 21 A. Yes. Page 255	1 A. They were notes for myself, I believe, for the 2 conversation with Dr. Romano. 3 Q. And do you remember this conversation? Feel 4 free to take a second to read through it if it's 5 helpful. 6 (Witness peruses document.) 7 THE WITNESS: Okay. 8 BY MR. CRAIN: 9 Q. Do you remember the context of this discussion? 10 A. I don't with certainty but based on the -- 11 Q. Context clues? 12 A. -- context clues, it would be to talk about 13 maybe changing the imputation approach -- 14 Q. And -- 15 A. -- and missing data thresholds. 16 Q. Okay. 17 And you see it mentions AHA responses sort 18 of towards the bottom third of the page? 19 A. AHA responses? 20 Q. There's a bullet that says exceptions are BCMA. 21 A. Yes. Page 257

1 Q. Okay. 2 And just stepping back for a second, do you 3 recall a time where Leapfrog no longer had access to the 4 AHA data? 5 A. There was a point where AHA revoked Leapfrog's 6 license to use the data. 7 Q. Do you know why they did that? 8 A. My understanding is they had gotten -- strike 9 that. 10 I don't know why AHA revoked the license. 11 Q. When you said "my understanding," did you have 12 something that you heard about it? 13 A. I had heard that, you know, they were getting 14 complaints from their member hospitals about how those 15 data were being used by Leapfrog. 16 Q. Got it. 17 And complaints with respect to the 18 imputation into the methodology? 19 A. Complaints on two fronts. One was how the data 20 were being translated into scores for Leapfrog. Also, 21 some of the hospitals' data were pretty old, and they Page 258	1 Do you know where she got it? 2 A. I don't know. 3 Q. Okay. 4 Anything else you remember about why AHA 5 stopped licensing? 6 A. That's all I'm aware of. 7 Q. Okay. 8 So I want to look specifically at -- you 9 see in this document imputing data? 10 A. Yes. 11 Q. If you go down to the third bullet -- well, 12 let's go to the second bullet first for context. It 13 says: "Current Approach: Exclude the measure and 14 recalculate the weights for the affected hospitals using 15 only those measures for which data are available." 16 Do you see that? 17 A. Yes. 18 Q. And can you sort of translate what that means? 19 A. Yeah. So the earliest approach of imputation 20 that we followed was to -- if a hospital was missing a 21 measure, we ignored that measure and we redistributed Page 260
1 felt like it was outdated and there really wasn't a 2 mechanism for them to update it. And there were sort of 3 logistical challenges, and my understanding is I think 4 AHA was like, we're out. 5 Q. We're out of this business? 6 A. Right -- what's that? 7 Q. We're out of this business? 8 A. We're out of this business. 9 Q. And when you say old, so I know like CMS data 10 has a lag, right? Yes? 11 A. Some of it does, yes. 12 Q. Was the AHA data a bigger lag than CMS? 13 A. I don't know the exact lag period for the AHA 14 survey. 15 Q. And what you had heard about why the AHA did 16 not want to license anymore, do you recall who that came 17 from? 18 A. The information that I heard from? 19 Q. Yeah, that you just shared with us about -- 20 A. From Missy Danforth. 21 Q. Got it. Okay. So Ms. Danforth told you that. Page 259	1 the weights to other measures for which they did have 2 data. 3 Q. Okay. 4 And then there's a -- the next bullet says 5 exceptions, right? 6 A. Correct. 7 Q. And it says: "Exceptions are BCMA, CPOE, and 8 IPS, in which case we have created crosswalks between 9 the AHA responses and Leapfrog performance categories." 10 Do you see that? 11 A. Yes. 12 Q. What does the crosswalk mean? 13 A. The crosswalk was we looked at -- for hospitals 14 that reported to both the AHA survey and to the Leapfrog 15 Hospital Survey, we were able to compare their responses 16 on both and understand in an aggregate way what the 17 relationship was between a hospital's responses to the 18 AHA survey and how they were performing on the Leapfrog 19 Hospital Survey standards. 20 Q. So just to rearticulate, is it fair to say that 21 you had identified that the AHA data was a reasonable Page 261

1 enough proxy for the BCMA, CPOE, and IPS scores for 2 Leapfrog? 3 A. In our review and discussions of the AHA 4 survey, we felt like it represented a reasonable 5 approximation of the same quality -- or the same safety 6 standards. 7 Q. And is that the original reason why those three 8 became imputed measures, as opposed to discarded 9 measures? 10 A. Yes. 11 Q. Okay. 12 After Leapfrog lost the AHA data, do you 13 recall any time at which other crosswalks were 14 considered? 15 A. We explored other potential secondary data 16 sources. I can specifically remember having lots of 17 calls with HIMMS, H-I-M-M-S, which is a technology 18 consortium, to see if we could get relevant data related 19 to computerized physician order entry. And as we 20 reviewed their data, we didn't feel confident in that it 21 was getting us the same thing that we needed. Page 262	1 historical fact of Leapfrog having those crosswalks to 2 the AHA data, that those three are imputed as opposed to 3 other measures that are discarded that you're aware of? 4 A. I could argue that there is, perhaps, some 5 clinical, additional clinical relevance to those. I 6 mean, they do get higher weights in the safety grade. 7 They have been shown to be more effective as it relates 8 to safety and improving safety. So that's what I would 9 speak to. 10 Q. So my question is a little different, though. 11 You are, I think, providing a reason for why those are 12 valuable measures, right? 13 A. Correct. 14 Q. And, in fact, I could show you websites. I'll 15 just represent to you that sometimes Leapfrog puts out 16 information that says those are among the most important 17 measures. It sounds like you might agree with that? 18 A. Correct. 19 Q. Yeah. And they're significantly weighted, 20 right? 21 A. They have higher weights than some other Page 264
1 So we explored other options, just nothing 2 met. 3 Q. Okay. 4 So is it fair to say that those three 5 measures were essentially grandfathered in from the 6 period in which Leapfrog was using AHA as the crosswalks 7 to the Leapfrog scores? 8 A. We had been imputing scores for those measures 9 using the AHA datasets. That would be true. 10 Q. And it was grandfathered into the next 11 instantiation of the imputation methodology? 12 A. I would need to have better notes on what was 13 the next phase of the imputation methodology -- 14 Q. Okay. 15 A. -- to remember what came next after that. 16 Q. Fair enough. Fair enough. 17 So subsequently -- like, the current 18 methodology still imputes on these three measures, 19 right? 20 A. Correct. 21 Q. Is there any particular reason, except for the Page 263	1 measures. 2 Q. I think the four imputed measures are 3 approximately a quarter to 30 percent of the grade. Are 4 you aware of that? 5 A. I couldn't agree or disagree with that. 6 Q. I mean, it's in the methodology document. 7 A. Right. 8 Q. We can set it aside. I'm not trying to, you 9 know, test you on it. It's all right. 10 So you're giving me reasons for why they 11 are important measures, correct? I want to know the -- 12 whether there's an empirical reason or an evidence-based 13 reason for continuing imputation of them outside of the 14 crosswalks that we see in this email. 15 MS. LAWSON: Do you understand the question? 16 Are you clear on what the question is? 17 THE WITNESS: I think I am. 18 MS. LAWSON: Okay. I think he's asking is 19 there a historical -- like, other than the historical 20 experience -- 21 MR. CRAIN: I think I'd asked just for no Page 265

1 speaking objections or coaching. 2 MS. LAWSON: Yeah, but I just want to make sure 3 that he's clear because we're covering this a second 4 time. We've asked it a -- you know, and I understand. 5 So I understand what your question is, and I just want 6 to make sure he understands so he can answer what you're 7 asking. 8 BY MR. CRAIN: 9 Q. Let me ask it again because I want to make sure 10 the record is clear. 11 So I said: You're giving me reasons for 12 why they are important measures, correct? 13 A. Correct. 14 Q. And I want to know whether there is an 15 empirical reason or some evidence-based reason for 16 continuing to impute these three measures in this email 17 outside of the crosswalks that Leapfrog had identified 18 between the AHA responses and Leapfrog performance 19 categories. 20 A. So the reason it would be important to keep 21 those measures in and to be imputed is because they have Page 266	1 Q. Yeah. Glad to. 2 The automatic assignment of limited 3 achievement for the four imputed measures for a 4 nonparticipating hospital is not grounded in any actual 5 evidence about a nonparticipating hospital's performance 6 today, correct? 7 A. Back to the earlier point, we know the hospital 8 is not being transparent about their safety performance 9 and that safety is an important component of a culture 10 of safety. 11 Q. Okay. So I'll go down the line. An automatic 12 assignment of limited achievement for BCMA is not 13 grounded in any actual facts about a hospital's 14 performance on BCMA, right? 15 A. An imputed score is based on an assumption. 16 Q. Okay. And not actual facts on the ground about 17 performance, right? 18 A. Correct. 19 Q. Okay. 20 A. And that's true of all imputation. 21 Q. It wasn't necessarily true when you had the Page 268
1 a significant impact to patient safety. So to create a 2 composite score that doesn't include those measures 3 would be missing some very key components. 4 Q. For Step 2, where you're automatically 5 assigning limited achievement, doesn't that rationale 6 cut the other way? 7 A. I would disagree. We're actually imputing a 8 score for those because those measures are important. 9 Q. So I take it that those measures are important. 10 Set that aside for a second. 11 We've talked about the limited achievement, 12 right, the automatic assignment is not grounded in any 13 actual evidence about a given hospital's performance, 14 right, today? 15 A. The imputation is -- has an error component to 16 it by definition. 17 Q. Yes. So just -- I want you to answer my 18 question yes or no. The automatic assignment is not 19 grounded in any actual evidence about a given hospital's 20 performance today, correct? 21 A. Can you repeat that? Page 267	1 crosswalks, right? 2 A. That's not completely true. 3 Q. Okay. Explain it for me. 4 A. Because when we had the crosswalks, we were 5 looking at large numbers of hospitals. So we might have 6 had 500 hospitals that reported to both the Leapfrog 7 Hospital Survey and the AHA survey. What we looked at 8 was what was basically the average performance. 9 If a hospital answered this in the AHA 10 survey, how did they, on average, perform on the 11 Leapfrog Hospital Survey? Some of the hospitals 12 performed better. Some performed worse. So there is a 13 degree of error there in imputation. 14 Q. But you had some sort of analysis to build that 15 out, right? 16 A. We had some secondary data sources to help us 17 inform those imputed scores. 18 Q. And today, for the methodology, there is no 19 secondary data source to help you inform the imputed 20 assignment of limited achievement? 21 A. Correct. Page 269

1 Q. Okay. 2 So is it fair to say that the reason these 3 three remain as imputed measures is largely, as you said 4 for the other ones, a historical artifact or no? 5 A. I think it's a combination of historical 6 artifact and their importance to the broad concept of 7 patient safety. 8 Q. Got it. Okay. So they're significant, so 9 Leapfrog didn't want to lose them, and also they had 10 been imputing based on other secondary data sources. 11 That combination is why they are still imputed measures 12 today. Is that fair? 13 A. Fair. 14 Q. Okay. 15 Why hand hygiene, which is not represented 16 here? Can you give me the history of that one? 17 A. So hand hygiene was introduced to the Leapfrog 18 Hospital Survey after -- well, don't quote me on this. 19 I believe after the AHA had pulled their data license. 20 Q. Okay. Got it. 21 Okay. So you had no opportunity to create Page 270	1 (Exhibit No. 24 was marked for 2 identification as of 9/25/2025.) 3 BY MR. CRAIN: 4 Q. This is an Armstrong-produced document. Do you 5 see that on the bottom right? 6 A. Yes. 7 Q. And the top email is from you to a group of 8 folks at Leapfrog, I think, and Preeti Joshi. Do you 9 see that? And maybe a couple others. 10 A. Yes. 11 Q. And there's an attachment. It says: Leapfrog 12 Hand Hygiene Report Analysis June 3, 2024. Do you see 13 that? 14 A. Yes. 15 Q. And you write to the group, "As a follow-up 16 from our meeting a few weeks ago, attached are the 17 requested analyses for the hand hygiene report. I think 18 the analyses are pretty self-explanatory, but we are 19 happy to have a call to review if that would be 20 helpful." 21 Do you see that? Page 272
1 the crosswalk, correct? 2 A. Correct. 3 Q. Okay. 4 I want to show a document. So talking 5 about hand hygiene, again, is it your testimony today 6 that the limited achievement automatic assignment of 7 hand hygiene for nonparticipating hospitals in Step 2 -- 8 stay with me -- is an accurate reflection of a 9 hospital's hand hygiene performance, an accurate 10 estimation? 11 A. My testimony is that it's an imputed score for 12 that hospital's performance on hand hygiene. 13 Q. And is it an accurate estimation of their 14 performance on the ground? 15 A. Imputation, by definition, has error. 16 Q. Okay. So for certain hospitals it may be 17 inaccurate? 18 A. Correct. 19 Q. Okay. 20 So I want to look at -- 21 MR. CRAIN: This will be Exhibit 24. Page 271	1 A. Yes. 2 Q. And then you go in I guess starting with -- 3 first question: Did you draft -- I'm looking at page 4 5116. Do you see that? 5 A. Yes. 6 Q. Did you draft what looks like it's titled 7 Leapfrog Hand Hygiene Analysis for Landslide Report? 8 A. Preeti Joshi did this. 9 Q. Okay. Did you review it? 10 A. Yes. 11 Q. Okay. And what was the purpose of this 12 document? 13 A. Leapfrog was interested in putting out a 14 national report on its hand hygiene standard and where 15 hospitals had -- how they've improved over time on the 16 standard. 17 Q. Okay. 18 And so you go, it looks like to me, you go 19 question by question through the Leapfrog survey. Is 20 that right? 21 A. We looked at it both at the individual question Page 273

1 level -- yes. In this first part, it's looking at each 2 individual question. 3 Q. Okay. And fair to say for some questions there 4 is pretty -- you know, there's change between 2020 and 5 2023, and for others there's less change. Is that 6 right? I can be more concrete. 7 MS. LAWSON: I was going to object to form 8 there. 9 MR. CRAIN: Fair enough. I'll take it back. 10 BY MR. CRAIN: 11 Q. So question number one is provision of hand 12 hygiene training. Do you see that? 13 A. Yes. 14 Q. And in 2020, it looks like 92.8 percent -- 15 well, tell me what the percentage reflects. 16 A. Yeah, that represents the percentage of 17 hospitals -- yeah, the denominator is the number of 18 hospitals that submitted responses to the hand hygiene 19 section of the Leapfrog survey. So the numerator would 20 be those that answered yes, that they meet Leapfrog's 21 requirements for that question. Page 274	1 hand hygiene questions. Is that fair to say or no? 2 A. So Leapfrog actually has fairly high standards, 3 and so for a hospital to meet a domain, they actually 4 have to answer "yes" to all of the questions in that 5 domain. 6 So, for example, in domain training and 7 education, only 85.7 percent answered yes to question 8 two in 2023. So at most, 85.7 percent of hospitals meet 9 that domain, and it's probably something less than that, 10 right. 11 So looking at individual questions may not 12 be the most accurate indicator of how hospitals are 13 doing on each of the domains as Leapfrog has defined 14 them. 15 Q. Okay. So in each of these four domains, you're 16 saying only the lowest denominator respondent are those 17 that passed the domain? 18 A. The lowest percentage within a domain would be 19 the absolute ceiling of the percentage of hospitals that 20 can meet that domain. 21 Q. Got it. Okay. Page 276
1 Q. So 92.8 percent of hospitals in 2020 responding 2 to the survey met question one. Is that right? 3 A. Yes. 4 Q. Okay. 5 And that increases to 96.8 percent in 2021, 6 96.8 percent in 2022, and 97.9 percent in 2023. Do you 7 see that? 8 A. Yes. 9 Q. Okay. 10 And I guess the question that I have on any 11 of these, really, is: Is it your assumption that a 12 hospital that is not participating in the survey will 13 perform worse than these numbers as compared to the 14 participating hospitals? 15 A. Can you say that one more time, please? 16 Q. Yeah. So I'm trying to get at -- let's back up 17 a little bit. 18 So I'm trying to understand why Leapfrog 19 imputes for hand hygiene, right. And my question is it 20 seems like, at least based on this analysis, that most 21 hospitals, at least that report, do fairly well on the Page 275	1 So for domain one, the most -- the highest 2 number of hospitals that would have met that domain are 3 85.7 percent of responding hospitals in 2023, correct? 4 A. Correct. 5 Q. Okay. 6 And do you have any basis to suggest that 7 nonperforming hospitals would be so much worse in 8 performance than 85.7 percent? 9 A. We don't have any information to know how they 10 would perform. 11 Q. So why is it fair to those hospitals to give 12 them the lowest score when the gross majority of 13 hospitals, at least in this domain, pass? 14 MS. LAWSON: Object to form. Go ahead. 15 THE WITNESS: So there are 15 percent of 16 hospitals, at least, that are not meeting the domain, 17 right. So how would we know if hospitals that don't 18 report are part of that 15 percent or part of the 19 85 percent? 20 21 BY MR. CRAIN: Page 277

1 Q. You don't know either way, right? 2 A. We don't know either way. 3 Q. Okay. But you assume that the hospitals in 4 that domain that are not reporting are necessarily part 5 of the 15 percent, right? 6 A. We don't have any information about those 7 hospitals, so we are imputing a score. 8 Q. You're imputing a score that estimates that 9 their performance is failing, essentially? 10 A. That they are in the bottom performance 11 category. 12 Q. Okay. 13 And then if you go to domain two, this is 14 infrastructure, do you see that? 15 A. Yes. 16 Q. And this is things like hand sanitizers? 17 A. Correct. 18 Q. Okay. 19 Forgive the question, but have you ever 20 been to a hospital for care? 21 A. Yes. Page 278	1 A. -- in 2023 -- 2 Q. In 2023, correct. 3 A. -- would be the absolute ceiling. 4 Q. Yes. 5 Do you have any sense for what the number 6 actually is for the number of hospitals that passed this 7 domain? 8 A. I don't know offhand. 9 Q. Okay. Fair to say it's likely quite high 10 because of these numbers? 11 MS. LAWSON: Object to form but go ahead. 12 THE WITNESS: Yeah, I mean, I could -- you 13 know, you could assume that all of these were 14 independent, and if you multiply them together, you 15 would come up with an answer that's somewhere in the 16 63 percent, which is probably the floor. So it's 17 somewhere between 63 and 90.5. 18 BY MR. CRAIN: 19 Q. Okay. 20 So but, again, for hospitals that don't 21 participate, for this domain, effectively, they get the Page 280
1 Q. Do you recall any room that you were in without 2 a sanitizer? 3 MS. LAWSON: Object to form. 4 THE WITNESS: So the Leapfrog survey questions 5 about hand sanitizers are fairly specific about the 6 location of them, whether they produce the correct 7 amount of alcohol-based hand gel, and whether or not the 8 hospital does audits to know if they actually have hand 9 gel in them. Because I think we've all experienced 10 going up to one and nothing comes out. 11 BY MR. CRAIN: 12 Q. Not fun. 13 A. So there is more than just about do you have 14 hand sanitizer dispensers. There's a lot more to that 15 standard. 16 Q. Fair enough. 17 So taking your bottom number, if you look 18 at domain two, this would imply that 90.5 percent, at a 19 maximum, passed this domain, right? 20 A. Ninety-one -- 90.5 -- 21 Q. Ninety point five, right. Page 279	1 lowest possible score, right? 2 A. So to be clear, the hand hygiene standard has 3 five domains. For a hospital to be in achieved the 4 standard, they need to -- if they're only collecting 100 5 hand hygiene observations a month, they need to meet all 6 five domains, which means they're saying "yes" to every 7 single question. 8 Q. Okay. 9 A. Seventy-four percent of hospitals in 2023 10 achieved the standard, so 26 percent did not. 11 Q. Yep. Okay. And that achieved the standard is 12 the highest, right? 13 A. Correct. 14 Q. Then how do you quantify the next three down? 15 A. We have a scoring algorithm that's available 16 online that details that. I couldn't recite what that 17 is, but the idea is basically if you meet a subset of 18 the domains, you get one category; if you meet fewer 19 domains, you get a lower category. 20 Q. Okay. 21 A. It's sort of assessed at the domain level but Page 281

1 then it rolls up into an overall score. 2 Q. Okay. No, fair enough. 3 So I guess then my question is why is hand 4 hygiene one of the imputed measures and not one of the 5 discarded measures? 6 A. Because its clinical relevance to patient 7 safety is paramount. 8 Q. Okay. 9 So, again, it's the same point. When we 10 talked about the other three, there were two reasons. 11 The first was the historical what I call grandfathering 12 in combined with the significance, right? 13 A. Correct. 14 Q. For this one, there's no historical, but it's 15 just, you're saying, it's so important, Leapfrog feels 16 it has to impute? 17 A. Correct. 18 Q. Okay. Okay. Let's leave it at that. 19 A. Okay. 20 MR. CRAIN: All right. I think we've been 21 going about an hour. Do you mind if we take a break? Page 282	1 A. Yes. 2 Q. Okay. And the subject is: Final updates to 3 Leapfrog Hospital Safety Grade methodology for Fall of 4 2024. Do you see that? 5 A. Yes. 6 Q. And generally, can you tell me what this email 7 is? 8 A. This email is an email to the expert panel with 9 the attachment of the final updates to the safety grade 10 methodology for Fall of 2024. 11 Q. Okay. And you say, "Based on the expert 12 panel's thoughtful input and guidance, Leapfrog has 13 decided to move forward with updates to imputation 14 methodology used in the Hospital Safety Grade, effective 15 Fall '24." Do you see that? 16 A. Yes. 17 Q. Okay. Fall of 2024. Sorry. I think I said 18 that wrong. Do you see that as well? 19 A. Yes. 20 Q. Okay. 21 Now, just for the record, I want to be Page 284
1 MS. LAWSON: That's fine. 2 MR. CRAIN: Okay. Courtney, are you good? 3 MS. WOOD: Uh-huh. 4 THE VIDEOGRAPHER: This marks the end of media 5 unit number six. We're going off the record. The time 6 is 3:26 p.m. 7 (Whereupon a short break was had, after 8 which the proceedings continued as 9 follows.) 10 (Exhibit No. 25 was marked for 11 identification as of 9/25/2025.) 12 THE VIDEOGRAPHER: This marks the beginning of 13 media unit number seven. We're going back on the 14 record. The time is 3:43 p.m. 15 BY MR. CRAIN: 16 Q. Thank you, Dr. Austin. 17 So I've handed you what has been marked as 18 Exhibit 25. Do you see that document? 19 A. Yes. 20 Q. And this is an email from you to what I think 21 is the safety grade expert panel. Do you see that? Page 283	1 clear. Did Leapfrog decide to adopt this methodology, 2 or did the expert panel decide to adopt it? 3 A. Leapfrog makes all the decisions about their 4 ratings and ratings programs. The work of the expert 5 panel, expert panels, myself, is all in a recommendation 6 advisory capacity. 7 Q. Okay. And are you aware of any document in 8 which the expert panel weighed in on this final proposal 9 as a group? 10 A. Not that I am aware of. Not that I'm aware of. 11 Q. Okay. 12 Do you know sitting today whether the 13 entire expert panel approved of this path forward? 14 A. We did not query the expert panel about whether 15 they approved this or not. 16 Q. Okay. Is it your view that they did approve 17 it? 18 A. It is -- from my point of view, we heard their 19 input and guidance. Leapfrog made a decision of how it 20 wanted to move forward, and we communicated that to the 21 expert panel. Page 285

1 Q. Okay. 2 Okay. All right. You can set that aside. 3 MR. CRAIN: Okay. I want to move on to another 4 topic. Tab 15, please. This will be Exhibit 26. 5 (Exhibit No. 26 was marked for 6 identification as of 9/25/2025.) 7 BY MR. CRAIN: 8 Q. All right. So Dr. Austin, you have in front -- 9 well, what do you have in front of you? 10 A. I have in front of me our 2013 prepublished 11 ahead of print publication from the Journal of Patient 12 Safety. 13 Q. And we talked about this document a little bit 14 earlier today, right? 15 A. Correct. 16 Q. Okay. This is the document that was peer 17 reviewed that analyzed the methodology at least as it 18 stood back in 2023, right? 19 A. This was the methodology in 2012, early 2013. 20 Q. Okay. And you are the lead author on this 21 paper, correct? Page 286	1 Q. Okay. And it says, the next sentence -- 2 A. And we do some analyses of early rounds of the 3 grades to demonstrate what that looks like. 4 Q. Some early rounds of the grades to 5 demonstrate -- say more about what you mean. 6 A. Yeah. So let me look in the -- so we had done 7 some data analysis using composite safety scores for 8 2,652 general acute care hospitals, and we calculated 9 safety scores for those. 10 Q. Okay. 11 A. And we show that in figure one. 12 And then in tables two and three, we did 13 some analysis to look at how those safety scores varied 14 by different hospital characteristics, as well as by 15 state in the United States. 16 Q. Okay. And this is the document that we saw 17 that was linked to Leapfrog's website, right? 18 A. Correct. 19 Q. Okay. 20 I want to go to page 4, and I think it's 21 Bates number 668. Page 288
1 A. Correct. 2 Q. As well as it looks like other folks on the 3 expert panel, safety grade expert panel? 4 A. Correct. 5 Q. And I see, for instance, Dr. Romano is here, 6 right? 7 A. Correct. 8 Q. Okay. 9 I want to ask you a few questions about 10 this. I'm going to go to -- starting at the top, do you 11 see the little -- on the left side at the top it says 12 "Methods." 13 A. Yes. 14 Q. And it says: "The Leapfrog Group sought advice 15 [sic.] from a panel of national patient safety experts 16 to develop a composite score." Do you see that? 17 A. Yes. 18 Q. Does that describe generally what this paper is 19 about? 20 A. The paper describes how -- the process Leapfrog 21 used to develop a composite score. Page 287	1 A. Yes. 2 Q. And there's a section, Dealing with Missing 3 Data. Do you see that? 4 A. Yes. 5 Q. And it says: "Although the expert panel 6 selected nationally reported measures, some data were 7 missing for hospitals that did not report to The 8 Leapfrog Group, and other data were missing because 9 hospitals did not meet CMS's minimum sample requirements 10 to publicly report their results." 11 Do you see that? 12 A. Yes. 13 Q. So this is the section that's, for lack of a 14 better word, dealing with missing data, right? 15 A. Correct. 16 Q. Okay. 17 So the next paragraph lays out, what it 18 looks like, five possible approaches for assessing 19 hospital performance when data were missing. Do you see 20 that? 21 A. Yes. Page 289

1 Q. Okay. And I'm going to not march through, but 2 it looks like number four is: "Give the hospital zero 3 credit for the measure." Do you see that? 4 A. Yes. 5 Q. And that's not -- Leapfrog has never done zero, 6 right? 7 A. Correct. 8 Q. They've done limited achievement, correct? 9 A. Correct. 10 Q. Okay. And limited achievement, just to be 11 clear, is the lowest measure, which can range anywhere 12 from 5 to 25 depending on the measure, right? 13 A. Correct. 14 Q. Okay. 15 And then number five says: "Exclude the 16 measure and recalibrate the weights for the affected 17 hospitals using only those measures for which data are 18 available." Right? 19 A. Correct. 20 Q. Now, the -- if you look at -- further down 21 there's a paragraph that says "After." Do you see that? Page 290	1 So then the paragraph keeps going. The 2 next sentence is -- let's see. It's on the top of page 3 4 on the right side. "In this way." Do you see that? 4 A. Yes. 5 Q. "In this way, we avoided making questionable 6 assumptions about the performance of hospitals with 7 missing data, and we also maintain variation of the 8 final calculated scores by not imputing identical values 9 for all missing observations." 10 Do you see that language? 11 A. Yes. 12 Q. Okay. 13 So at least as of 2013, Leapfrog -- this 14 group of authors peer reviewed, came to the conclusion 15 that excluding the measure was the way to avoid making 16 questionable assumptions about the performance for 17 hospitals. Do you see that? 18 A. Yes. 19 Q. Okay. That changed, right? 20 A. That has evolved. 21 Q. Okay. Is it your view that Leapfrog is making Page 292
1 A. Yes. 2 Q. Okay. And it says: "After conducting 3 sensitivity analyses using each of the above approaches, 4 the panel recommended approach number five to address 5 missing data, excluding the measure for a hospital and 6 recalibrating the weights for those measures for which 7 performance data were available, for most measures." 8 Do you see that? 9 A. Yes. 10 Q. Okay. And was that generally the approach that 11 Leapfrog took in the ensuing years? 12 A. That was the approach Leapfrog used initially 13 with the hospital safety grades. 14 Q. Okay. 15 A. As previously mentioned, Leapfrog has evolved 16 its imputation approaches, working through actually at 17 least four out of the five here. 18 Q. Fair enough, yeah. So it's been a moving 19 target. 20 A. It's been evolving. 21 Q. Evolving. Fair enough. Page 291	1 questionable assumptions today about the performance of 2 hospitals? 3 A. I don't believe that to be true. 4 Q. Okay. What's changed between this analysis and 5 today? 6 A. So what has changed is that the -- that we've 7 actually evolved through different imputation 8 approaches. So we started with number five, right. 9 Then we moved to number two, imputing based on other 10 available data. Then we moved to number one, which is 11 imputing performance at the national mean or median, 12 although we did that by cohorts. And then we eventually 13 landed here now at number three, which is imputing a 14 score above or below the median or mean. 15 So all of these are valid imputation 16 approaches. I think the choice of an imputation 17 approach needs to be in the context of sort of time, 18 place, situation. 19 So in 2012, when Leapfrog rolled out these 20 hospital safety grades, hospitals did not know these 21 were coming. So that needed to be sort of the context Page 293

1 in which an imputation decision was made. 2 If we fast-forward to 2024, now we've been 3 issuing safety grades for 25 rounds. Hospitals are very 4 aware of the grades. They're very aware of the measures 5 that go into the survey, and so you might have your 6 imputation approach evolve with that. 7 Q. So the assumptions change? 8 A. I don't know if assumptions have changed, but 9 the context has changed. 10 Q. So let me -- so first going back, you said 11 number three, impute a score above or below the median 12 or mean; e.g., minus one standard deviation. Do you see 13 that? 14 A. Yes. 15 Q. That's not what Leapfrog does today, right? 16 A. It is imputing a score below the mean. 17 Q. Below the mean, fair, but not by one standard 18 deviation, right? 19 A. That was just an example of how that could be 20 operationalized. 21 Q. The measure of limited achievement is more than Page 294	1 A. From my point of view, it feels like the 2 context and times have changed, and so I would say, yes, 3 that would feel like a more fair decision to make. 4 Q. More fair. Okay. 5 Is it more or less fair than limited 6 achievement? 7 A. It's probably less fair to assign zero than 8 limited achievement. With limited achievement, 9 hospitals are getting some credit. They're not getting 10 zero credits. 11 Q. No one gets zero, right? 12 A. No one gets zero. 13 Q. Okay. Zero is not an available score, correct? 14 A. Correct. 15 Q. Okay. 16 Then so the questionable assumption, just 17 to make sure I understand it, is about the startup of 18 the safety grade, as opposed to assumptions about 19 performance generally? 20 A. It's assumptions about the rollout of the 21 imputation and whether or not it was fair to assign a Page 296
1 one standard deviation below, right? 2 A. I have not looked at a distribution of scores 3 to be able to answer that. 4 Q. Do you have an estimate as to what -- how much 5 lower than the standard deviation below -- one standard 6 deviation below the mean it is? 7 A. I don't know what that would be. 8 Q. Okay. 9 Okay. So going back, do you recall what 10 the questionable assumption the authors were worried 11 about in this paper was? 12 A. So I think the biggest concern was around 13 option number four, which would be to give the hospitals 14 zero credit for not reporting to Leapfrog. 15 Q. Why is that the biggest concern? 16 A. That was a concern in that hospitals didn't 17 know that this was coming, that we weren't really being 18 fair to hospitals to just assign zero right from the 19 get-go for not reporting. 20 Q. Is it more fair to assign -- would it be more 21 fair to assign zero now? Page 295	1 score that penalized hospitals when they didn't know 2 that the safety grades were coming. 3 Q. Do you know if that language is in this paper? 4 A. I'm not sure that that -- I would have to 5 reread it. 6 Q. I mean, if you want to take a second and read 7 this section, which I think is the only section dealing 8 with this and just goes to the next page, I'm curious 9 does it articulate that as the questionable assumption 10 in here. 11 A. So in the -- that paragraph at the top of page 12 4, in the second paragraph it says: Finally, the third 13 and fourth approaches were rejected to avoid creating a 14 structural bias in favor of Leapfrog reporting 15 hospitals. 16 So as I mentioned, there was a concern 17 about doing that right from the get-go. 18 Q. But that doesn't say get-go, though. It's 19 talking about reporting versus nonreporting, right? 20 A. It was at that -- the article was written at a 21 point in time with experience only up until that point Page 297

1 of time, and that was our experience up 'til that point. 2 Q. Is there any structural bias today in favor of 3 reporting hospitals? 4 A. There are hospitals that report to the Leapfrog 5 Hospital Survey that score limited achievement. So a 6 score of limited achievement is not just for hospitals 7 that don't report. There are some hospitals that report 8 that receive that score as well. 9 Q. What does structural bias mean? 10 A. I guess in that context I would think of it as 11 some sort of bias in how we assign scores based on 12 whether they report or don't report to Leapfrog. 13 Q. And so based on that definition, you're still 14 maintaining there's no structural bias in favor of 15 reporting hospitals? 16 A. Based on what we just discussed, I would say 17 there is a structural bias against nonreporting 18 Leapfrog -- nonreporting hospitals. 19 Q. Okay. There is a structural bias? 20 A. There is a structural bias. 21 Q. Okay. That makes sense. Okay. Page 298	1 Q. Got it. 2 So the methodology doesn't take any 3 measures to address that structural bias? 4 A. Correct. 5 Q. Okay. 6 Okay. And then the other -- if you keep 7 going on that paragraph, it says: "By scoring hospitals 8 on" -- tell me when you're ready. 9 "By scoring hospitals on the available 10 data, the composite scores were based on what was known 11 about the hospital's performance, with no penalties for 12 missing data." 13 Do you see that? 14 A. Yes. 15 Q. Okay. Now, that also is different for today, 16 right? 17 A. That is different than today. 18 Q. Okay. 19 And at this time, scoring hospitals based 20 on what was known about the hospital's performance was 21 something this group of authors deemed advisable, right? Page 300
1 And that's one of the reasons this group of 2 authors, which included yourself and many of the safety 3 grade expert panelists, like Dr. Romano, rejected this, 4 it looks like, the third and four approaches, right? 5 A. At that point in time. 6 Q. Okay. And your position is the structural bias 7 has changed? 8 A. It's not that it has changed. It is more 9 apparent and can be addressed, right. So in the early 10 days of the safety grade, hospitals didn't even know 11 these grades were coming. A lot of them had never 12 completed the Leapfrog Hospital Survey. 13 Fast-forward 12 years, we're in a different 14 place where hospitals are very aware of the safety 15 grades. They're very aware of the survey, and so the 16 context has changed. 17 Q. So just to be clear, when you say addressed, 18 that's not addressing within the methodology. That's an 19 addressing in the context of hospitals could decide to 20 report? 21 A. Correct. Page 299	1 A. So to be clear, what we're representing is the 2 Hospital Safety Grade methodology. Not all authors were 3 part of the expert panel. And just to remind you, all 4 of the decisions about the methodology are ultimately 5 Leapfrog's to make. 6 Q. Yes. 7 A. So what we're writing up is the implications of 8 that decision. So when you asked about whether authors 9 agreed, to me it's not an agreement or disagreement. 10 It's were we stating what the facts were at that time. 11 Q. Okay. No, that's fair. So I got it. So 12 you're saying it's an empirical observation? 13 A. Correct. 14 Q. So the observation is by scoring hospitals on 15 the available data, the composite scores were based on 16 what was known about the hospital's performance with no 17 penalties for missing data. You're saying, just to make 18 sure I understand, you're not making a judgment about 19 whether that's good or bad. You're saying it's what's 20 being done? 21 A. Correct. Page 301

1 Q. Okay. Got it. 2 Now, this is the paper that Leapfrog touts 3 as having peer reviewed its methodology, right? 4 A. Correct. 5 Q. But there are multiple components, at least in 6 this paragraph that we've seen, that don't apply 7 anymore, right? 8 A. There are -- can you repeat the question? 9 Q. So we've walked through this paragraph about 10 different observations, the questionable assumptions, 11 the structural bias, and then the penalties for missing 12 data, all of which you said are not what Leapfrog does 13 today. They're not reflective of the methodology 14 Leapfrog uses today, correct? 15 A. Correct. 16 Q. Is it fair to say that this paper is a peer 17 reviewed assessment of the methodology today? 18 A. I'm going to be a little careful because I 19 don't know if Leapfrog's website says that it's a peer 20 reviewed of today, right. It's a peer reviewed of their 21 methodology, right. Page 302	1 measure. 2 Q. So we talked about, maybe an hour ago, that the 3 imputed measures are significant, right? 4 A. I don't know if that's what we discussed. 5 Q. Okay. You talked about how they're 6 clinically -- they matter, right? 7 A. Correct. They're important elements of patient 8 safety. 9 Q. Yes. 10 A. Yes. 11 Q. And they weight quite heavily, right? 12 A. They make up somewhere between 20 and 13 30 percent. 14 Q. Yes, as we talked about. 15 A. Yeah. 16 Q. Is it -- so 30 percent, 20 to 30 percent of the 17 methodology is derived from an imputation model that 18 this paper did not comment on, correct? 19 MS. LAWSON: Object to form. Go ahead. 20 THE WITNESS: As listed under the imputation 21 methods, one of them is exactly what we're doing today. Page 304
1 So I'll go back to the previous point that 2 I think the overall structure of the composite score, 3 that it's based on two domains of measures, the data 4 sources, we're going to do relative weights, has 5 remained consistent and constant through time. 6 Have some of the individual decisions about 7 imputation -- obviously, some of that has evolved and 8 changed. So I don't know how to say whether or not it's 9 a fair representation of Leapfrog's methodology or not. 10 Q. Do you agree, yes or no, that Leapfrog's 11 current methodology has been peer reviewed? 12 A. Are you speaking of the Fall 2024 methodology? 13 Q. The one that's operative today. 14 A. I think it sort of depends on your definition 15 of what we mean by methodology. And I don't mean to get 16 into semantics, but I would still come back to like the 17 general structure of all of this is still the same. 18 Some of the nuance differences are different, but that 19 happens continuously throughout the last 12 years. 20 So I don't know how you would write a new 21 paper every time we change one measure or re-weight one Page 303	1 BY MR. CRAIN: 2 Q. Which one? Three? 3 A. Number three. 4 Q. Okay. Impute a score below the mean, correct? 5 A. Correct. 6 Q. Okay. I guess this doesn't say how much far 7 below, right? 8 A. Correct. 9 Q. Because if the means that we saw earlier from 10 Ms. Campione's emails were in the 70s, 80s, and 90s, and 11 the imputation is 15, was that the type of difference 12 below the mean that you were contemplating when you 13 wrote this piece? 14 A. I think there was room for -- there was room 15 for decisions to be made around number three and what 16 sort of score above or below the mean or median. The 17 minus one standard deviation was just an example. 18 Obviously, number four is a more extreme example of 19 zero. So there's a range of options in between those 20 two. 21 Q. Okay. Page 305

1 So then I guess going back to my question, 2 we've talked about the imputation methodologies being 20 3 or 30 percent, being significant. Is it fair to say 4 that the current methodology has been peer reviewed 5 given that that substantial portion of it was never 6 reviewed? 7 A. I don't know how to answer that. I feel like 8 it is fair to say that because the primary structure of 9 the methodology has remained the same. Now, others 10 could have a different assessment of that. Some could 11 say, oh, wow, the imputation approaches make this 12 nonrepresentative. I guess that's just a disagreement 13 in how maybe we see the world. 14 Q. Okay. Fair enough. 15 So let me ask this question. The 16 imputation model, has that been peer reviewed? 17 A. No. 18 Q. Okay. 19 Okay. You can set that aside. 20 MR. CRAIN: Let's go to tab 21. This will be 21 Exhibit 27. Page 306	1 is a big, bold "Unintentional consequences of how we 2 currently treat missing data"? Do you see that header 3 on page -- it's the first page? 4 A. Yes. 5 Q. Okay. And I want to go to page 2. And do you 6 see the bullet number two? 7 A. Yes. 8 Q. It says: "Imputation of the score when we have 9 missing data." 10 A. Yes. 11 Q. And it says: "Matt mentioned that expert panel 12 discussed this in the past and did not feel it supported 13 the goal of the safety grade." Do you see that? 14 A. Yes. 15 Q. So I want to break this down a little bit. 16 Now, do you recall making this statement at 17 an expert panel meeting? I recognize it's a while ago. 18 A. I don't remember -- 19 Q. Okay. 20 A. -- that conversation. 21 Q. Is it accurate, to the best of your knowledge Page 308
1 (Exhibit No. 27 was marked for 2 identification as of 9/25/2025.) 3 BY MR. CRAIN: 4 Q. Okay. So this is another, you see at the 5 bottom, Armstrong-produced document? 6 A. Yes. 7 Q. Do you recognize this one? 8 A. Yes. Well, it's been a while. 9 Q. What does it look like? 10 A. It says it's the meeting agenda. What it 11 actually represents is notes from the meeting. 12 Q. Maybe somebody built out the notes within the 13 agenda? 14 A. Correct. 15 Q. Okay. 16 A. And we just forgot to change the title. 17 Q. Any reason to think this isn't a true and 18 accurate depiction? 19 A. No. 20 Q. So I just have a couple of questions. If you 21 go to -- where is it again -- page 76, do you see theirs Page 307	1 today, that, looking at the top bullet, imputation of 2 the score when you have missing data is something the 3 expert panel discussed in the past? 4 A. So, yes, we have discussed imputation with 5 them. 6 Q. Okay. Just to build out the -- 7 A. Right. Yes, that's fine. 8 Q. Just to get on the same page. 9 A. Yes. 10 Q. And now it says: Did not feel it supported the 11 goal of the safety grade. 12 A. I don't know what that refers to. 13 Q. Okay. 14 A. I will take ownership that the note-taking here 15 may not have been all that accurate, because I don't 16 even know what that refers to because I don't think they 17 -- they have never indicated that imputing scores 18 doesn't support the goal of the safety grade. 19 Q. Okay. 20 A. So I'm thinking that there might have been some 21 nuance to that that wasn't captured in the notes. Page 309

1 Q. What could the goal have been referring to? 2 A. I don't know for sure. 3 Q. Okay. 4 So if you go to the next bullet, do you see 5 how -- "Imputing scores for individual measures, like 6 safe practices, would incentivize them to report on the 7 survey." Do you see that? 8 A. Yes. 9 Q. First of all, does that reflect that the safety 10 grade expert panel considered imputing for safe 11 practices? 12 A. That was something that was, I guess, discussed 13 at that meeting. 14 Q. And as we talked about before, was decided 15 against, right? 16 A. Leapfrog has never imputed scores for -- 17 Q. Safe practices? 18 A. -- safe practices. 19 Q. One or two? 20 A. One or two. 21 Q. Now, imputing -- it says: "Imputing scores for Page 310	1 Q. And goal -- we talked about goals. 2 So you have no recollection or 3 understanding as to why imputation, at least at this 4 time, would be deemed not supportive of the goal of the 5 safety grade, at least the two goals that we've talked 6 about? 7 A. Yeah. I do not understand how that note ties 8 to everything else I know and understand. 9 Q. Okay. So you just don't remember, or it just 10 doesn't make sense anymore? 11 A. I don't remember what that was intending to -- 12 Q. To say? 13 A. To say. 14 Q. Okay. I have to ask. 15 Okay. Let me just see. Yeah. Okay. You 16 can set that aside. 17 MR. CRAIN: And then just one more historical 18 document. Can we do tab 30. This is Exhibit 28. 19 (Exhibit No. 28 was marked for 20 identification as of 9/25/2025.) 21 Page 312
1 individual measures would incentivize them to report on 2 the survey." Is that different from the goal reflective 3 in bullet one? 4 A. That I don't know how those connect. 5 Q. We've talked a little bit today about what the 6 goals of the safety grade are. I think we've talked 7 about information, right, as one goal, getting 8 information out there, correct? 9 A. Correct. 10 Q. We've talked about accuracy as another goal, 11 correct? 12 A. Yes. 13 Q. Are there any other goals that you can think 14 of, of the safety grade, that we haven't -- besides 15 those two? 16 A. None come to -- immediately come to mind. 17 Q. Okay. 18 So looking at this bullet, you noted 19 earlier today you endeavor to be accurate in these 20 notes, right? 21 A. That is our goal. Page 311	1 BY MR. CRAIN: 2 Q. Dr. Austin, you have in front of you an email 3 thread between you, Ms. Danforth, Mr. Card, and Emma 4 Domico. Do you see that? 5 A. Correct. 6 Q. Who is Emma Domico? 7 A. Emma was the research analyst who was working 8 for me at the time on the Leapfrog contract. 9 Q. What Ms. Joshi does now? 10 A. Correct. She was in between Jordan and Preeti. 11 Q. Got it. 12 And who is Mr. Card? 13 A. Mr. Card worked for The Leapfrog Group and was 14 the analyst who was supporting the Hospital Safety 15 Grade. So he preceded Alex. 16 Q. Got it. 17 So I want to just look -- so it's a little 18 bit of a confusing email, but I'm going to walk you 19 through at least how I think I read it. So go to the 20 bottom, which is the first one. 21 A. Yes. Page 313

1 Q. And it's from you and it's dated August 25th, 2 2021, right? 3 A. Yes. 4 Q. And just for context, is this around the time 5 where AHA was rescinding the license? 6 A. I don't know -- I don't know the timing of the 7 AHA license. 8 Q. Okay. Do you remember generally what was 9 happening in 2021? 10 A. I don't other than COVID was. 11 Q. Fair enough. We all remember that one. 12 A. Yeah, but I don't remember what -- I don't 13 remember the timing of the AHA data because that was all 14 between Leapfrog and -- 15 Q. Got it. Okay. 16 So I will at least represent to you that 17 this was -- well, we'll go through the document. 18 A. Okay. 19 Q. So you write -- you say, "Missy, Andrew: Next 20 Friday is the HSG" -- Hospital Safety Grade. Yes? Is 21 that right? Page 314	1 Do you see that? 2 A. Yes. 3 Q. Now, we'll come back to this, but I just want 4 to explain to you what the gray is. So if you go one 5 up, the prior page, you see Ms. Danforth writes: "See 6 below"? 7 A. Yes. 8 Q. Okay. 9 So the gray, is it correct to say, those 10 are her comments interlined with your agenda? 11 A. Yes. 12 Q. Okay. 13 So on number two, she says in response to 14 your agenda point, she says, "Yes, and the idea to 15 impute for all missing, including safe practices and HH. 16 I will send a follow-up to the email that Andrew sent." 17 So can you tell me generally what are you 18 proposing as an agenda item, and what did you 19 understanding her response was? 20 A. So what we were proposing as an agenda item was 21 to discuss with the expert panel our imputation methods Page 316
1 A. Yes. 2 Q. Okay. 3 A. Correct. 4 Q. -- "expert panel call. As Emma and I were 5 walking through agenda items, we would benefit from your 6 input/expertise." Do you see that? 7 A. Yes. 8 Q. And I want to focus on number two and start 9 with the bold. Do you see there's two pieces of text. 10 There's a bold and a sort of grayed one on each line? 11 A. Yes. 12 Q. Okay. So let's start with the bold. You say, 13 number two: "How to score hospitals missing 14 process/structural measures. Are we looking for 15 suggestions on imputation methods?" Do you see that? 16 A. Yes. 17 Q. And then if you go to four, it says: 18 "Penalizing hospitals if they don't report. Is this 19 part of agenda item number two? And is Leapfrog really 20 open to this idea? If not, I don't want to keep asking 21 their opinions." Page 315	1 for process and structural measures. 2 Q. Okay. 3 A. And Missy suggested back the idea that maybe we 4 impute for all missing, including safe practices and 5 hand hygiene. 6 Q. Okay. 7 And then if you go to four, you say -- you 8 have a separate agenda item, right? 9 A. Correct. 10 Q. And it says: "Penalizing hospitals if they 11 don't report. Is this part of agenda item number two? 12 And is Leapfrog really open to this idea?" You all caps 13 "really." Do you see that? 14 A. Yes. 15 Q. So why were you all capping really? 16 A. So back to attachment 27, back to Old Town 17 Alexandria, the Hilton, that was actually a point where 18 the expert panel actually brought up the idea of moving 19 towards an imputation approach where -- to penalize 20 hospitals -- 21 Q. Okay. Page 317

1 A. -- if they didn't complete the Leapfrog 2 Hospital Survey. 3 So even though it got implemented in 2024, 4 as far back as 2017 conversations were happening about 5 whether or not this was the direction to go into. 6 Q. Okay. 7 A. So in 2021, it was like, is Leapfrog open to 8 this? Are they not open to this? I don't want to keep 9 asking the expert panel over and over again about this 10 if Leapfrog is not open to moving in this direction. 11 Q. Okay. 12 A. So that was the intent of that. 13 Q. And by this direction, you mean a penalty? 14 A. It could be a penalty. It could be an 15 imputation below the mean or median. It could take many 16 different forms, and I don't think a specific proposal 17 had been floated at that point. 18 Q. Okay. 19 And then -- so look at her response. She 20 says: "Remove. This is really covered in number two." 21 Do you see that? Page 318	1 transparent. So that was one idea of how that could be 2 manifested. This could be other ways of manifesting it. 3 Q. Yeah. No, I get that. I'm just trying to 4 understand. So the agenda item number two is how to 5 score hospitals missing process and structural measures. 6 Do you see that? 7 A. Correct. 8 Q. And the question of penalizing hospitals is 9 bound up in that discussion as well, correct? 10 A. I think what Missy was saying is she didn't see 11 that as being a unique part of the agenda, that that 12 would be -- could be incorporated into number two. 13 Q. Well, she said covered in number two, right? 14 A. Correct. 15 Q. And you agree with her? 16 A. I would agree that that, as we've discussed, 17 that that is an option for imputation. 18 Q. And is it fair to say over the years when this 19 topic has come up, the notion of penalizing hospitals 20 has been covered by the topic in number two? 21 A. It's been brought up in that space, yeah. Page 320
1 A. Correct. 2 Q. Okay. And it sounds like you agree with that? 3 A. Well, I agree that that decision is part of 4 imputation, right. So as we go back to the five 5 imputation methods, number three was one of the possible 6 options, right. So that is part of the imputation 7 discussion is do we impute that a hospital is an average 8 performer? Do we impute that they're a better 9 performer? Right? Like, those are all decisions around 10 imputation. 11 Q. So and when you say "those," you mean the 12 decision of whether to penalize a hospital is part of 13 the analysis of how to impute or whether to impute? 14 A. So there were a couple of approaches that could 15 be taken, right. So if we go back to number 27, Old 16 Town Alexandria, one suggestion from the expert panel 17 was, well, would we want to assign some sort of explicit 18 negative penalty. 19 So we wouldn't necessarily work that into 20 the imputation of individual scores, but we would take 21 so much off of the final score for not being Page 319	1 Q. Okay. Okay. 2 Let me take another look. I think that may 3 be it for this email. Yeah, we can set this one aside. 4 So I'm going to shift gears again. We're 5 getting there. 6 A. How many gears are there on this car? 7 Q. I've got a lot of gears. I've got a lot of 8 gears. We're getting close to the end gear. I've only 9 got so much time. 10 I want to talk about the 2019 white paper. 11 A. Okay. 12 Q. Okay? Oh, you seem excited for it. 13 A. I love it. 14 Q. Okay. 15 MR. CRAIN: So I want to start with -- let's go 16 to tab 58. And this is Exhibit 29. 17 (Exhibit No. 29 was marked for 18 identification as of 9/25/2025.) 19 BY MR. CRAIN: 20 Q. So, Dr. Austin, you see this is an email from 21 you to Ms. Campione, Ms. Danforth, and Ms. Bailey from Page 321

1 2025. 2 A. Yes. So this is not in reference to the 3 2019 -- 4 Q. Yes. 5 A. -- report. 6 Q. It's the lives saved, lives lost, right? 7 A. Correct. 8 Q. Okay. This was the update you were talking 9 about, right? 10 A. This is the update that we've worked on but 11 have not published. 12 Q. Okay. I want to walk through this one, if I 13 can. 14 A. Okay. 15 Q. Okay. So maybe I was a little unfair. I'm 16 starting with 2025 and then I want to lead into the 17 white paper -- 18 A. Okay. 19 Q. -- but I want to talk about your numbers here. 20 A. Okay. 21 Q. Okay? Page 322	1 analysis done on the 2016 white paper, and the 2019 2 reflects the update? 3 A. Correct. 4 Q. Okay. And 2025 reflects, at least in draft 5 form, what the current numbers would be? 6 A. They represent, if we were to maintain the same 7 methodology we used in 2019, what the numbers would look 8 like in 2025. 9 Q. Okay. Can you -- and I'm happy to give you 10 documents if it's helpful, but can you generally 11 describe what that methodology is? 12 A. Yep. 13 Q. And if you need a document, we can get you that 14 document. 15 A. No, no. I can. 16 So what we do is for each grade, "A", "B", 17 "C", and we lump "D" and "Fs" together -- 18 Q. Why is that? 19 A. Primarily due to small sample sizes of "F" 20 hospitals. 21 Q. Got it. Page 324
1 So let's go to page -- so I want to look 2 at -- you see Ms. Campione's email on the bottom? It's 3 from her to you, and there's a table on page 0900. Do 4 you see that? 5 A. Yes. 6 Q. Okay. Now, this table -- tell me what this 7 table is. 8 A. So what this table represents is for three 9 points in time, 2016, 2019, and 2025, we have estimated 10 the number of lives lost due to preventable medical 11 mistakes that are captured through the Leapfrog Hospital 12 Safety Grade measures. 13 We also have estimated the number of lives 14 that could be saved if "B," "C," "D," and "F" hospitals 15 all performed as well as "A" hospitals. So we've 16 estimated that at three different points in time. 17 We also have done relative comparisons 18 between "B" and "A" hospitals, "C" and "A", "D" and "A" 19 and "F", and then we break the numbers down. 20 Q. So the chart that we're looking at here on page 21 0900, is it correct that the 2016 column reflects the Page 323	1 A. We're looking at less than 20 or 25. 2 Q. Okay. 3 A. For each of the outcome measures that are 4 included in the Hospital Safety Grade, we calculate a 5 mean incidence rate for each cohort of hospitals. So 6 "A" hospitals, how do they do on foreign objects 7 retained? "B" hospitals, how do they do on foreign 8 objects retained? 9 So we have basically an estimated incidence 10 rate of these events by hospitals. 11 Q. And just to translate that, estimated incidence 12 rate means how many times this thing happened? 13 A. Correct. 14 So we display it as a percentage, right? 15 You can think of like, oh, 1.2 percent of patients 16 develop a central line associated blood stream infection 17 in an "A" hospital. Some of those measures, outcome 18 measures are applicable just to patients who have had 19 surgery. Some are just applicable to patients who have 20 been in the intensive care unit. 21 And so we discount the total patients based Page 325

1 on who those -- who those measures apply to. 2 Q. Yep. 3 A. Then in terms of estimating the lives lost, 4 from the literature, we've identified the attributable 5 mortality rate to that event happening to a patient in a 6 hospital and their -- yeah, attributable mortality rate. 7 So as previously discussed, like for 8 central line associated blood stream infections, one out 9 of every seven patients who develop C infection in the 10 hospital will die. 11 And we're using that same attributable 12 mortality rate for all categories of hospitals. So that 13 is one of our limitations. We may have variation in 14 that "A" hospitals could actually have a lower mortality 15 rate than "D" and "F" hospitals, but we're making the 16 assumption of that mortality rate. 17 And so that is -- and then in addition to 18 the outcome measures, we're also using ICU physician 19 staffing because there is strong evidence linking 20 improvements in intensivists managing and comanaging 21 patients in the ICU and reduced mortality hospital-wide. Page 326	1 no intensivist and high intensivist staffing. 2 And so we actually go back to seventh or 3 eighth grade math, and we have the slope of a line. And 4 this is where hospitals are now at, and, therefore, if 5 we calculate the slope, it would be this point on the 6 line. 7 Q. Oh, boy. You're testing my math skills. 8 A. I test my own as well. 9 And so basically, hospitals that are fully 10 implemented we think have -- we estimate that they have 11 achieved the full impact of that. 12 Q. Okay. 13 A. And if hospitals are somewhere along that 14 continuum, they've achieved a portion of that impact. 15 Q. Okay. 16 So the mortality rating for ICU physician 17 staffing, am I right that it is based on a 2004 article 18 by Dr. Pronovost? 19 A. It's definitely by an article by Dr. Pronovost. 20 I couldn't speak to the year. 21 Q. Okay. Can we grab it? Page 328
1 Q. Okay. 2 A. Well, both in the ICU and hospital-wide. And 3 so that's the one process and structural method that we 4 use as part of the analysis. 5 Q. So looking at this chart again, just as a 6 grounding mechanism, it looks like to me that there are 7 19 outcome measures and 1 process measure. Is that 8 right? That's what I'm seeing, the 19 and the 1. 9 A. Correct. 10 Q. Okay. And the one is, as you said, ICU 11 physician staffing, correct? 12 A. Correct. 13 Q. Okay. And so basically you're taking the 14 incidence times the mortality and outputting the amount 15 of estimated deaths? 16 A. We are for the outcome measures. 17 Q. Okay. 18 A. What we're doing for ICU physician staffing is 19 we're going back to the historical literature that 20 established the standard to say that there is a 21 30 percent reduction in hospital-wide mortality between Page 327	1 A. I don't disagree with you that it was 2004. 2 Q. You don't know for sure? 3 A. I don't know for sure. 4 Q. I'll represent to you it's 2004. We may as 5 well pull it out. We have it if you want to take a 6 look. 7 A. Okay. 8 Q. My question is have you looked at the research 9 that's come sense to test that estimate? 10 A. So Leah Binder at The Leapfrog Group has asked 11 us to look at that. We have not found anything recently 12 that would be a better way for us to estimate that 13 value. 14 Q. Okay. 15 So I guess, one, have you heard of -- 16 there's an article by -- do you know who Deena Kelly 17 Costa is? 18 A. I do not. 19 Q. Okay. I guess I'll just mark it to see if 20 you've seen this article before. 21 MR. CRAIN: Let's mark it as Exhibit 30. Page 329

1 (Exhibit No. 30 was marked for 2 identification as of 9/25/2025.) 3 BY MR. CRAIN: 4 Q. Does this article look familiar to you at all? 5 A. I'm not familiar with it. 6 Q. Okay. 7 So the title is: The Association Between 8 Daytime Intensivist Physician Staffing and Mortality in 9 the Context of Other ICU Organizational Practices: A 10 Multicenter Cohort Study. 11 Do you see that? 12 A. Yes. 13 Q. Do any of the authors -- are they familiar to 14 you, Dr. Wallace, Dr. Kahn, and Dr. Costa? 15 A. I do not know any of them. 16 Q. Okay. 17 Do you know the journal here? 18 A. I am familiar with critical care medicine, yes. 19 Q. Reputable journal? 20 A. As far as I know. 21 Q. Okay. Page 330	1 individually to assess whether there is a relationship 2 or not a relationship, right. I think if we think about 3 -- through humankind, there's lots of studies that have 4 been done. One will show red wine is good for the 5 heart. The next one will show, oh, no, you should stay 6 away from alcohol, right. And over time we sort of 7 build a body of literature. 8 What an additional -- one of the strengths 9 of the Pronovost article, if I'm remembering it 10 correctly, is it was actually a meta analysis. So it 11 actually looked at 15 to 20 different studies and 12 synthesized those results. 13 So it's not to say that every study is 14 going to show a relationship, but one study doesn't 15 necessarily negate a wider body of literature. 16 BY MR. CRAIN: 17 Q. Okay. 18 This is dated 2015. Do you see that? 19 A. Correct. 20 Q. And you've not seen this article, right? 21 A. I have not seen this. Page 332
1 Now, I want to go down to Measurements and 2 Main Results, and there's a sentence just at the end 3 which seems to sort of give the bottom line starting 4 with "there." Do you see that? 5 A. Yes. 6 Q. "There was no association between daytime 7 intensivist physician staffing and in-hospital 8 mortality. After adjusting for interprofessional rounds 9 and protocols for mechanical ventilation, the effect of 10 daytime intensivist physician staffing remained 11 nonsignificant." 12 Do you see that? 13 A. Yes. 14 Q. I know you haven't read this article, but at 15 least based on the first page -- and feel free if you 16 want to flip through -- does this undermine the 17 assumptions that the white paper makes with respect to 18 IPS and mortality? 19 MS. LAWSON: Object to form. 20 THE WITNESS: So I think in research there 21 is -- I don't think one can look at one study Page 331	1 Q. Okay. Is it something that you think you 2 should review in the next iteration or no? 3 A. I would be happy to review it and see what we 4 come to in terms of a conclusion. 5 Q. Okay. Okay. 6 So I want to go back to -- I want to just 7 go back to the chart again. 8 A. Yeah. Okay. 9 MS. LAWSON: Is that Exhibit 29? 10 MR. CRAIN: Yeah, 29, the email and the invite. 11 BY MR. CRAIN: 12 Q. Now, I want to just look at the differences in 13 mortality, right. So when you look at -- just take -- 14 starting with "D" and "F," right, at the bottom. Do you 15 see that? 16 A. Yes. 17 Q. It says, focusing primarily -- focusing on the 18 outcome measures. It says 1.46 in 2019. Do you see 19 that? 20 A. For "D" and "F," correct. 21 Q. Correct. Page 333

1 And is that, just to make sure I understand 2 the numbers, is 1.46, that's 1.46 deaths? 3 A. Correct. 4 Q. Okay. 5 And then if you go down to "C," it's 1.40, 6 right? 7 A. Correct. 8 Q. To "B," it's 1.31, right? 9 A. Correct. 10 Q. And 1.22 for "A." Do you see that? 11 A. Correct. 12 Q. Is the difference just for outcome measures 13 between 1.22 for an "A" and 1.46 statistically 14 significant in your view? 15 A. I would need to do a statistical test to 16 determine whether that there is a statistical difference 17 there. 18 Q. Okay. It's not twice, right? There are not 19 two times as many deaths between -- in that comparison, 20 right? 21 A. Not in just comparing the outcome measures. Page 334	1 twice, both in the outcome measures and the ICU 2 physician staffing. 3 So the methodological decision was to cut 4 the outcome measures in half. So we take each value and 5 divide by two so that we aren't double counting between 6 the two. 7 Q. And what was that based on? That's the 8 50 percent number? 9 A. Yeah, the 50 percent. That was just an 10 educated guess. 11 Q. Okay. Is it based on a study or is it based on 12 -- 13 A. No. It was just sort of a collective wisdom of 14 people. 15 Q. The authors or other people? 16 A. Other people as well. 17 Q. Who were the other people? 18 A. So the initial work for this actually came out 19 of some work that The Leapfrog Group had done, Leah 20 Binder, with another consultant. 21 Q. Okay. Who is that? Page 336
1 Q. Just comparing the outcome measures. 2 A. Correct. 3 Q. With respect to the ICU physician staffing, 4 fair to say the difference is more substantial, right? 5 A. Correct. 6 Q. Is the -- would you agree that the analysis 7 places -- like the number of deaths in the analysis is 8 significantly weighted to the ICU physician staffing 9 metric? 10 A. Yes. Although, there is a methodological 11 clarification that I should make because this will help 12 explain it to some degree. We actually take the number 13 of outcome measures, or we take the lives lost in the 14 outcome measures and actually divide that by two. 15 Q. Okay. 16 A. And the reason we do that is because we 17 recognize that there are some deaths that are probably 18 occurring in the ICU that are a result of not good care, 19 right. 20 So you may have developed a central line 21 blood stream infection. We didn't want to count that Page 335	1 A. I don't remember his name. 2 Q. Okay. 3 A. I can sort of picture him, but I don't remember 4 the name. And so it was out of that that the decision 5 was made to multiply it by 50 percent. 6 Q. Okay. 7 So if we look at the bottom, you're saying 8 that "D" and "F," the actual number is closer to 3 than 9 1.46? 10 A. Correct. 11 Q. Okay. Got it. 12 Okay. So then that's still I guess -- my 13 question still remains. The biggest difference, at 14 least it appears to me, between a "D" and "F" hospital 15 and an "A" hospital is the physician staffing mortality. 16 Is that right? 17 A. That is -- from what we're able to quantify in 18 terms of harm, that is where the biggest differences 19 are. 20 Q. Okay. And the mortality rating for that is 21 based on the Pronovost article, right? Page 337

1 A. Correct. 2 Q. Okay. 3 And then so let's go to another document. 4 I want to look primarily -- let's look at the chart, 5 actually, on the right side, so the 2025 metric. 6 A. Okay. 7 Q. Now, in all -- this is the first time, at least 8 for IPS and I think everywhere else, there's a slash. 9 Do you see that? 10 A. Yes. 11 Q. What does the slash reflect? 12 A. The slash is reflecting if we -- the value to 13 the right of the slash would be if we were to remove the 14 imputed scores for IPS. 15 Q. Yeah. And say more about that. You mean 16 remove the mortality for nonparticipating hospitals? 17 A. No. We would remove -- if a hospital had an 18 IPS score that was imputed, we would remove that from 19 the calculation. 20 Q. Okay. And that's the right side? 21 A. That is the right side. Page 338	1 pretty different. 2 BY MR. CRAIN: 3 Q. Fair enough. 4 If you go to "D" and "F," the difference is 5 7.98 on the left and 3.89 on the right. Do you see 6 that? 7 A. Correct. 8 Q. And if you go to "C," 4.92 and 2.52, right? 9 A. Correct. 10 Q. Now, the differences get smaller. So "B," it's 11 2.12 and 2.01, right? 12 A. Correct. 13 Q. And then "A," it's 1.53 versus 1.5, right? 14 A. Correct. 15 Q. And if I recall correctly, there were only two 16 hospitals that got an "A" with imputed scores, right? 17 A. Correct. 18 Q. So that -- did that explain why that's so close 19 together? Correct? 20 A. I would need to go back and look at the math, 21 but your statement about that there's two hospitals is Page 340
1 Q. So the left side reflects -- tell me if this is 2 wrong. I'm just trying to understand. The left side of 3 the slash reflects the hospitals that are participating 4 with IPS scores based on their actual performance data, 5 and the right side includes nonparticipating hospitals 6 with the limited achievement assignment? 7 A. So the left-hand side would be the scores for 8 all hospitals that received a safety grade, including 9 those that were imputed. 10 Q. Okay. 11 A. The right-hand side would be just hospitals 12 that had a score reported through the Leapfrog Hospital 13 Survey. 14 Q. And that's the 80 percent of inpatient beds 15 we've been talking about? 16 A. Correct. 17 Q. Okay. Got it. 18 So the numbers are pretty different, right, 19 at least in certain categories? 20 MS. LAWSON: Object to form. Go ahead. 21 THE WITNESS: I don't know how you would define Page 339	1 correct. 2 Q. Yeah. Okay. 3 Do you have a theory as to why the numbers 4 are so different left and right, at least for "D" and 5 "F" and "C"? 6 A. The difference between the two values is the 7 inclusion or exclusion of the imputed values. 8 Q. Is the number on the left or the right more 9 likely an accurate estimate? 10 MS. LAWSON: Object to form. 11 BY MR. CRAIN: 12 Q. Let me step back. You're trying to estimate 13 mortality of "A," "B," "C," "D," and "F" hospitals, 14 right? 15 A. Correct. 16 Q. You want to be accurate in the estimate as best 17 you can? 18 A. Yes, recognizing it's an estimate. 19 Q. Yes. So I'm going to posit that 4.92 versus 20 2.52 for the "C" hospitals, pretty different number of 21 deaths. Is that fair to say or you disagree? I mean, Page 341

1 it's almost double, right, on the left side. 2 A. That last part is true. It is almost double. 3 Q. So we'll just go with numerical. It's almost 4 double. 5 What is a more accurate estimate of the 6 mortality of "C" hospitals as a result of ICU physician 7 staffing? Is it 4.92 or is it 2.52? 8 A. I will say both are incorrect. 9 Q. Okay. I'm eager to hear why. 10 A. Well, one includes imputed values, which, by 11 definition, are not exact values. 12 Q. Okay. 13 A. The other one is excluding hospitals that we 14 don't have any data for. So there is some lives lost 15 attached to them. So both of them are actually -- both 16 of them are estimates in two different scenarios. 17 Q. You said a moment ago both of them are 18 incorrect. 19 A. Okay. Both of them are incorrect. 20 Q. Okay. 21 A. It's an estimate, so unless you hit it right on Page 342	1 can read it all, but the tenor seems to be there's a 2 discussion about whether you include the imputed scores 3 in the mortality or not, right? 4 MS. LAWSON: Take a minute and read the email. 5 MR. CRAIN: Yeah, take a second. 6 (Witness peruses document.) 7 THE WITNESS: So, yeah, this is -- the tenor is 8 about the table that we just went through. 9 BY MR. CRAIN: 10 Q. Whether to include the imputed scores or not, 11 right? 12 A. Correct. 13 Q. Okay. 14 And you at the end say, "I would vote for 15 keeping the imputed IPS scores in place. My guess is 16 the averages with the imputed scores are closer to the 17 truth than averages excluding the imputed scores." 18 Right? 19 A. Correct. 20 Q. So what's that based on? 21 A. Well, I think I used the word "guess," so I Page 344
1 the dot, an estimate is going to be incorrect. 2 Q. Which one is more incorrect? 3 A. I don't know how to judge that. 4 Q. Okay. So you don't know one way or another? 5 A. I don't know one way or another. 6 Q. Okay. 7 MR. CRAIN: So I want to take a look at a few 8 documents here. Give me one second. Oh, no wonder I 9 can't find it. It's actually in this document. Iason 10 knows them better than I do. 11 THE WITNESS: Which one? 12 BY MR. CRAIN: 13 Q. So this is Exhibit 30, what we were just 14 looking at -- oh, sorry, 29 I mean was the chart. 15 MS. LAWSON: 29. 16 MR. CRAIN: Yeah, Exhibit 29 with the chart. 17 BY MR. CRAIN: 18 Q. Okay. And this is from you to Ms. Campione, 19 Ms. Danforth, and Ms. Bailey, right? 20 A. Correct. 21 Q. Okay. So you send an email, and the tenor -- I Page 343	1 will qualify that. I guess it's somewhat informed by 2 that, you know, hospitals that choose not to disclose 3 likely may not be meeting Leapfrog's standards. Because 4 if they were meeting them, they would be more likely to 5 disclose them. So it was probably with that assumption. 6 Q. So that -- so okay. But it's multiple levels 7 of assumptions, right? I can build it out to see what I 8 mean. 9 So assumption one is that hospitals that 10 are not reporting are not meeting Leapfrog's standards, 11 right? 12 A. That is the assumption I just stated. 13 Q. And assumption two is that the failure to meet 14 Leapfrog's standards yields a higher mortality rate? 15 A. Correct, based on the literature. 16 Q. Okay. So it's an assumption, but you're saying 17 it's backed by literature? 18 A. Correct. 19 Q. And, again, meaning the Pronovost article? 20 A. Correct. 21 Q. Okay. So your guess is based on those two Page 345

1 assumptions? 2 A. Correct. 3 Q. Okay. 4 Do you have any understanding of where 5 Leapfrog is landing on this question, whether to include 6 the imputed or nonimputed? 7 A. I do not know. 8 Q. And just going back to the chart, I want to 9 just look at the numbers. Just go right to the top. 10 You see lives lost, lives saved? Do you see that? 11 A. Yes. 12 Q. Okay. And it's -- the numbers, again, you 13 know, are -- so I'll be factual about it. Lives lost, 14 if you exclude the imputed hospitals, it's about 30,000 15 fewer, right? 16 A. Correct. 17 Q. Okay. And if you exclude the imputed values, 18 it's also about 30,000 fewer on lives saved, right? 19 A. Correct. 20 Q. Okay. And so your view is that it is -- your 21 best guess is that those 30,000 are -- bear some Page 346	1 MR. CRAIN: Yeah, I think that's right. 2 BY MR. CRAIN: 3 Q. Page 2 and it's under the second -- we talked 4 about -- remember this question? "Why should people 5 worry about a hospital's patient safety?" Do you 6 remember that? 7 A. Yes. 8 Q. And if you go to the end of that paragraph: 9 "All hospitals are not the same. Some hospitals are 10 much safer than others. John Hopkins Medicine 11 researchers estimate that patients are twice as likely 12 to die of a preventable problem at a "C," "D," or "F" 13 hospital than an "A" hospital, and over 50,000 lives 14 would be saved if all hospitals performed the way "A" 15 hospitals did." 16 Do you see that? 17 A. Yes. 18 Q. Okay. Now, first of all, the 50,000 lives, 19 based on this chart, going back to Exhibit 29, refers to 20 2019, right? 21 A. Correct. Page 348
1 relation -- have some accuracy to them -- strike that. 2 That was a bad question. I know you were going to 3 object. And it was fair. 4 So let me ask another question then. 5 You said the numbers bear out the twice as 6 likely mortality point. Do you remember earlier in the 7 day we talked about Leapfrog says on its website that 8 Johns Hopkins researchers say you're two times likely to 9 die if you go to a "D" or an "F" hospital, as opposed to 10 an "A"? 11 A. I remember that conversation, but I don't 12 remember in what context. 13 Q. We were looking at the website, which we can 14 look at if someone will tell me the exhibit number, and 15 we talked about -- so maybe we can get that document out 16 just to ground us. I think it's exhibit -- 17 MR. TOGIAS: It was tab 65. 18 MR. CRAIN: Sixty-five. So that's Exhibit 9. 19 MR. TOGIAS: Frequently asked questions. 20 MR. CRAIN: Yeah. 21 MS. LAWSON: It's on page 2. Page 347	1 Q. Okay. 2 Your 2025 numbers, I understand, are in 3 draft form, but it would either be 49,000 or 20,000 4 depending on the imputed scores, right? 5 A. Correct. 6 Q. Okay. 7 Now, this Johns Hopkins Medicine 8 researchers estimate that patients are twice as likely 9 to die of a preventable problem at a "C," "D," or "F" 10 hospital than an "A" hospital, do you see that? 11 A. Yes. 12 Q. Now, that -- is that based on the 2019 numbers? 13 A. Yes. 14 Q. Okay. 15 Now, you had said that that was also true 16 as for 2025, albeit in draft form. Do you recall that 17 testimony? 18 A. I think I mentioned that we were seeing 19 probably similar trends. 20 Q. Okay. Is that reflected here? Can you explain 21 to me just on this chart how that works? Page 349

1 A. Yeah. So I think Leapfrog took a little 2 liberty with the "twice," but if you take the 87 and the 3 91.8 -- 4 Q. Where are you on that? 5 A. Sorry. 2019. 6 Q. Yep. Yep. I see that. 7 A. Those are close to 100 percent, or one could 8 make the argument, so that would be twice as likely -- 9 Q. From 2019? 10 A. From 2019. 11 Q. Okay. 12 And what about today? 13 A. And then today the numbers are actually higher. 14 I was just sort of hedging a little bit about what that 15 would be because they range anywhere between 16 46.6 percent and 353.6. 17 Q. Okay. So that's -- it's different whether you 18 include the imputed or not, right? 19 A. Correct. 20 Now, as I look at this further, what I 21 think I would argue is that the number of lives saved Page 350	1 A. It's fewer lives lost. So we've seen 2 improvements. We've gone from 161,000 lives lost due to 3 medical error to 134,000. 4 Q. It's fewer lives lost than 2019 but more lives 5 lost than without the imputed values? 6 A. Correct. 7 Q. Okay. 8 And then you're saying -- so how does that 9 equate now to the twice as likely to die for "C," "D," 10 and "F"? Can you walk me through that? 11 A. Yeah, yeah. So that's what I was -- if you 12 look at the -- 13 Q. The percent. 14 A. -- 2019 column -- 15 Q. Yes, that I'm clear on. 16 A. The "C" versus "A," "D" and "F" versus "A," 17 those are somewhere in the 100 percent range. Like I 18 said, I think Leapfrog took a little liberty there. 19 Q. Yeah. 20 But 2025? 21 A. For 2025, if we exclude -- if we include the Page 352
1 when we take out the imputed scores, the 20,252, is such 2 a significant drop-off. I don't know if that's -- 3 that's where I had caution about why I thought that 4 seemed questionable to exclude the imputed scores. 5 Same with the 105. To be more clear, the 6 105 is quite a drop, and I don't think we've seen that 7 level of improvement in patient safety in the country, 8 and so I think that would oversell our efforts in 9 patient safety. 10 Q. Is this an annual number? 11 A. That would be an annual number. 12 Q. Okay. 13 A. Correct. 14 Q. So you're saying it would surprise you if it 15 was only 105,000 patients dying, as opposed to 161,000? 16 A. Correct. 17 Q. Okay. Got it. Okay. 18 A. So the 134 on the face felt like more of a 19 reasonable level of improvement that we would have seen. 20 Q. Because it's fewer lives -- it's more lives 21 lost? Page 351	1 imputed scores, it's actually 133 to 353,000. We would 2 have to do some sort of blended average of those since 3 it says "C," "D," and "F." 4 Q. Yeah. And if you don't include it, it's 46 to 5 204? 6 A. Correct. 7 Q. Okay. And as you said, blended average because 8 there are -- I think there are more "C" hospitals -- 9 A. There's a lot more "C" hospitals, right. 10 Q. Okay. Got it. 11 So maybe you just don't know today, but do 12 you have an estimate today as to whether it's really 13 accurate that you're twice as likely to die if you go to 14 a "C," "D," or "F" hospital as compared to an "A" 15 hospital? 16 A. Well, given my statement in the email about 17 Leapfrog, that I feel like the numbers with the imputed 18 scores are more reflective of the actual reality, that 19 would be something greater than twice. It would be 20 probably two and a half times. 21 Q. So -- Page 353

1 A. So what we're seeing nationally is bigger gaps 2 between "A" hospitals and hospitals at the back of the 3 pack. 4 Q. And what's driving that in your view? 5 A. I believe it's -- I think hospitals have -- 6 some hospitals have chosen to really invest time, 7 resources, energy, have created more of a learning 8 health system. I think they have just prioritized 9 safety in ways that other hospitals have chosen not to. 10 Q. And when you say those hospitals, you're 11 talking about the ones that report or the ones that 12 don't report? 13 A. A combination. 14 Q. Okay. 15 Okay. And then I'm going to show you one 16 more document. 17 So if you actually keep that exhibit in 18 front of you, 29, do you see there's a document -- go to 19 the first page. 20 A. Of 29? 21 Q. Of 29, yeah. Page 354	1 version, yeah, 2025 version. 2 Q. And are you the author of this document? 3 A. Myself and the analyst together. 4 Q. Okay. Got it. 5 Okay. And this is a true and correct copy 6 of the Excel Spreadsheet we're talking about? 7 A. As far as from what I can see, yes. 8 Q. Yeah. And the two pages, right? 9 A. Yeah. 10 Q. Okay. 11 MR. CRAIN: Okay. Can we take five? Go off. 12 THE VIDEOGRAPHER: This marks the end of media 13 unit number seven. We're going off the record. The 14 time is 4:55 p.m. 15 (Whereupon a short break was had, after 16 which the proceedings continued as 17 follows:) 18 (Exhibit No. 32 was marked for 19 identification as of 9/25/2025.) 20 THE VIDEOGRAPHER: This marks the beginning of 21 media unit number eight. We're going back on the Page 356
1 A. Okay. 2 Q. The email that we've been talking about with 3 the chart. 4 A. Yeah. 5 Q. Do you see there's an attachment that says 6 Lives Lost, Lives Saved Calculator 250515? 7 A. Yeah. 8 Q. Okay. 9 MR. CRAIN: So I just want to mark this as 10 Exhibit 31. 11 (Exhibit No. 31 was marked for 12 identification as of 9/25/2025.) 13 BY MR. CRAIN: 14 Q. So this is an Excel Spreadsheet. Do you see 15 the document? 16 A. Yes, I do. 17 Q. Do you know what this document is? 18 A. Yeah. It's the excel file we use to calculate 19 the lives lost and lives saved. 20 Q. And is that the one attached to this email? 21 A. This is the 2025 -- actually, this is the '25 Page 355	1 record. The time is 5:07 p.m. 2 BY MR. CRAIN: 3 Q. All right. Thank you, Dr. Austin. We're in 4 the home stretch. 5 I've given you what's been marked as 6 Exhibit 32. Do you see it's an Armstrong-produced 7 Document, 14327? 8 A. Yes. 9 Q. Okay. And it's an email from Mr. Derk to you. 10 Do you see that? 11 A. Yes. 12 Q. And it's dated June 5th, 2019? 13 A. Yes. 14 Q. And it says, Subject: Lives Saved 15 Presentation. Do you see that? 16 A. Correct. 17 Q. And there's an attachment. Can you read that 18 attachment into the record? 19 A. Lives lost, Leapfrog partners 02190610.pptx 20 [sic.] 21 Q. And the rest of the document, is that the pptx Page 357

1 you just mentioned? 2 A. In reviewing it, I believe that is the case, 3 but there's nothing on here indicating the file name 4 so -- 5 Q. Fair enough. 6 If you look at the title, is says: Lives 7 Lost, Lives Saved: The Comparative Analysis. 8 Do you see that? 9 A. Yes. 10 Q. And it's dated June 10th, 2019? 11 A. Yes. 12 Q. Okay. 13 So to the best of your understanding, this 14 is the PowerPoint attached to the email? 15 A. Yes. 16 Q. And I'll also note Armstrong produced it 17 sequentially from 14327 and forward. 18 A. Yeah. The only thing that strikes me as a bit 19 odd is how the presentation is dated June 10th, 2019, 20 but he sent the email on June 5th, 2019. 21 Q. Could it have been a draft? Page 358	1 and accurate depiction of the email and the attachment? 2 A. No, there's no reason to believe that. 3 Q. Okay. 4 Do you remember anything about this 5 presentation at all? 6 A. I don't other than I think we were trying to 7 summarize the lives lost, lives saved analysis. 8 Q. Okay. So just flipping through, that's what 9 this PowerPoint does, it summarizes the methodology? 10 A. Yes. 11 Q. Okay. 12 And then I think you can set that one 13 aside. 14 And then just a question going back to the 15 2019 white paper. Was the 2019 white paper peer 16 reviewed? 17 A. It was not peer reviewed. 18 Q. Was the 2016 white paper peer reviewed? 19 A. The 2016 paper was reviewed by a couple of my 20 colleagues. 21 Q. Is that peer reviewed in the way that we talked Page 360
1 A. That's a possibility. 2 Q. Like for a future presentation? 3 A. Yeah. That makes sense. 4 Q. So flip through the PowerPoint and just -- you 5 know, does it look like a true and accurate depiction of 6 the PowerPoint presentation that either you or he 7 prepared? 8 A. Are you asking me to verify whether each slide 9 is accurate? 10 Q. No, no. Fair enough. Let me start over. 11 Do you recognize this PowerPoint 12 presentation? 13 A. I don't remember this PowerPoint presentation. 14 Q. Okay. Do you recall giving a presentation in 15 2019 on the lives lost, lives saved? 16 A. I don't remember that -- 17 Q. Okay. 18 A. -- but that's not to say I didn't do it. 19 Q. Okay. 20 Any reason to think this is not -- you 21 know, again, produced by Armstrong -- this is not a true Page 359	1 about earlier? 2 A. Peer reviewed in terms of journal articles is 3 usually the editors selecting who is going to review 4 your paper. This was me asking two colleagues who I 5 knew and trusted to look through it and provide input 6 and comments. 7 Q. So not peer reviewed in the academic sense? 8 A. Correct. 9 Q. Okay. 10 And 2019 was not peer reviewed in any 11 sense? 12 A. Correct, in the sense that it was an update 13 from 2016. So all we had done was update numbers. 14 Q. Is it right that Ms. Binder edited the white 15 paper in 2019? 16 A. It is possible that Ms. Binder provided some 17 edits to the white paper. 18 Q. Okay. 19 MR. CRAIN: With that, I will, pursuant to the 20 agreement of the parties, for division of time, pass the 21 witness and reserve the balance for recross. Page 361

1 MS. WOOD: You want to go off the record while 2 I get mic'd up? 3 MR. CRAIN: It's up to you. I'm happy to go 4 off. Yeah, that's fine. Let's go off. 5 THE VIDEOGRAPHER: This marks the end of media 6 unit number eight. We're going off the record. The 7 time is 5:11 p.m. 8 (Whereupon a short break was had, after 9 which the proceedings continued as 10 follows:) 11 THE VIDEOGRAPHER: This marks the beginning of 12 unit number nine. We're going back on the record. The 13 time is 5:13 p.m. 14 EXAMINATION 15 BY MS. WOOD: 16 Q. Dr. Austin, my name is Courtney Wood. I 17 represent the defendant, The Leapfrog Group, in this 18 matter. 19 I know you testified earlier that we had 20 met before previously when the subpoena came in. It's 21 good to see you again. Page 362	1 Q. My apologies because I'm not going to know what 2 page it's on but -- 3 A. That's fine. I actually know. It is actually 4 on page 6 and 7; 10, correct. 5 Q. Okay. Perfect. 6 And then is it fair to me -- for me to say 7 that those 10 outcome measures all come from CMS data? 8 A. For the five healthcare-associated infections, 9 the primary data source is the Leapfrog Hospital Survey, 10 and a secondary data source is the Centers for Medicare 11 & Medicaid Services. 12 Q. Correct. 13 And then for the process and structural 14 measures, there are 12 of those. Is that correct? 15 A. Correct. 16 Q. Okay. 17 And then are you aware that of those -- 18 well, let's strike that. 19 So the 12 structural and process measures 20 come from survey data. Is that correct? 21 A. The seven of them, the Leapfrog Hospital Survey Page 364
1 A. Good to see you as well. 2 Q. I don't have much to ask you today. However, I 3 have enjoyed listening to all of your testimony today, 4 and we appreciate you being here, so I just want to 5 thank you for that. 6 But to start, are you familiar with the 7 hospital grade calculator? 8 A. Yes, I am. 9 Q. Okay. And so is it fair to me -- fair for me 10 to say that there are 10 outcome measures that are 11 included on that grade calculator? 12 A. I couldn't speak to the current version of the 13 calculator. I have not seen it. 14 Q. Okay. But to your knowledge, are there 10 15 outcome measures that are used in the methodology 16 currently? 17 A. Can I refer to the -- 18 Q. Sure. Yeah. 19 A. Okay. 20 Q. Was that Exhibit 3? 21 A. I think it's Exhibit 3, yeah. Page 363	1 is the primary data source. For 5 out of the 12, the 2 Centers for Medicare & Medicaid Services is the primary 3 data source. 4 Q. Right. And then we call those HCAHPS. 5 A. Correct. 6 (Whereupon, the court reporter seeks 7 clarification, which colloquy will not be 8 captured on the written record.) 9 BY MS. WOOD: 10 Q. Okay. And so to your knowledge, if a hospital 11 does not respond to the Leapfrog survey, then it does 12 not receive a score for the safe practices 1, safe 13 practices 2, and then the nursing care hours per patient 14 day. We were talking about that earlier. Is that still 15 correct? 16 A. Correct. 17 Q. Okay. 18 And so then to your knowledge, when a 19 nonreporting hospital does not respond to the hospital 20 survey, then those weights are redistributed to the 21 other nine measures in that process and structural? Page 365

1 A. Correct. 2 Q. Okay. 3 MR. CRAIN: I'm just going to object to form. 4 BY MS. WOOD: 5 Q. Okay. And then of those nine measures, we had 6 just indicated that five of those are the HCAHPS and 7 then the other four are the imputed measures that we 8 were talking about earlier. Is that correct? 9 A. So of the 12, process and structural measures, 10 5 of them come from HCAHPS, which is a patient 11 experience survey that goes to patients. The other 12 seven, the Leapfrog Hospital Survey is the primary data 13 source. 14 As previously discussed, four of those are 15 imputed if the hospital doesn't respond to the survey 16 and three are not imputed. 17 Q. Right. Okay. 18 So what I'm trying to get at is when the 19 hospital doesn't respond -- so those three that we were 20 talking about, the safe practice 1, the safe practice 2, 21 and then the nursing, we take those out and then the Page 366	1 scores now play a bigger role in going into the Hospital 2 Safety Grade. Is that correct? 3 MS. LAWSON: Object to form. 4 MR. CRAIN: Objection. 5 MS. LAWSON: You can still answer. 6 THE WITNESS: If the hospital does not have 7 data for those three measures, safe practice 1, safe 8 practice 2, nursing workforce, or nursing hours per 9 patient day, more weight is put on the remaining nine 10 measures and that would include the five HCAHPS 11 measures. 12 BY MS. WOOD: 13 Q. Right. 14 So is it fair to say then that if a 15 hospital had poor HCAHPS scores, then those would be 16 weighed heavier and could have a greater impact on the 17 Hospital Safety Grade? 18 MR. CRAIN: Objection to form. 19 THE WITNESS: So independent of the hospital's 20 performance, more weight would be put on those nine 21 measures. So I guess I'm just clarifying that whether Page 368
1 weights are redistributed on those other nine, which are 2 the five HCAHPS and then the four imputed measures. Is 3 that correct? 4 MR. CRAIN: Objection to form. I just want to 5 lodge a standing objection to the leading, and then I 6 won't interrupt. But is it okay to stipulate to that? 7 MS. WOOD: Sure. 8 BY MS. WOOD: 9 Q. Is that your understanding? 10 A. Yes. 11 Q. Okay. 12 And would you agree with me when I say -- 13 if I made the assertion that if a hospital performed 14 poorly on their HCAHPS scores, then those measures now 15 are getting greater impact on the overall grade? 16 MS. LAWSON: Object to form. 17 BY MS. WOOD: 18 Q. Yeah, let me rephrase it. 19 So since the weights are now a little bit 20 heavier on those HCAHPS scores and the four imputed 21 scores, it would be arguable that those five HCAHPS Page 367	1 they're a good performer or poor performer, more weight 2 is going to be put on those. 3 BY MS. WOOD: 4 Q. Understood. And I would agree with that. 5 And do you have any opinion on how 6 significant that impact can be, whether, you know, say 7 if you're a great hospital and you have great HCAHPS 8 scores, and say you have bad -- and then you get the 9 imputed score because you're a nonresponding hospital, 10 do you have any opinion on what that impact might look 11 like on the Hospital Safety Grade? 12 MR. CRAIN: Object to form. 13 MS. LAWSON: Object to form. 14 THE WITNESS: So the -- I mean, one could test 15 out different scenarios of that question, right. So one 16 could -- the hospital may do really well on certain 17 measures, may not do well on others. There's not 18 necessarily universal, like, just because you're doing 19 well on one HCAHPS, that you're doing well on all 20 HCAHPS. 21 So one could sort of empirically test Page 369

1 different what-if scenarios, but I don't know if there's 2 a universal answer to your question. 3 BY MS. WOOD: 4 Q. Okay. 5 And so would it be true that if a hospital 6 was performing well on those five HCAHPS scores and then 7 still got those low imputed scores, that maybe those 8 five HCAHPS scores would actually -- let me rephrase 9 that. 10 So if the five HCAHPS scores were really 11 great scores and then you got those four imputed scores, 12 would it be fair to say that maybe those four imputed 13 scores wouldn't really have an impact then on the 14 overall Hospital Safety Grade? 15 MR. CRAIN: Objection to form. 16 THE WITNESS: There would be a potential 17 scenario where if the hospital does well on the HCAHPS 18 scores and does well on the outcome measures, that they 19 could have a pretty good safety score and safety grade. 20 BY MS. WOOD: 21 Q. Okay. And then would that be applicable as Page 370	1 we needed to translate those into some sort of numerical 2 value. 3 And so we've used different approaches 4 through the years and for different measures for how to 5 assign those values. If we use hand hygiene as an 6 example, the assigned values are 100, 75, 50, and 25. 7 It was basically to give hospitals some numerical credit 8 for being in a performance category. 9 Q. And is it true that those numerical values on 10 the performance is used for both reporting and 11 nonreporting hospitals? 12 A. So the imputed values for those four measures 13 match what hospitals who report and get limited 14 achievement receive. 15 Q. Okay. 16 And do you ever recall speaking with 17 anybody, whether it's the expert panel or anybody at 18 Leapfrog, about considering imputing a zero for any of 19 those four measures rather than doing the limited 20 achievement, the considerable achievement? 21 A. I don't remember any explicit discussion about Page 372
1 well if there were poor scores for the HCAHPS? 2 A. Once again, it's -- the measures are not looked 3 at simply in isolation, right, because I think one would 4 also need to look at the outcome measures. So just -- 5 it needs to be a slightly more holistic view of 6 performance. 7 Q. Okay. 8 And then we were talking about earlier how 9 there is never a zero that is imputed for any of those 10 four measures. Is that correct? 11 A. To the best of my recollection, that is 12 correct. 13 Q. Okay. And do you know why that is? 14 A. So we -- for the Leapfrog Hospital Survey 15 measures, we did have to come up with a way to assign a 16 numerical value to the performance categories, right. 17 So in the Leapfrog Hospital Survey, for those four 18 imputed measures hospitals get reported out as achieved 19 the standard, considerable achievement, some 20 achievement, and limited achievement. But for purposes 21 of incorporating those into the Hospital Safety Grade, Page 371	1 zero; although, it's not to say that that hasn't come up 2 as a potential option. 3 Q. Okay. 4 And I want to look at Exhibit 27 again, and 5 this is the -- I think you had said earlier that these 6 were actually your notes from this expert panel meeting. 7 Was that right? 8 A. These were a set of notes. 9 Q. Okay. Because it just had said agenda at the 10 top, but then I think you had said that these were notes 11 following -- 12 A. These are notes. I don't -- your question was 13 are these my notes. I don't know if they were my notes 14 or if these were notes prepared by someone else. 15 Q. Oh, okay. That's fair. But these would have 16 been notes following that meeting on this day? 17 A. Correct. 18 Q. And then if we can flip to that second page and 19 number three, and it's the last bullet point under 20 number three. It says: "The panel wondered what the 21 distributions would look like if Leapfrog assigned a Page 373

1 score of zero or lowest score possible for the missing 2 elements. Matt and Jordan will look into this following 3 the meeting." 4 Does that refresh your recollection in any 5 way on whether you or Jordan looked into that? 6 A. I don't remember what scenarios we actually ran 7 as a result of that meeting. It's possible that we -- I 8 don't remember. We could have just ran the lowest 9 possible scores. I don't know if we ran zero. I would 10 have to be refreshed on that. 11 Q. Yeah. That's okay. 12 And then do you remember anything else 13 regarding -- any other discussions during this meeting 14 about imputing zeros for those imputed measures? 15 A. Other than what's in the notes -- 16 Q. Okay. 17 A. -- that the panel discussed that as a potential 18 scenario. 19 Q. Okay. 20 And then even after seeing this bullet 21 point, you don't recall speaking to anybody else on the Page 374	1 BY MS. WOOD: 2 Q. Okay. And so then we were -- I was going to 3 use the handwashing as an example as well. So it's your 4 understanding that 15 is the imputed score for limited 5 achievement for handwashing? 6 A. Let me refer to Exhibit No. 3. 7 Q. Sure. No problem. 8 A. So slide 16 hand hygiene. Was that your -- 9 Q. Yep. 10 A. Fifteen is the -- 11 Q. Limited? 12 A. -- yep, limited achievement. 13 Q. Perfect. Thank you. 14 And then we were looking at Exhibit 3 again 15 for that, page 16. Hand hygiene, limited achievement, 16 the corresponding measure score is 15. 17 And so I think what you had just testified, 18 that that is both for nonreporting and reporting 19 hospitals, correct? 20 A. That is the score that's assigned to 21 nonreporting hospitals as well as reporting hospitals Page 376
1 expert panel about this? 2 A. I don't remember. 3 Q. Do you recall if you ever spoke with Arjun 4 about this? 5 MR. CRAIN: Objection to form. 6 THE WITNESS: I don't remember if I spoke to 7 Arjun in particular about this topic. 8 BY MS. WOOD: 9 Q. Okay. 10 And usually, after following expert panel 11 meetings, do you ever reach out to some of the panelists 12 to discuss bullet points like this independently? 13 A. Yeah, we do. 14 Q. Okay. So it wouldn't be weird if you had 15 spoken with Arjun, but you just don't recall today? 16 That's something that you might do? 17 A. Correct. 18 Q. Okay. In addition to other panel members as 19 well. Arjun is just an example. 20 A. Correct. 21 MR. CRAIN: Objection to form. Page 375	1 who failed to meet the some achievement criteria. 2 Q. Right. 3 And so would you agree with me that 4 nonreporting hospitals are actually still receiving a 5 benefit by reviewing a score -- receiving a score that 6 is based on responding hospitals? 7 MS. LAWSON: Object to form. 8 MR. CRAIN: Object to form. 9 THE WITNESS: They are receiving a score -- can 10 you maybe explain more about when you say benefit? 11 BY MS. WOOD: 12 Q. Sure. 13 So if I'm a reporting hospital and I meet 14 the criteria for limited achievement, I get a 15 15 imputed. Is that correct? 16 A. Repeat that one more time. 17 Q. Sure. 18 So a hospital that responds to the survey 19 and they are filling out the hand hygiene portion of the 20 survey and based on the criteria they receive a 15 and 21 they get the limited achievement? Page 377

1 A. If the hospital doesn't meet the criteria for a 2 higher performance category -- 3 Q. Correct. 4 A. -- they will get limited achievement. 5 Q. Right. 6 But then for the nonresponding hospitals, 7 we don't necessarily know what their hand hygiene 8 policies may be -- or I think earlier we were talking 9 about the hand sanitizer. You had mentioned that there 10 were several different criteria, correct? 11 A. Correct. 12 Q. And so would you say to me -- or would you 13 agree with me when I say that assigning a nonresponding 14 hospital the same score for limited achievement as a 15 responding hospital is giving the nonresponding hospital 16 a benefit? 17 MR. CRAIN: Objection to form. 18 MS. LAWSON: Object to form also. 19 THE WITNESS: I think that's a little bit in 20 the eye of the beholder. Is it better than zero? Yes. 21 Is it as good as 50? No. Page 378	1 quickly, and I will have you -- I'm sorry. I'll wait 2 until you're there. And then it's like this webpage. 3 Yes. 4 Okay. And can you flip to the second page 5 that we were talking about earlier. And then you see 6 the asterisk next to the number 15, and it says "This 7 Hospital's Score"? 8 A. Yes. 9 Q. And you would agree with me that that's the 10 limited achievement score for handwashing, correct? 11 A. That 15 is the same value that's assigned, yes, 12 to hospitals that receive limited achievement. 13 Q. Okay. 14 And then right next to it on the right 15 there it says "handwashing." So this would indicate 16 that this hospital, Delray Medical Center, received a 15 17 on the handwashing measure? 18 A. Yes. 19 Q. Okay. 20 And then I know earlier we were talking 21 about the asterisk next to the number 15 indicates to Page 380
1 BY MS. WOOD: 2 Q. Right. 3 A. So I don't know how to really answer that. 4 Q. Okay. So I guess I can ask it another way. 5 So if Leapfrog is not imputing a zero, 6 rather, they're imputing the 15, is Leapfrog making an 7 assumption that the hospitals who are not reporting are 8 actually performing to some extent rather than not 9 performing at all? 10 MR. CRAIN: Objection to form. 11 THE WITNESS: So Leapfrog in that situation is 12 giving nonreporting hospitals an equivalent score to 13 hospitals that have not met the criteria for some 14 achievement, and that can be a range, right. That can 15 be from a hospital that barely missed some achievement 16 to a hospital who has done nothing. 17 So there is a range of hospitals that are 18 getting the limited achievement based on responding. 19 BY MS. WOOD: 20 Q. Understood. 21 And now I want to look at Exhibit 19 Page 379	1 the reader to go down to the end of the webpage there to 2 that disclosure. 3 A. Yes. 4 Q. Okay. And that disclosure says: "The hospital 5 declined to report their performance on this measure, so 6 a score was assigned to reflect the lack of information 7 available." Is that right? 8 A. Yes. 9 Q. Okay. 10 And I think earlier we were talking about 11 the "how," and I believe the question that you were 12 asked was does this webpage show how the score was 13 assigned. Do you recall being asked that question? 14 A. Yes. 15 Q. Okay. And would you agree with me that when it 16 says, so a score was assigned to reflect the lack of 17 information available, that that does indicate the how 18 here? 19 MR. CRAIN: Objection to form. 20 THE WITNESS: So I personally would agree with 21 that. I think the opposing counsel saw that Page 381

1 differently. 2 BY MS. WOOD: 3 Q. That's fair. I would agree with you on that 4 one. 5 So let's take it one step further. So if 6 we go back up to where the asterisk is linked to under 7 the hospital safety score 15 asterisk, and then do you 8 see right below that it says best hospital's score 100? 9 A. Yes. 10 Q. And then right below that it says average 11 hospital's score 74.40? 12 A. Yes. 13 Q. And then right below that it says worst 14 hospital's score 15? 15 A. Yes. 16 Q. Okay. 17 And so would you agree with me now, looking 18 at it from this perspective, considering those four 19 hospital scores in conjunction with the asterisk and the 20 disclosure at the bottom, that that shows how the scores 21 are assigned for this handwashing measure? Page 382	1 that matches at the bottom the worst hospital's score 2 15? It just doesn't include the asterisk? 3 A. Correct. 4 Q. Okay. 5 And I think earlier you may have testified 6 about whether or not the imputation model and the 7 current methodology penalizes hospitals. Do you 8 remember testifying about that? 9 A. We had a lot of conversation about imputation 10 today, so I would need to be refreshed on what -- 11 Q. Sure. 12 A. Yeah, more detail might be needed there. 13 Q. Sure. 14 In your view, when Leapfrog was considering 15 the Fall 2024 methodology change, was the intent or the 16 purpose to change this imputation model to penalize 17 hospitals? 18 A. The goal was not to assess a penalty. The 19 goals were to improve the accuracy of the data and to 20 incentivize -- as a sub goal, incentivize survey 21 participation. Page 384
1 MS. LAWSON: Object to form. 2 MR. CRAIN: Object to form. 3 THE WITNESS: I personally don't think that the 4 display of the other three scores, the best hospital 5 average and worst, helps nor hurts the explanation of 6 how that 15 was assigned. 7 BY MS. WOOD: 8 Q. Okay. But do you think it makes it easier for 9 the reader of this webpage to look and see that if 15 is 10 this hospital's score and 15 is the worst hospital's 11 score, they can come to the conclusion that this 12 hospital is being assigned the worst hospital's score? 13 MS. LAWSON: Object to form. 14 MR. CRAIN: Objection to form. 15 THE WITNESS: I don't want to speculate what 16 people who come to the website, how they understand the 17 material. 18 BY MS. WOOD: 19 Q. That's fair. 20 But you would agree with me that at the 21 top, when it says this hospital's score 15 asterisk, Page 383	1 Q. Okay. 2 And then would it be fair to say that, 3 rather, the result then of the Fall 2024 methodology 4 change may be that hospitals feel penalized by receiving 5 those limited achievement scores? 6 MS. LAWSON: Object to form. 7 MR. CRAIN: Object to form. 8 THE WITNESS: I can't speak to how hospitals 9 feel. 10 BY MS. WOOD: 11 Q. Okay. 12 I think you said earlier that the 13 penalization is a byproduct of the imputation score. Do 14 you remember? And I'm not trying to mischaracterize 15 your testimony in any way. I just remember you 16 referencing it as being a byproduct. 17 A. Yeah, there may be a feeling of, yes, a 18 penalty. 19 Q. Okay. But that wasn't the intent or the 20 purpose of Leapfrog, to your knowledge? 21 A. That was not the stated intent. Page 385

1 Q. Okay. 2 Do you believe that hospitals should report 3 to the Leapfrog Hospital Survey? 4 A. I do. 5 Q. And why do you believe that? 6 A. Because I am a strong believer in transparency. 7 I think in transparency we create a better healthcare 8 system where we understand where our successes are, 9 where our failures are, and that those who are using the 10 healthcare system and those who are paying for the 11 healthcare system know how it's operated. 12 Q. And I know you have testified earlier that 13 sometimes you speak with hospitals in various 14 capacities. Have you ever heard any hospitals refer to 15 the Leapfrog Hospital Survey as kind of a benchmark or 16 an outline to improve their patient safety? 17 A. I -- can you repeat the question? 18 Q. Sure. Yeah. 19 I just know earlier you had testified that 20 sometimes you speak to hospitals in different 21 capacities. So the question I'm about to ask you, I'm Page 386	1 over that one. 2 BY MS. WOOD: 3 Q. Based on all your experience and working with 4 Leapfrog, it's been over a decade, almost two decades, 5 would you say that you understand what Leapfrog's 6 mission is? 7 A. Yes. 8 Q. And can you explain that to me in your own 9 words? 10 A. To me, it would be to drive improvements in the 11 quality of our healthcare system primarily using 12 transparency as the mechanism to do that. 13 Q. And do you believe that that's always been 14 Leapfrog's mission? 15 A. Yes. 16 Q. And do you believe that continues to be 17 Leapfrog's mission today? 18 A. Yes. 19 Q. Okay. 20 And so in your experience as a researcher 21 and as a principal faculty member at the Armstrong Page 388
1 not insinuating that you have heard this before. I'm 2 asking if anybody at a hospital has discussed this with 3 you before. 4 But have any of the hospitals told you 5 that -- sorry. Now I'm forgetting my own question -- 6 oh, that the Leapfrog Hospital Survey helps them put in 7 benchmarks and outline how they can improve on patient 8 safety measures? 9 A. So for purposes of the Leapfrog Hospital 10 Survey, I have had at least one conversation with a 11 hospital who does see the survey as an opportunity for 12 benchmarking their performance relative to others. 13 Q. And do you believe that to be true? 14 A. I believe it is a source of information for 15 hospitals on a very broad quality improvement journey. 16 Q. And based on your experience in working with 17 Leapfrog, would you understand that you -- or would you 18 testify to me that you understand the mission of 19 Leapfrog? 20 MR. CRAIN: Objection to form. 21 MS. WOOD: Yeah, I can fix that. I tripped Page 387	1 Institute for patient safety and quality, do you believe 2 that Leapfrog's Hospital Safety Grade provides a benefit 3 to consumers? 4 A. I think sharing information in summary form is 5 what patients and consumers are seeking. So whether 6 that be a star rating, a letter grade, the research is 7 clear that that is what they find helpful for their 8 decision-making. 9 Q. Okay. 10 And have you done any research on whether 11 or not the patients benefit from those star ratings or 12 the Hospital Safety Grade? 13 A. No, I have not done any research on that. 14 Q. Have you read any research or peer reviewed 15 articles on that? 16 A. I have read some research on consumers' use of 17 publicly available quality and safety information. I 18 can't say it's the most recent. There may be more 19 recent information out there. 20 Q. And do you believe that consumers would lose 21 any sort of benefit if hospitals were not graded through Page 389

1 the Hospital Safety Grade? 2 MR. CRAIN: Objection to form. 3 THE WITNESS: Can you repeat the question one 4 time? 5 BY MS. WOOD: 6 Q. Sure. 7 If Leapfrog stopped grading hospitals, do 8 you think that that would have any negative impact on 9 consumers? 10 A. So the greatest benefit that's been noted for 11 public reporting of quality and safety information has 12 actually been the hospital's use of that information to 13 drive improvements within their own healthcare system. 14 -- hospital or healthcare system. 15 I don't want to be the bottom performer, 16 right, so I'm going to do what I need to do to get out 17 of the bottom. So in a sense, that improvement in 18 quality and safety has universal benefit, right. 19 Every patient that comes to that hospital 20 has some benefit of the hospital working to improve 21 their quality and safety. Page 390	1 care. 2 BY MS. WOOD: 3 Q. And are you aware of any other rating systems 4 that are comparable to Leapfrog? 5 MR. CRAIN: Objection to form. 6 THE WITNESS: Can you define comparable? 7 BY MS. WOOD: 8 Q. Sure. 9 Do you believe think -- do you believe that 10 Leapfrog has any direct competitors? 11 A. There's no other entity I know that's putting 12 out a composite, composite and noncomposite 13 information -- well, let me start again. 14 I'm not aware of any other entity that's 15 putting out a composite score around the specific area 16 of patient safety. There are other entities, like the 17 Centers for Medicare & Medicaid Services that do publish 18 information about the quality and safety of care, 19 similar to what Leapfrog does. 20 Q. And do you have any knowledge about the CMS 21 star ratings? Page 392
1 Q. And would you say that the Hospital Safety 2 Grade also creates some competition between the 3 hospitals? 4 A. I don't know enough about that. 5 Q. Okay. I just wasn't sure if that's what you 6 were getting at. So that's okay. 7 And so then is it fair to say that if 8 Leapfrog stopped grading hospitals and now patients did 9 not have access to information on patient safety and 10 these measures, that could potentially harm patients? 11 A. I don't know about what the implications of 12 that would be. 13 Q. Okay. 14 Do you think that when patients have the 15 most accurate and transparent data when making their 16 informed decisions on where to treat, that that makes 17 them safer and protects them? 18 MS. LAWSON: Object to form. 19 MR. CRAIN: Object to form. 20 THE WITNESS: I believe that having information 21 is helpful in making a decision to where to receive Page 391	1 A. I do. 2 Q. And what is your knowledge with regard to the 3 CMS star ratings? 4 MR. CRAIN: Object to form. 5 BY MS. WOOD: 6 Q. I guess we can start with do you have 7 experience with working with CMS in regard to those CMS 8 star ratings? 9 A. I do. I served on their technical expert 10 panel. 11 Q. Okay. Can you explain to me a little bit what 12 that was like? 13 A. Yeah. So that is a -- this is actually written 14 into federal legislation that CMS needs to publish a 15 star rating for hospitals. It is considered to be a 16 summary of all of the information that is shared on 17 their care compare website. 18 So early on in the technical expert panel 19 meetings, I would say, well, what are we actually trying 20 to measure? And the contractor was like, well, we're 21 supposed to summarize all the information. I'm like, Page 393

1 well, what's the underlying construct? We're just 2 supposed to summarize the information. 3 So it's not clear exactly what CMS is 4 measuring, but it is intended to be a summary of 5 information. And so what they do is they take the 6 measures that are publicly reported and have put those 7 into domains, and different domains get different 8 weights. They use Z-scores. It's all -- it's very 9 similar to how Leapfrog has gone about calculating 10 scores but just with a different set of measures and a 11 different set of constructs. 12 Q. To your knowledge, does CMS have any patient 13 safety measures that go into that star rating system? 14 A. They do. 15 Q. Okay. 16 And I know Leapfrog on their website 17 usually says, when looking at the Hospital Safety Grade, 18 consider other options or look to other sources. Does 19 that sound familiar to you? 20 MS. LAWSON: Object to form. 21 MR. CRAIN: Object to form. Page 394	1 MR. CRAIN: Objection to form. 2 THE WITNESS: So I can speak to my experience 3 with Johns Hopkins Medicine. The Board of Directors for 4 Johns Hopkins Medicine, as well as senior leaders, 5 have -- are very, very interested in the hospital safety 6 grades. And when they see that the safety grades are 7 dropping, there is usually a call for what's going to be 8 done to get us back to an "A" or to a "B." 9 So I think it's been a way to engage health 10 system leaders, Board of Directors, around the issue of 11 patient safety. That's just my experience with Johns 12 Hopkins Medicine. 13 BY MS. WOOD: 14 Q. Yeah. 15 And then does Johns Hopkins Medicine also 16 discuss their star ratings? 17 A. I believe so. 18 MS. WOOD: I think that's all that I have for 19 you. 20 THE WITNESS: Thank you. 21 MR. CRAIN: I have a little recross. Page 396
1 THE WITNESS: I don't know what's said on the 2 website so... 3 BY MS. WOOD: 4 Q. Okay. Have you ever heard people at Leapfrog 5 discuss that patients should not only consider the 6 Hospital Safety Grade when choosing where to seek care? 7 A. Yes. 8 Q. Okay. And would you say that other -- strike 9 that. 10 Another source that patients could look at 11 is CMS star ratings. Is that correct? 12 MR. CRAIN: Object to form. 13 THE WITNESS: That is another publicly 14 available rating of hospitals. 15 BY MS. WOOD: 16 Q. And do you have any knowledge on how, I guess, 17 popular those star ratings are? You know, in your line 18 of business or speaking with hospitals, do you tend to 19 see that people rely on them or talked about relying on 20 them? 21 MS. LAWSON: Object to form. Page 395	1 FURTHER EXAMINATION 2 BY MR. CRAIN: 3 Q. So just a few questions, Dr. Austin. 4 At one point counsel was asking you 5 questions about whether the Leapfrog survey was a 6 benchmark. Do you recall that line of questions? 7 A. Correct. 8 Q. And you said something like hospitals don't 9 want to be the bottom performers. Do you recall 10 testifying something to that effect? 11 A. Correct. 12 Q. Why don't hospitals want to be a bottom 13 performer? 14 A. What I hear is that, specifically when you're 15 dealing with physicians, they generally are individuals 16 who have excelled throughout their lifetime in terms of 17 academics and don't want to be perceived as being at the 18 bottom. 19 Q. So to put it concretely, doctors working at a 20 hospital don't want to work for an "F." Is that fair to 21 say? Page 397

1 A. I can't speak for doctors working at "F" 2 hospitals. 3 Q. But the ones, the doctors you were just talking 4 about -- 5 A. Yeah, they would -- yes. They would not want 6 to work at an "F" hospital. 7 Q. And fair to say that an "F" can damage a 8 hospital's reputation? 9 MS. LAWSON: Object to form. 10 THE WITNESS: I don't know -- well, what 11 reputation are you referring to? 12 BY MR. CRAIN: 13 Q. Fair enough. 14 So hospitals -- in your experience, do 15 hospitals have reputation in their communities, just 16 reputations for quality of care, for safety, that sort 17 of thing? 18 A. I think there are perceptions within 19 communities around which hospitals have higher quality 20 care than others. 21 Q. Can an "F" hospital -- can an "F" grade from Page 398	1 counsel went back to look at the Delray website again, 2 right. And you testified something to the effect of the 3 asterisk at the bottom of the page explains the how a 4 grade is assigned, right? 5 So I don't have a piece of paper for you, 6 but I'm going to do something a little avant-garde and 7 show you a website. 8 So I want to just direct you -- and just so 9 counsel can see, it's another Hospital Safety Grade 10 website. Do you see that? 11 So this is a hospitalsafetygrade.org 12 website. Can you see it okay? 13 A. I can. 14 Q. And do you see it says Pikeville Medical 15 Center? Do you see that? 16 A. Yes. 17 Q. And Pikeville is in Pikeville, Kentucky. Do 18 you know anything about Pikeville, Kentucky? 19 A. I do not. 20 Q. Okay. 21 What's the grade it gets? Page 400
1 Leapfrog influence that perception? 2 A. I don't know. 3 Q. You have no opinion one way or another? 4 A. You didn't ask my opinion. You asked what I 5 knew. 6 Q. Okay. Fair enough. Fair enough. 7 Do you have an opinion? 8 You're getting good at this. 9 A. I don't know how much -- if reputation is -- 10 well, let me start over. 11 I don't know how -- I don't know the 12 literature well enough to know how hospitals form 13 reputations in their communities. 14 Q. Okay. 15 A. Obviously, a component of that is consumers and 16 patients directly. There is media. There's a lot of 17 different influences, and I don't know how each of those 18 is tying into the Hospital Safety Grade and influencing 19 the reputation. 20 Q. Okay. Fair enough. I get it. 21 Okay. We talked -- you went back -- Page 399	1 A. They received a "D" in the Spring 2025 Hospital 2 Safety Grade. 3 Q. Okay. 4 So I want to go down and just look at safe 5 medication administration. Do you see that's toggled 6 there? 7 A. Yes. 8 Q. And that is the BCMA? 9 A. Correct. 10 Q. Okay. 11 So now, do you see what their score is? 12 A. It's a 25. 13 Q. Okay. And what's the worst score? 14 A. Twenty-five. 15 Q. Okay. And it has the little asterisk, right? 16 A. Correct. 17 Q. Now, read the asterisk for me. Can you read it 18 into the record? 19 A. The hospital declined to report their 20 performance on this measure, so a score was assigned to 21 reflect the lack of information available. Page 401

1 Q. Do you have any idea how the score was imputed? 2 A. Are you asking me do I know that, or do I know 3 that from what I'm reading there? 4 Q. From the information you have gathered from 5 this website or otherwise -- but you don't know 6 Pikeville, so I assume it's from this website -- how was 7 Pikeville's limited achievement score assigned? 8 A. I, Matt Austin, know that it was assigned based 9 on them not reporting to the survey, and they get 10 assigned a score based on that nonsubmission. 11 Q. So that's why it was assigned, right? It was 12 assigned because they didn't report, right? 13 A. Uh-huh. 14 Q. The question of how it was assigned I see as 15 conceptually different. Does that seem fair to you or 16 no? 17 A. I guess I see them as linked and maybe one in 18 the same. That's where I'm struggling to distinguish. 19 Q. So let me -- I can make it more concrete. 20 The imputation methodology as it applies 21 today has two steps, right? Page 402	1 whether Pikeville got limited achievement through Step 1 2 or Step 2, correct? 3 A. I don't know that. 4 Q. Now, you -- sorry. Just to be clear. Correct? 5 A. Correct. I do not know whether they were 6 assigned a Step 1 or Step 2. 7 Q. Now, is it fair to say Step 1 is a little more 8 accurate because it relies at least on the prior year's 9 survey that Pikeville or another hospital might submit? 10 A. The underlying assumption is that a hospital's 11 specific information from a recent time period would be 12 a better indicator of current performance than just a 13 general imputed score. 14 Q. So Step 1 can be a better, I think you said, 15 better indicator of current performance, right? 16 A. Correct. 17 Q. Okay. And yet you have no idea whether 18 Pikeville is Step 1 or Step 2, right? 19 A. Not from what's shown here. 20 Q. Which, again -- can you state for the record 21 what is being shown here? Page 404
1 A. Correct. 2 Q. Right? There is Step 1, historical, and Step 3 2, limited achievement, right? 4 A. Correct. 5 Q. Do you have any idea how Pikeville -- which 6 step was applied to Pikeville? 7 A. I know from the Hospital Safety Grade 8 methodology that declining to report on the measure is 9 what resulted in them getting a score assigned. 10 Q. But I'm asking a different question. I'll just 11 do it more directly. Did Pikeville get assigned limited 12 achievement through Step 1 or Step 2? 13 A. I don't know from what this is telling me 14 whether -- 15 Q. And yet, to be clear, you testified earlier 16 that this asterisk explained how the score was assigned, 17 right? 18 A. I testified that the why and how to me were 19 sort of one in the same. 20 Q. Okay. So then just setting the semantics 21 aside, just looking at this asterisk, you have no idea Page 403	1 A. What's being shown here is the hospital's score 2 with an asterisk, which says the hospital declined to 3 report their performance on this measure, so a score was 4 assigned to reflect the lack of information available. 5 So that could be either Step 1 or Step 2. 6 Q. Great. Okay. 7 So we'll set Pikeville aside, our dear 8 friends in Kentucky. 9 A couple other questions. So counsel 10 raised the question of whether the limited achievement 11 score was a benefit, right? Do you recall that line? 12 A. Yes. 13 Q. Okay. Is it your testimony that assigning 14 limited achievement automatically in Step 2 is a 15 benefit? 16 A. I did not testify to that. 17 Q. I just want to understand if it is your 18 testimony. 19 A. That is my testimony, that it is not 20 necessarily a benefit. 21 Q. Can it be a benefit ever? Page 405

1 A. For some hospitals it could be a benefit. 2 Q. Now, why is that, though? 3 A. If the alternative was to assign zero, 4 assigning a 15 is better than a zero. But if we 5 assign -- if the decision was to assign 50, assigning 15 6 would be a negative. So I don't know if there's a 7 universal way of answering that question. 8 Q. Fair enough. So let me just lay it out this 9 way. If a hospital participated in the survey and 10 failed on every hand hygiene question, what score did 11 they get? 12 A. They would receive limited achievement. 13 Q. They wouldn't achieve zero, right? 14 A. They would be scored as limited achievement. 15 Q. So what is the benefit vis-à-vis the 16 nonparticipating hospital and the hospital that scores 17 zero down the line? Is there a benefit? Let's start 18 with that. 19 A. Can you repeat that again? 20 Q. Yeah. 21 Counsel was suggesting there's a benefit Page 406	1 honestly can't remember if it was this meeting or a 2 different meeting. 3 Q. I guess what I'll say is do you remember, 4 actually have a memory of what was said, or you just 5 have no reason to doubt the notes? 6 A. I have -- I do remember at this in-person 7 meeting, I do remember the conversation about whether an 8 explicit penalty should be something that's on the table 9 or if Leapfrog should consider assigning an explicit 10 penalty. 11 Q. Okay. 12 A. I do remember that, but I don't remember 13 whether it was this meeting or another meeting. But 14 when I look at these notes, this seems to corroborate 15 that it was this meeting. 16 Q. Okay. Fair enough. 17 And then I want you to just tell me 18 everything you remember about the discussion about the 19 penalty you're referring to just so it's clear. 20 A. So what I remember, which may be different than 21 what's in the notes, is specifically Dr. Andrew Bindman, Page 408
1 that Leapfrog gives limited achievement versus zero. 2 But just to be clear, no hospital gets zero, right? 3 A. In the current scoring methodology, no hospital 4 gets zero. 5 Q. Even if the hospital failed every one of the 6 questions we looked at for hand hygiene, they would get 7 I think it's 15, right? 8 A. Correct. 9 Q. Okay. 10 A couple other lines. So we talked about 11 the Alexandria, Virginia notes. Do you remember that 12 document? 13 A. Yes. 14 Q. I think that was Exhibit -- 15 A. Twenty-seven. 16 Q. -- 27. And you said at one point other than 17 the notes, I don't remember anything. I just want the 18 record to be clear. Do you remember the meeting, or are 19 you just looking at the notes? 20 A. I remember having an in-person meeting with the 21 expert panel. I can picture a conference room. I Page 407	1 who at the time was the head of -- the director of the 2 Agency for Healthcare Research and Quality, which is the 3 federal agency that oversees quality and safety work. 4 From what I remember, Andy is -- broached the subject 5 of, well, hospitals should just be reporting to the 6 survey. Shouldn't we just like assign some sort of 7 penalty for them if they aren't reporting? That will 8 get them to report. 9 Q. Fair enough. Okay. 10 A. So that's what I remember. 11 Q. Yep. 12 A. Because I sort of remember where I was sitting, 13 where he was sitting. 14 Q. Okay. And anything else you remember about 15 that -- 16 A. No. That's what I remember. 17 Q. Okay. 18 A couple of last questions. HCAHPS. So 19 you talked a little bit with counsel about HCAHPS, 20 right? 21 A. Correct. Page 409

1 Q. What does HCAHPS measure? 2 A. HCAHPS measures the patient experience of their 3 inpatient hospital stay. 4 Q. Okay. So if a hospital is loud, is that 5 reflected in HCAHPS? 6 A. So there are different domains within the 7 HCAHPS survey. One is quietness of the hospital 8 environment. 9 Q. Okay. Can you give us a sense of the others? 10 A. Yeah. So the five that are included in the 11 Hospital Safety Grade include physician communication, 12 nurse communication, communication about medicines. 13 Q. Not a memory test. 14 A. The other -- the five that we've included are 15 all related to communication -- 16 Q. Okay. 17 A. -- and sort of the importance of communication 18 as it relates to patient safety. 19 Q. And there are other HCAHPS domains that are not 20 included? 21 A. Correct. Page 410	1 measures -- 2 Q. Yes. 3 A. Yes, in each domain. 4 Q. So I want to just -- a quick question for you. 5 Does Leapfrog -- for nonparticipating hospitals that are 6 imputed, does Leapfrog impute secondary data to assign a 7 score? 8 A. Is -- can you repeat that? 9 Q. Yeah, let me break it down. So let's go back 10 to the AHA days, right. So back then when Leapfrog was 11 using the American Hospital Association data, it was 12 using the AHA data as a secondary source that it was 13 imputing into the safety grade score. Is that fair or 14 no? 15 A. Correct. So the AHA data was the data that was 16 being used to impute a score. 17 Q. Okay. Because the imputation model is not 18 secondary data itself. It's a method of imputing 19 secondary data, right? 20 A. Correct. 21 Q. Okay. To impute, one needs secondary data, Page 412
1 Q. Okay. 2 And HCAHPS, as you said, relates primarily 3 to patient satisfaction? 4 A. Patient experience. 5 Q. Experience. I'm sorry. 6 A. Yes, which is considered a different construct 7 than patient satisfaction. 8 Q. Got it. And is it a different construct from 9 safety? 10 A. There are -- there is probably some conceptual 11 overlap between safety and patient experience. 12 Q. Okay. 13 A. There's probably some overlap between patient 14 experience and patient satisfaction, to be fair. 15 Q. So like a Venn diagram? 16 A. Correct. 17 Q. Okay. Got it. 18 I think the last sequence, I want to go 19 back to Exhibit 3, the methodology document that you 20 were asked about. Do you recall that? 21 A. I remember being asked about the number of Page 411	1 right? 2 A. No. 3 Q. No. Okay. Tell me why. 4 A. So as outlined in the famous email where we 5 list the five different imputation options, one of them 6 is using secondary data to arrive at some sort of 7 estimate of the hospital's performance. 8 Q. Got it. 9 A. But one could just assign zero. One could 10 assign some value above or below the mean, right. So 11 one does not necessarily require secondary data to 12 impute a score. 13 Q. Okay. But if one is imputing secondary data, 14 there needs to be a secondary data source, in theory, 15 right? 16 A. Correct. 17 Q. Okay. 18 So I want to go to page 5 of the 19 methodology document, Exhibit 3. You see it's the 20 measures you were talking about before? 21 A. Yes. Page 413

1 Q. And do you see the top three at least are three 2 of the imputed measures, right? 3 A. Which page are you on? 4 Q. I'm looking at five. 5 A. Okay. 6 MS. LAWSON: Is it four of the slide, or is it 7 five of the slide? 8 BY MR. CRAIN: 9 Q. Oh, I'm sorry. It's the one -- I may be -- 10 page 4. You're right. Page 4. 11 A. Okay. 12 Q. Okay. I'm pulling if off my electronic 13 version. 14 So my question is do you see where it says 15 Computerized Physician Order Entry right there? 16 A. Yes. 17 Q. And Primary Data Source is the 2024 Leapfrog 18 Hospital Survey, right? 19 A. Right. 20 Q. That's accurate, correct? 21 A. Correct. Page 414	1 You good? 2 You're free to go unless Sara wants to go. 3 MS. LAWSON: We can go off the record. 4 MR. CRAIN: Off the record. 5 THE VIDEOGRAPHER: This concludes the 6 deposition of Dr. Matthew Austin. This ends media unit 7 number nine. We're off the record. The time is 8 6:06 p.m. 9 THE COURT REPORTER: Ms. Lawson, will you be 10 handling signature for the witness, or are you waiving 11 signature? 12 MS. LAWSON: We'll read and sign. 13 She'll prepare a transcript of it so that 14 you can review your testimony and note any corrections. 15 THE COURT REPORTER: Ms. Wood, do you need a 16 rough draft as well? 17 MS. WOOD: Yes, if I can get a rough as soon as 18 possible. 19 (The deposition adjourned at 6:06 P.M.) 20 21 Page 416
1 Q. Secondary data source says the imputation model 2 applied, right? 3 A. Correct. 4 Q. For any hospital under Step 2, there isn't a 5 secondary data, right? 6 A. In the -- are you asking about the current? 7 Q. Yes. 8 A. In the current methodology, there is not 9 secondary data, correct. 10 Q. Under Step 2? 11 A. Under Step 2. 12 Q. Is there under Step 1, or would you not call 13 the historical secondary data? 14 A. I wouldn't call that secondary data. 15 Q. Okay. 16 So fair to say for CPOE, BCMA, IPS, and 17 hand hygiene there is no secondary data? 18 A. We are currently not using secondary data as 19 part of the imputation models. 20 Q. Okay. 21 MR. CRAIN: Okay. Nothing further from me. Page 415	1 I, Marlene Kerr, a Notary Public of the 2 District of Columbia, do hereby certify that the 3 within-named witness personally appeared before me at 4 the time and place herein set out, and after having been 5 duly sworn by me, according to law, was examined by 6 counsel. 7 I further certify that the examination was 8 recorded stenographically by me, and this transcript is 9 a true record of the proceedings. 10 I further certify that I am not of counsel 11 to any of the parties, nor in any way interested in the 12 outcome of this action. 13 As witness my hand this 29th day of 14 September, 2025. 15 16  Marlene Kerr Notary Public 17 18 19 My Commission Expires: 20 July 28, 2026. 21 Page 417

1 CERTIFICATE OF DEPONENT 2 3 I hereby certify that I have read and 4 examined the foregoing transcript, and the same is a 5 true and accurate record of the testimony given by me. 6 7 Any additions or corrections that I feel 8 are necessary will be made on the Errata Sheet. 9 10 _____ 11 Matthew Austin 12 _____ 13 Date 14 15 (If needed, make additional copies of the Errata Sheet 16 on the next page or use a blank piece of paper.) 17 18 Job Number: 7616361 19 20 21 Page 418	1 2 September 29, 2025 3 Good Samaritan Medical Center Inc, Et Al. v. The Leapfrog Group 4 DEPOSITION OF: Dr. Matthew Austin (# 7616361) 5 The above-referenced witness transcript is 6 available for read and sign. 7 Within the applicable timeframe, the witness 8 should read the testimony to verify its accuracy. If 9 there are any changes, the witness should note those 10 on the attached Errata Sheet. 11 The witness should sign and notarize the 12 attached Errata pages and return to Veritext at 13 errata-tx@veritext.com. 14 According to applicable rules or agreements, if 15 the witness fails to do so within the time allotted, 16 a certified copy of the transcript may be used as if 17 signed. 18 Yours, 19 Veritext Legal Solutions 20 21 22 23 24 25 Page 420
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Federal Rules of Civil Procedure

Rule 30

(e) Review By the Witness; Changes.

(1) Review; Statement of Changes. On request by the deponent or a party before the deposition is completed, the deponent must be allowed 30 days after being notified by the officer that the transcript or recording is available in which:

(A) to review the transcript or recording; and

(B) if there are changes in form or substance, to sign a statement listing the changes and the reasons for making them.

(2) Changes Indicated in the Officer's Certificate. The officer must note in the certificate prescribed by Rule 30(f)(1) whether a review was requested and, if so, must attach any changes the deponent makes during the 30-day period.

DISCLAIMER: THE FOREGOING FEDERAL PROCEDURE RULES ARE PROVIDED FOR INFORMATIONAL PURPOSES ONLY.

THE ABOVE RULES ARE CURRENT AS OF APRIL 1, 2019. PLEASE REFER TO THE APPLICABLE FEDERAL RULES OF CIVIL PROCEDURE FOR UP-TO-DATE INFORMATION.

VERITEXT LEGAL SOLUTIONS

COMPANY CERTIFICATE AND DISCLOSURE STATEMENT

Veritext Legal Solutions represents that the foregoing transcript is a true, correct and complete transcript of the colloquies, questions and answers as submitted by the court reporter. Veritext Legal Solutions further represents that the attached exhibits, if any, are true, correct and complete documents as submitted by the court reporter and/or attorneys in relation to this deposition and that the documents were processed in accordance with our litigation support and production standards.

Veritext Legal Solutions is committed to maintaining the confidentiality of client and witness information, in accordance with the regulations promulgated under the Health Insurance Portability and Accountability Act (HIPAA), as amended with respect to protected health information and the Gramm-Leach-Bliley Act, as amended, with respect to Personally Identifiable Information (PII). Physical transcripts and exhibits are managed under strict facility and personnel access controls. Electronic files of documents are stored in encrypted form and are transmitted in an encrypted

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EXHIBIT 6

Johns Hopkins' Armstrong Institute to Aid the Leapfrog Group in Grading the Safety and Quality of U.S. Hospitals

Release Date: December 12, 2012

A team of researchers at Johns Hopkins' Armstrong Institute for Patient Safety and Quality has been tapped to provide scientific guidance to The Leapfrog Group, a national nonprofit known for publishing report cards detailing how hospitals perform in key quality and safety measures. The Johns Hopkins experts will apply their knowledge and research of health care performance measures to guide the methodology behind the two primary mechanisms Leapfrog uses to assess hospitals: the Leapfrog Hospital Survey and the Hospital Safety Score.

"Patients should have access to the most accurate and current data on hospital safety and quality when making important decisions on where they and their loved ones should receive care," says Peter Pronovost, M.D., Ph.D., senior vice president of quality and safety at Johns Hopkins Medicine. "This collaboration highlights The Leapfrog Group's commitment to bringing the best information available to health care consumers."

In support of the Leapfrog Hospital Survey, the team at the Armstrong Institute will assess an ever-evolving list of quality and safety indicators - from whether newborns receive recommended screenings to how often health care workers wash their hands - to create the best overall picture of hospital safety and quality possible.

To support the Hospital Safety Score, the Armstrong team will work closely with the Blue Ribbon Expert Panel, a nine-member group of patient safety experts who have provided guidance to Leapfrog around the Hospital Safety Score.

Armstrong Institute instructor Matt Austin, Ph.D., who is the former director of the Leapfrog Hospital Survey, will lead the Johns Hopkins team's efforts.

"This partnership reflects the Armstrong Institute's strong commitment to empower and engage patients and families to be active participants in their care," Austin says. The institute recently received a \$9.4 million grant to better involve the families of ICU patients in their loved ones' care. The joint initiative builds upon prior collaborations between the two patient safety-focused groups. Pronovost, the Armstrong Institute's director, is the longtime chair of Leapfrog's ICU Physician Staffing expert panel - a key measure in assessing if hospitals are using specially trained physicians in caring for the sickest patients.

The Leapfrog Group is best known for their annual survey, which, for the past 11 years, has publicly reported national hospital quality and safety data for health care consumers and purchasers. Their Hospital Safety Score, a more recent initiative that awards hospitals a letter grade based on their overall performance on publicly reported data, provides a standardized method to evaluate patient safety across hospitals, including facilities that opt out of the survey.

"The Armstrong Institute has demonstrated that they are experts in applying research to practice," says Leah Binder, M.B.A., president and CEO of The Leapfrog Group. "We look forward to bringing this expertise to the work of The Leapfrog Group."

EXHIBIT 7

Why Leapfrog
Data Users &
Licensure Programs
Contact Us
Data User Login

Leapfrog Hospital Survey

The information on hospital performance collected through the Leapfrog Hospital Survey is unique and unavailable anywhere else. Unlike many other data sources, Leapfrog's data is available by individual bricks-and-mortar facility, providing a robust data set unlike any other. [Contact us](#) to access a sample data set.



Why Leapfrog Data Matters: Maternity Care

Maternity Care Ratings



The Leapfrog Hospital Survey includes:

- **C-section rates**, rates of early elective deliveries, rates of episiotomy, and high-risk delivery capabilities
- Practices for safer health care, including **hand hygiene**, nursing workforce, culture of safety, **leadership pertaining to safety** and teamwork training
- **Safe surgical volumes** for high-risk surgeries
- ICU staffing to **reduce mortality**
- **Infection rates** for hospital-acquired infections
- Hospitals' **Never Events policies**
- Use of **bar code technology** to reduce medication errors

Driven by Purchasers

In 1999, the Institute of Medicine reported that nearly 98,000 Americans were dying annually due to medical errors. In response, a group of large employers gather to form The Leapfrog Group.

Their goal? To collect data that ensures they are receiving the best possible value for their employees' health benefits and to drive giant leaps forward in hospital safety, quality and transparency.

Together with leading hospital safety and quality researchers, physicians and academics, they developed the Leapfrog Hospital Survey. Twenty years later, over 2,200 hospitals participate in the annual Survey.

Start Using Leapfrog Data.

[Contact Us Today](#)

EXHIBIT 8

“Innovators for Leapfrog” Launching to Fuel Investment in Patient Safety

May 9, 2023

The Leapfrog Group, an independent national watchdog organization of employers and other purchasers focused on health care safety, announced today a new resource for hospitals, ambulatory surgery centers (ASCs) and employers invested in patient safety called [Innovators for Leapfrog](#). Today Leapfrog launches a website showcasing the innovators, including products, services and technologies that can help hospitals, employers and ASCs meet safety standards like those on the annual [Leapfrog Hospital](#) and [ASC Surveys](#).

Innovators for Leapfrog (IFL) was created for Leapfrog’s community of over 42,000 professionals in health care quality, hospital leadership, payors, employers, and other stakeholders who support Leapfrog’s work to transform patient safety in the U.S.

“Over 500 people die every day in U.S. hospitals due to preventable medical errors. The good news is there are increasing numbers of companies working to change this,” said Leah Binder, President and CEO, The Leapfrog Group. “We created Innovators for Leapfrog to help connect those innovators with the hospital, ASC and employer leaders who are focused on improving patient safety.”

The new Innovators for Leapfrog website features products and services in seven categories:

- Employee Benefits Solutions
- Environmental Care
- Hand Hygiene
- Infection Control
- Patient Care and Safety
- Technology and Data
- Workforce Engagement

Charter members of the IFL include [BioVigil](#), [Care.AI](#), [CenTrak](#), [Ecolab](#), [GOJO Industries](#) (the maker of PURELL), [Intelligent Observation](#), [Medisolv](#), [Medline Industries](#), [Nevoa, Inc.](#), [Nozin](#), [RENSAIR](#), [SureWash](#), [Surfacide](#), and [SwipeSense](#) (part of SCJ Professional).

Companies with innovations aimed to help meet the challenges faced by today’s hospitals and ASCs have joined IFL in advance of the launch. Hear from leaders of charter member organizations:

“We are honored to join Innovators for Leapfrog and this community that shares our mission to improve quality and safety of health care in the United States,” said Zahid Butt, MD, FACC, Founder and CEO, Medisolv.

“We are proud to be part of the Innovators of Leapfrog because we share the same mission of making hospitals safer for patients,” said Katie Treptow, MBA, Senior Director of Marketing, Medline.

“We’re thrilled to partner with Leapfrog through the Innovators for Leapfrog program,” says Frederik Hendriksen, Co-founder at Rensair, a longstanding supporter of the organization.

"At Surfacide, our mission is to provide innovative, evidence-based infection prevention and environmental disinfection solutions that prioritize patient safety, quality and transparency," said Gunner Lyslo, Founder and CEO of Surfacide.

While The Leapfrog Group does not authorize, endorse, or sponsor the products, services and technology showcased in the IFL, Leapfrog encourages users to explore these offerings that support Leapfrog's mission of making giant leaps for patient safety.

For more information about the Innovators for Leapfrog, including details on how you can list your company's innovations, please contact Paul Alper, Senior Advisor, at palper@leapfrog-group.org.

About The Leapfrog Group

Founded in 2000 by large employers and other purchasers, The Leapfrog Group is a national nonprofit organization driving a movement for giant leaps for patient safety. The flagship Leapfrog Hospital Survey and new Leapfrog Ambulatory Surgery Center (ASC) Survey collect and transparently report hospital and ASC performance, empowering purchasers to find the highest-value care and giving consumers the lifesaving information they need to make informed decisions. The Leapfrog Hospital Safety Grade, Leapfrog's other main initiative, assigns letter grades to hospitals based on their record of patient safety, helping consumers protect themselves and their families from errors, injuries, accidents, and infections. For more, follow us on Twitter and Facebook, and sign up for our newsletter.

EXHIBIT 9

Leapfrog Hospital Survey Hard Copy

QUESTIONS & REPORTING PERIODS
ENDNOTES
MEASURE SPECIFICATIONS
FAQS



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Welcome to the 2025 Leapfrog Hospital Survey

<https://leapfroggroup.org/hospital>

Dear Hospital Leaders,

This year marks Leapfrog's 25th anniversary, and I want to thank you, our annual Survey participants, for being a critical part of our successful journey.

As we reflect on the progress made over the past quarter-century, it is clear that the work we have done together has reshaped health care for the better. Your transparency and willingness to be held to the highest standards of excellence have elevated American health care, empowering patients and families while challenging all of us to do better.

Of course, the journey ahead is still long, and we have much more work to do to achieve the uniform level of excellence that all Americans need and deserve from health care. But it is worth taking a few moments to reflect on the impact we've made together to date driving giant leaps for patient safety.

Over this milestone year, you will hear more from Leapfrog on our analysis of the progress our country has made in patient safety and quality of care. There are many bright spots. We are grateful to you and your colleagues for your leadership, hard work and bold transparency that makes it possible. You are saving lives.

We look forward to the journey forward with you.

With gratitude,



Leah Binder
President & CEO
The Leapfrog Group



Important Notes About the 2025 Survey

1. The Leapfrog Hospital Survey webpages are located at <https://leapfroggroup.org/hospital>. Please bookmark this URL.
2. Note the word “hospital” used throughout this Survey refers to an individual hospital. If your hospital is part of a multi-hospital health care system or a multi-campus hospital, you will need to complete the Survey for each individual hospital. Please refer to [Leapfrog’s Multi-Campus Hospital Reporting Policy](#).
3. To submit a Survey via the Online Hospital Survey Tool, hospitals are required to complete and affirm the following six sections: Section 1: Patient Rights and Ethics, Section 2: Medication Safety, Section 4: Maternity Care, Section 5: Physician and Nurse Staffing, Section 6: Patient Safety Practices, and Section 7: Managing Serious Errors. However, hospitals are urged to submit all sections of the Survey and can indicate within a section if a measure does not apply. Hospitals that would like to be eligible for [Top Hospital](#) must submit all sections of the Survey.
4. Adult and general hospitals that indicate they have a Computerized Physician Order Entry (CPOE) system in at least one inpatient unit are asked to demonstrate, via a test, that the inpatient CPOE system can alert prescribers to at least 60% of frequent serious medication errors known to cause harm to patients. Hospitals will have access to the CPOE Evaluation Tool immediately after completing the Hospital Profile in the Online Hospital Survey Tool. Hospitals cannot submit the Survey, including results from the Adult Inpatient CPOE Test until all the following Survey sections have been completed and affirmed: Section 1: Patient Rights and Ethics, Section 2: Medication Safety, Section 4: Maternity Care, Section 5: Physician and Nurse Staffing, Section 6: Patient Safety Practices, and Section 7: Managing Serious Errors. Hospitals are urged to ensure that the Adult Inpatient CPOE Test is submitted along with the Survey (i.e., in the same month) to meet the deadlines for the Leapfrog Hospital Survey and Leapfrog’s other programs such as Top Hospital and the Leapfrog Hospital Safety Grade.
5. Adult and pediatric hospitals reporting on Section 7B: Healthcare-Associated Infections are required to join Leapfrog’s NHSN Group. Information about teaching status will also be pulled directly from NHSN. More information, including important deadlines, is available on the [Join NHSN Group webpage](#).
6. Leapfrog Hospital Survey Results will be available on the Hospital Details Page beginning July 12 and publicly reported on the [public reporting website](#) on July 25 for hospitals that submit a Survey by the June 30 Submission Deadline. After July, the Hospital Details Page and public reporting website will be refreshed monthly within the first seven (7) business days of each month to reflect Surveys submitted or resubmitted between July 1 and November 30 and previously submitted Surveys that were corrected between December 1 and January 31. Survey Results are frozen from February to July 25.
7. All questions regarding the Leapfrog Hospital Survey should be submitted to the Help Desk at <https://leapfroghelpdesk.zendesk.com>. Questions submitted to the Help Desk will receive a response within 1-2 business days (see [Help Desk Holiday Schedule](#) for planned closures).
8. For hospitals that would like Leapfrog Hospital Survey Results included in their **Leapfrog Hospital Safety Grade**, please visit the “For Hospitals” section of the Hospital Safety Grade [website](#) for important information on Data Snapshot Dates. A Leapfrog Hospital Survey must be submitted by the Data Snapshot Date for Survey data to be used in the Hospital Safety Grade.
9. Leapfrog is committed to verifying the accuracy of Leapfrog Hospital Survey Results. Please review the information on the [Data Accuracy webpage](#).
10. The [Submission Deadline](#) for the 2025 Leapfrog Hospital Survey is **June 30, 2025**, and the Late Submission and Performance Update Deadline is **November 30, 2025**. Hospitals that do not submit a Survey or CPOE Evaluation Tool (adult and general hospitals only) before 11:59 pm Eastern Time on

2025 Leapfrog Hospital Survey – Hard Copy

General Information

November 30, 2025, will have to wait until the launch of the 2026 Leapfrog Hospital Survey on April 1, 2026 to submit a Survey.

Overview of the 2025 Leapfrog Hospital Survey

The Leapfrog Hospital Survey is divided into nine sections and the Hospital Profile. A description of each section is listed below. For a more detailed overview of the 2025 Leapfrog Hospital Survey, including a crosswalk of nationally endorsed measures and a description of how measures are publicly reported, visit the [Survey Overview webpage](#).

Section Number	Section Title	Brief Description
	<u>Hospital Profile</u>	The Hospital Profile includes questions about demographic and contact information. The Profile can be accessed and updated anytime throughout the year after logging into the Online Hospital Survey Tool . The Hospital Profile must be completed and submitted before you can access Sections 1-9 and the CPOE Evaluation Tool on the Survey Dashboard.
1	<u>Patient Rights and Ethics</u>	Section 1 includes questions about your hospital's billing ethics, health care equity, and informed consent processes. This section also includes questions on your hospital bed size, admissions, ICUs, and teaching status.
2	<u>Medication Safety</u>	Section 2 includes questions about your hospital's use of CPOE and BCMA, and (for adult and general hospitals) questions about your hospital's medication reconciliation process. The EHR application subsection (2B) is only applicable to adult and general hospitals and will not be scored or publicly reported. In 2025, three questions about Artificial Intelligence (AI) applications were added to subsection 2B – these questions are optional and will not be scored or publicly reported.
3	<u>Adult and Pediatric Complex Surgery</u>	Section 3 includes questions about your hospital's volume and process for privileging surgeons for eleven high-risk procedures, outcomes for mitral valve repair and replacement, and participation in The Society of Thoracic Surgeon's Congenital Heart Surgery Database for hospitals that perform the Norwood procedure. This section also includes questions about the implementation of a safe surgery checklist.
4	<u>Maternity Care</u>	Section 4 includes questions about maternity care volume and services, cesarean birth, episiotomy, newborn bilirubin screening, and DVT prophylaxis for women undergoing cesarean delivery. The section also includes questions about high-risk deliveries, including volume and outcomes. The subsection on cesarean birth (4C) includes questions about cesarean births stratified by race/ethnicity that will not be scored or publicly reported, however, responses will be used for confidential reporting on the Hospital Details Page in 2025.
5	<u>Physician and Nurse Staffing</u>	Section 5 includes questions about the management of critical care patients and the staffing structure of your hospital's adult and pediatric general medical, surgical, medical/surgical, and neuro ICUs, and questions about your hospital's nursing staffing and skill mix (previously included in Section 6).
6	<u>Patient Safety Practices</u>	Section 6 includes questions about your hospital's adherence to two National Quality Forum-endorsed Safe Practices, and questions about your hospital's hand hygiene practices. It also includes a subsection on diagnostic excellence (6D) and a new subsection on Hospital Boarding in the Emergency Department (ED) (6E) – both subsections are optional and will not be scored or publicly reported.

Section Number	Section Title	Brief Description
7	<u>Managing Serious Errors</u>	Section 7 includes questions about your hospital's response to Never Events. In addition, Leapfrog collects information via its NHSN Group about five healthcare-associated infections (CLABSI, CAUTI, MRSA, <i>C. diff.</i> , and SSI: Colon). Hospitals reporting on Section 7B: Healthcare-Associated Infections are required to join Leapfrog's NHSN Group. Important information and deadlines are available on the <u>Join NHSN Group webpage</u> .
8	<u>Pediatric Care</u>	Section 8 includes questions about patient experience (CAHPS Child Hospital Survey) and Computed Tomography (CT) radiation dose for pediatric patients.
9	<u>Outpatient Procedures</u>	Section 9 includes questions about the volume and safety of same-day procedures performed in hospital outpatient departments, as well as the experience of patients who had a same-day surgery performed.

Section 1: Patient Rights and Ethics, Section 2: Medication Safety, Section 4: Maternity Care, Section 5: Physician and Nurse Staffing, Section 6: Patient Safety Practices, and Section 7: Managing Serious Errors are required to submit a Survey via the Online Hospital Survey Tool. Hospitals are strongly urged to submit all sections of the Leapfrog Hospital Survey and can indicate within a section if a measure does not apply.

The hard copy of the Survey and the Online Hospital Survey Tool are organized in the same format for all nine sections:

- **General information** about The Leapfrog Group's standard (included in the hard copy only).
- **Reporting periods** to provide hospitals with specific periods of time for each set of questions.
- **Survey questions** which may include references to endnotes or FAQs. The Survey questions and endnotes match the Online Hospital Survey Tool exactly.
- **Affirmation of accuracy** by your hospital's CEO/Chief Administrative Officer or by an individual that has been designated by the hospital CEO. These statements affirm the accuracy of your hospital's responses and must be completed in the Online Hospital Survey Tool to submit a Survey.
- **Reference information** which includes "What's New" and "Change Summaries," important measure specifications, answers to frequently asked questions, and other notes that must be carefully reviewed before responding to any of the Survey questions (included in the hard copy only).

In addition to the Survey questions, adult and general hospitals that indicate they have a CPOE system in at least one inpatient unit are asked to demonstrate, via a test, that the inpatient CPOE system can alert physicians to at least 60% of frequent serious medication errors known to cause harm to patients. Adult and general hospitals can access the CPOE Evaluation Tool immediately after completing the Hospital Profile in the Online Hospital Survey Tool. Carefully review the information on the [Prepare for a CPOE Tool webpage](#).

Any changes made to the measure specifications after April 1 will be reflected in the hard copy of the Survey in the Reference Information sections under the "Change Summary" header (see [Table of Contents](#)). In addition, the updates to the specifications will be highlighted in yellow. If the changes are substantial, we will email the Primary Survey Contact your hospital provided in the Hospital Profile of the Online Hospital Survey Tool. If the notification is sent before your hospital submits a 2025 Leapfrog Hospital Survey, the email will go to the Primary Survey Contact provided in the previous year's Survey.

The Leapfrog Group and its participating members are committed to presenting information that is as current as possible, therefore we allow hospitals to update and resubmit their Survey until the **November 30** Late Submission and Performance Update Deadline. Please carefully review the reporting periods in each section before updating your Survey. Leapfrog Hospital Survey Results are updated monthly beginning in July on Leapfrog's [public reporting website](#). Hospitals are required to [update](#) the

2025 Leapfrog Hospital Survey – Hard Copy

General Information

information in their Survey within 30 days of any change in status. We reserve the right to decertify information that is not current. More information on updating your Survey is available on the [Updating Your Hospital Survey webpage](#).

Pre-Submission Checklist

Before you complete and submit the Survey via the Online Hospital Survey Tool, there are several steps you should complete:

- ☐ **Visit the Hospital Survey webpages at <https://leapfroggroup.org/hospital>.**
- ☐ **Make sure you have a 16-digit security code.** If you don't, download a [Security Code Request](#) form. If your hospital is part of a multi-hospital healthcare system, you will need a separate security code for each individual hospital within the system. Please refer to [Leapfrog's Multi-Campus Hospital Reporting Policy](#).
- ☐ **Download a hard copy of the Survey** (PDF or Word document) on the [Survey and CPOE Materials webpage](#). Read through the entire document to ensure that you understand what information is required.
- ☐ **Review the reference information** in each section of the Survey document and **download [other supporting materials](#)**. These documents and tools contain information that you will need to accurately respond to the Survey questions.
- ☐ **Join Leapfrog's NHSN Group.** Hospitals reporting on Section 7B: Healthcare-Associated Infections are required to join Leapfrog's NHSN Group. More information, including important deadlines, is available on the [Join NHSN Group webpage](#).
- ☐ **Accept the American Medical Association's Terms of Use and Download the CPT Code Workbook.** Hospitals reporting on Section 3 Adult and Pediatric Complex Procedures (that perform bariatric surgery for weight loss, total hip replacement surgery, or total knee replacement surgery) and Section 9 Outpatient Procedures (that perform outpatient procedures) must accept the American Medical Association's Terms of Use and download the CPT Code Workbook via the button on the [Survey Dashboard](#) in Section 9.
- ☐ **Identify individuals from your hospital to help you** gather the data you will need to complete the various sections of the Survey.
- ☐ **Complete a hard copy of the Survey before you log in to the Online Survey Tool.** This will expedite the data entry into the Online Survey Tool and help to avoid the Tool "timing out" after 20 minutes of idle time (a security precaution). Once all the information has been collected and recorded in the hard copy of the Survey, the CEO or the CEO's designee can typically complete the online data entry in less than an hour. Please note, responses must be entered into the Online Survey Tool to be submitted.
- ☐ **Download and review a copy of the Online Survey Tool Guide** on the [Get Started webpage](#) and includes important instructions on how to navigate the Online Hospital Survey Tool, including instructions on how to verify your hospital has successfully submitted the Survey.
- ☐ **Check Survey deadlines.** Carefully review Survey [deadlines](#) before you begin. Ensure that you have enough time to collect the data, complete a hard copy of the Survey, and complete and submit the Survey via the Online Hospital Survey Tool. In addition, for adult and general hospitals that have implemented CPOE in at least one inpatient unit, make sure you have enough time to take a [CPOE Evaluation Tool](#).
- ☐ **Download and review the 2025 Leapfrog Hospital Survey [Scoring Algorithms](#).**
- ☐ **Review Leapfrog's policies and procedures regarding data accuracy.** Detailed information can be found on the [Data Accuracy webpage](#).

Leapfrog Hospital Survey Binder: Hospitals should utilize the Leapfrog Hospital Survey Binder to assist in organizing the documentation used to complete the Survey. Download a copy of the binder on the [Survey and CPOE Materials webpage](#).

Instructions for Submitting a Leapfrog Hospital Survey

Important Notes:

Note 1: Please carefully review these instructions and the [Online Survey Tool Guide](#) before you begin.

Note 2: Each section of the Survey must be completed before it can be affirmed in the Online Hospital Survey Tool. Only sections that are affirmed can be submitted. Hospitals are responsible for ensuring that each submitted section is accurate.

1. Log into the [Online Hospital Survey Tool](#) using your 16-digit security code.
2. The first time you log into the 2025 Leapfrog Hospital Survey, you will need to complete and submit the Hospital Profile. The Hospital Profile includes demographic and contact information. The Hospital Profile should be updated throughout the year if any information changes and can be accessed at any time. **Failure to maintain current contact information could result in important, time-sensitive information being missed or sent to the wrong person.**
3. Once the Hospital Profile has been submitted, you will be taken to the Hospital Survey Dashboard.
4. You can navigate into sections of the Online Hospital Survey Tool using the linked section names on the Hospital Survey Dashboard. You can also access the CPOE Evaluation Tool immediately after completing the Hospital Profile using the Take CPOE Tool button on the Hospital Survey Dashboard. More information about navigating within the Online Hospital Survey Tool is available in the [Online Survey Tool Guide](#).
5. Within sections, you can enter responses to questions and/or update responses to previously submitted sections. The Online Hospital Survey Tool will automatically save your responses as you enter them. There is no “save” button.
6. Once you have completed each section, you will need to return to the Hospital Survey Dashboard to affirm each section of the Survey. Please remember that if you are making updates, all updated sections must be re-affirmed. Please note that affirmed sections are not yet submitted, please review Step 7 below to ensure successful submission.
7. Before you can submit the Survey (select the “*submit affirmed sections*” button on the Hospital Survey Dashboard), you will need to “*check for data review warnings*.” When you select the “*check for data review warnings*” button, the sections of your Survey that have been affirmed will be scanned for potential reporting errors. If any errors are identified, a data review warning message will be generated and will appear on the Hospital Survey Dashboard.
8. If any [data review warnings](#) are generated, you will still be able to submit your Survey. However, you will need to address the potential reporting errors identified during the scan or risk having the related sections of your Survey decertified (publicly reported as “Declined to Respond”). Please note this may not be a comprehensive list – you may still receive additional data verification messages via email.
9. Once you have checked for data review warnings, you can select the “*submit affirmed sections*” button to submit the Survey. Please review the Section Status column on the Hospital Survey Dashboard to verify which sections have been submitted.
10. Use the “*Print Last Submitted Survey*” button on the Hospital Survey Dashboard to print a copy of your Last Submitted Survey and review it for accuracy and completeness. Remember, sections that are not affirmed will not be submitted.
11. Review the 2025 Leapfrog Hospital Survey [Scoring Algorithms](#) to see how your Survey responses will be scored and publicly reported by Leapfrog.
12. Review your Survey Results on the [Hospital Details Page](#) or [public reporting website](#). Hospitals that submit by June 30 can preview their Survey Results on the Hospital Details Page beginning on July 12, before Leapfrog [publicly reports](#) Survey Results beginning on July 25. After July, the

Hospital Details Page and public reporting website will be refreshed monthly within the first seven (7) business days of each month following your (re)submission.

13. Adult and general hospitals submitting a CPOE Evaluation Tool should carefully review the instructions, scoring information, and FAQs available on the [Survey and CPOE Materials webpage](#) (see CPOE Tool Instructions under Other Supporting Materials).
14. Leapfrog is committed to verifying the accuracy of Leapfrog Hospital Survey Results. Please review our data accuracy protocols on the [Data Accuracy webpage](#).
15. Responses can be updated or corrected, and the Survey can be resubmitted at any point during the Survey Cycle (April 1 – November 30). Please remember that if you are making updates, all updated sections must be re-affirmed. More information on updating your Survey is available on the [Updating Your Hospital Survey webpage](#).

Reporting Policy Following Cybersecurity Events and Natural Disasters

Hospitals that experience a cybersecurity event or natural disaster that impacts data availability during one or more Survey reporting periods can complete and [submit a request form](#) in order to participate in the 2025 Leapfrog Hospital Survey. If approved, hospitals will report on the impacted measures using the data available and exclude data from the month(s) impacted by the cybersecurity event or natural disaster. Results will still be calculated if minimum reporting requirements are met and will be displayed on the [Survey Results website](#) with the following footnote: "Results are based on limited data due to a reported cybersecurity event or natural disaster." This revised policy closely aligns with the Extraordinary Circumstances Exception policy from the Centers for Medicare and Medicaid Services (CMS) but will only be applied to cybersecurity events and natural disasters.

For the purposes of the Safety Grade, a letter grade will still be calculated based on the data available, but any underlying measures impacted by the event will have results reported along with the following footnote: "Results are based on limited data due to a reported cybersecurity event or natural disaster." Hospitals will still be eligible for Leapfrog Top Hospital pending committee review and subject to meeting all criteria.

Verifying Submission

Use the following steps to verify that your submission was completed and that the appropriate sections were submitted:

- **Check the Hospital Survey Dashboard:** Refer to the "Section Status" column on the Hospital Survey Dashboard. All submitted sections will be marked as "Submitted."
- **Check your email:** You will receive a Survey submission confirmation email within five minutes of submitting a Survey. Please Note: This email will not specify which sections were submitted – you will need to use the other steps to determine which sections were submitted.
- **Print Last Submitted Survey:** The Survey submission date will be listed at the top of the page under the heading "Submitted Survey." Be sure to check the submission date, review each section for accuracy and completeness, and check that each affirmation is complete (Sections 1-9).
- **Review the Hospital Details Page:** Your Survey Results will be available beginning July 12 via the Hospital Details Page link on the Hospital Survey Dashboard. Carefully review your results, including data from VON for high-risk deliveries, and your NHSN information for applicable healthcare-associated infections.
- **Check your publicly reported results:** Always check your Leapfrog Hospital Survey Results on the public reporting [website](#). Results are posted on July 25 and are updated within the first 7 (seven) business days of the month following your submission starting in August.

Updating or Correcting a Previously Submitted Leapfrog Hospital Survey

*2025 Leapfrog Hospital Survey – Hard Copy**General Information*

Hospitals can update or correct previously submitted Survey responses at any point during the Survey Cycle (April 1 to November 30). Please review the [Survey Deadlines webpage](#). Most updates or corrections are made:

- At the request of Leapfrog:
 - Following Leapfrog's [Extensive Monthly Data Verification](#), the Primary Survey Contact, Secondary Survey Contact, and System Survey Contact will receive an email from the Help Desk detailing potential reporting errors.
- Following [On-Site Data Verification](#):
 - Hospitals selected for On-Site Data Verification will receive a report which will indicate any responses that need to be updated or corrected.
- At the discretion of the hospital:
 - To correct a data entry or reporting error.
 - To reflect a change in status or performance on a measure (e.g., closed a unit, stopped performing a procedure, implemented a new policy, etc.).
 - To provide more current responses based on the reporting periods outlined in the hard copy of the Survey.

Following any updates, hospitals should always use the steps for verifying submission provided [above](#).

Updating a Survey after Receiving a Help Desk Email

Leapfrog conducts [Extensive Monthly Data Verification](#) of responses submitted to the Leapfrog Hospital Survey starting with Surveys submitted by the June 30 Submission Deadline and monthly thereafter until the Online Survey Tool is taken offline on January 31. Following the Extensive Monthly Data Verification, the **Primary Survey Contact, Secondary Survey Contact, and System Contact** are notified by email of any Survey responses that need to be reviewed and/or updated by the hospital.

If you receive a Data Verification email, you are required to document that your original responses were correct or update/correct your previously submitted Leapfrog Hospital Survey by the end of the same month using the **original** reporting period that was used for that section of the Survey in the original submission. For example, if a hospital submitted a Survey for the first time on August 20, then received a Data Verification email at the beginning of September, they would update their responses based on the reporting period used in the August 20 submission.

Hospitals that receive a [Category A](#) Data Verification message at the beginning of the month for any measure will have until the end of that same month to contact the [Help Desk](#) to either (1) document that the original response was correct or (2) correct the data entry or reporting error, or they will be publicly reported as "Pending Leapfrog Verification" for that measure. This term is used to indicate that the hospital has self-reported Survey responses that are under further review by Leapfrog.

If any Category A Data Verification messages are not resolved by January 31 (when the Online Hospital Survey Tool is taken offline), the entire Survey will be decertified, and the hospital will be publicly reported as "Declined to Respond" for the entire Leapfrog Hospital Survey.

Updating a Survey following On-Site Data Verification

Hospitals that are selected for On-Site Data Verification will receive a findings report. If the findings report details any responses that need to be updated or corrected, please contact the [Help Desk](#).

Making General Updates (for hospitals that have not received a Help Desk email)

Leapfrog offers hospitals multiple reporting periods so that they can report the most current data. Except for Section 4E: High-Risk Deliveries (VON data only), Section 7B: Healthcare-Associated Infections, and Section 9D: Patient Follow-up (OP-32), updating a Survey is optional. However, we do recommend that if your performance or if a structure has changed significantly, you update your Survey within 30 days. In addition, hospitals should update their Surveys if they become aware of any reporting errors or data inaccuracies in their previous submission.

Hospitals may update one or more sections of the Survey without updating the entire Survey. In addition, hospitals are not required to retake the CPOE Evaluation Tool if making updates to Section 2A: CPOE questions #3 and #4.

General updates and corrections can be made at any point during the Survey Cycle (April 1 – November 30). The months of December and January are reserved for correcting data entry (i.e., correcting data entry errors) or reporting errors (i.e., in response to Leapfrog's [Extensive Monthly Data Verification](#)) to previously submitted sections of the Survey. Any updates made to reflect a change in performance must be made prior to the November 30 Late Submission and Performance Update Deadline. **Updates made to reflect a change in performance after November 30 will not be scored or publicly reported. New sections of the Survey submitted after November 30 will not be scored or publicly reported.**

Hospitals that are submitting general updates should:

- Use the stated [reporting period](#) at the top of each section selected based on the date of your resubmission.
- For Section 4: Maternity Care and Section 6A-6B: NQF Safe Practice #1 and #2, update responses to ALL questions within the section they wish to update using the same reporting period. For example, if a hospital submitted a Survey for the first time in June and then wanted to update the responses for the Cesarean Birth questions in subsection 4B in November, they would update the entire Section 4: Maternity Care based on the updated reporting period for November.

For information on Leapfrog's automatic updates to the VON data in Section 4E: High-Risk Deliveries, the NHSN data in Section 7B: Healthcare-Associated Infections, or the CMS data in Section 9D: Patient Follow-up, please review the [Section 4E: High-Risk Deliveries Measure Specifications](#), the [Join NHSN Group webpage](#), and the [Section 9D: Patient Follow-up Measure Specifications](#).

Quick Tip: Remember to re-affirm any section of the Survey that has been updated, check for data review warnings, and then resubmit the entire Survey. Always print a copy of your Last Submitted Survey and review it for accuracy and completeness. Check your updated Survey Results within the first 7 (seven) business days of the month following your resubmission on the [public reporting website](#) and the Hospital Details Page.

Deadlines

Deadlines for the 2025 Leapfrog Hospital Survey

The 2025 Leapfrog Hospital Survey, including the CPOE Evaluation Tool (if applicable), opens on April 1 and has a Submission Deadline of **June 30, 2025**. The Late Submission and Performance Update Deadline is **November 30, 2025**. Surveys and Adult Inpatient CPOE Tests must be submitted before 11:59 pm Eastern Time on **November 30**. The CPOE Evaluation Tool will not be available after **November 30**. The View CPOE Evaluation Tool results link on the Survey Dashboard can only be accessed between April 1 and November 30, so test results must be printed by November 30.

Corrections to Surveys submitted by **November 30** must be submitted by the **January 31, 2026** Corrections Deadline. The Online Hospital Survey Tool will not be available after **January 31, 2026**. Find detailed information about the 2025 Leapfrog Hospital Survey Deadlines, including deadlines for receiving free Competitive Benchmarking Summary Reports and consideration for Top Hospital Awards on the [Deadlines webpage](#).

Deadlines for Vermont Oxford Network Data

Hospitals participating in the Vermont Oxford Network (VON) may opt to report on the VON National Performance Measure in Section 4E: High-Risk Deliveries. Instructions, deadlines, and reporting periods can be reviewed in the [VON National Performance Measure Specifications](#).

Deadlines to Join Leapfrog's NHSN Group

Hospitals reporting on Section 7B: Healthcare-Associated Infections are required to join Leapfrog's NHSN Group. Please visit our [webpage](#) for instructions on how to join the group as well as information about important deadlines.

Deadlines Related to the Hospital Safety Grade

Hospitals that would like Leapfrog Hospital Survey Results used in their Leapfrog Hospital Safety Grade must submit a Survey and an Adult Inpatient CPOE Test by the [Data Snapshot Dates](#). The Leapfrog Hospital Survey and the Hospital Safety Grade are distinct programs administered by The Leapfrog Group. Though some measures from the Leapfrog Hospital Survey are used in the Hospital Safety Grade, the grade also utilizes publicly available data from other data sources. Find answers to Frequently Asked Questions in the "For Hospitals" section of the Hospital Safety Grade [website](#).

Technical Assistance

Leapfrog's Help Desk

Connect with Leapfrog's in-house subject matter experts via our dedicated Help Desk to get timely support for:

- Survey content and scoring questions,
- Data verification messages and requests for documentation, and
- Technical issues related to the Online Survey Tool, CPOE Evaluation Tool, or the Hospital and Surgery Center Ratings [website](#).

You can also schedule a 1:1 Hospital Survey Orientation and submit feedback on any of Leapfrog's ratings programs, including [Top Hospitals](#) and [Top ASCs](#), the [Hospital Safety Grade](#), the [Recognized Leader in Caring for People with Diabetes Program](#) and [Leapfrog's Value-Based Purchasing Program](#).

To quickly get you to the right in-house expert for the right level of support, submit your inquiry in writing through the Zendesk ticketing portal at <https://leapfroghelpdesk.zendesk.com>. You'll receive a reply within 1-2 business days, if not sooner. Tickets submitted during a CPOE Test receive a reply within 10 minutes during normal business hours. More information on submitting and managing Help Desk tickets can be found in the [Help Desk Guide](#).

The Help Desk is staffed Monday through Friday from 9:00 a.m. to 5:00 p.m. ET, except on federal holidays. Please review the Help Desk Holiday Schedule for closures and allow ample time for staff to respond to time sensitive requests before any program deadlines.

You can manage your open tickets through email and/or create an account with Zendesk to manage open and archived tickets.

To ensure that you receive our emails, please work with your IT department to add the following to your safe sender list:

- @leapfrog-group.org
- @leapfroghelpdesk.zendesk.com
- @em8434.leapfrog-group.org
- IP address: 159.183.167.150

Leapfrog Hospital Survey Webinar Series

The Leapfrog Hospital Survey Webinar Series is designed for Survey coordinators, hospital leaders, and others who would benefit from a more interactive presentation of Survey materials and information.

The Webinar Series is held monthly from March to December and includes monthly office hours in addition to monthly webinars. The one-hour webinars focus on specific topics related to the Survey, including new measures. Throughout each webinar, participants can ask questions live or via the Zoom Q&A function.

The monthly 30-minute office hours are designed to give participants another regular, interactive touch point with Leapfrog's Help Desk, so Survey coordinators always have the information they need, when they need it.

Join now and start benefiting from:

- **Monthly office hours with the Leapfrog Help Desk:** 30 minutes to get real-time technical assistance, answers to your questions, and help staying on top of upcoming deadlines. Staffed by Leapfrog's expert Help Desk.
- **Monthly webinars:** Timely and focused presentations on Survey and CPOE Evaluation Tool measures and specifications, scoring information, frequently asked questions, technical assistance, and public reporting. Each webinar concludes with a 20-minute open Q & A session.

- **Archive Library:** Slides and recordings from each webinar are archived in an online portal that participants can access from March to January.

The annual registration fee is \$500 per individual.

For a schedule of events and to register, please visit the Leapfrog [Hospital Survey Webinar Series webpage](#).

Support for Health Systems

Are you responsible for coordinating Leapfrog Hospital Survey submissions for more than one hospital? Leapfrog's Health System Support subscription for multi-hospital health systems is designed to help Survey coordinators and health system leaders become in-house experts on the Leapfrog Hospital Survey and the Hospital Safety Grade and make it easy to monitor, compare, and analyze your hospitals' Leapfrog Hospital Survey Results, Hospital Safety Grades, and Competitive Benchmarking scores. The subscription gives you timely data for all your hospitals in a series of easy-to-use Excel workbooks, so you can quickly perform analysis, benchmark performance, build performance dashboards, and identify areas for improvement.

The support package includes the following:

- Hospital Webinar Series (one registration per health system)
- Leapfrog Hospital Survey Responses and Results
- Leapfrog Hospital Safety Grades
- Competitive Benchmarking Scores

More information is available on the [Support for Health Systems webpage](#). Please contact the [Help Desk](#) for more information.

Reporting Periods

Important Note: Reporting periods should be selected based on the date of Survey or section submission. However, hospitals do not need to use the same reporting period throughout the Survey.

	Survey Submitted <u>Prior to</u> September 1	Survey (Re)Submitted <u>on or</u> <u>After</u> September 1
Survey Section/ Measure	Reporting Period	Reporting Period
1A Basic Hospital Information	12 months ending 12/31/2024	12 months ending 06/30/2025
1B Billing Ethics	N/A	N/A
1C Health Care Equity	N/A	N/A
1D Informed Consent	N/A	N/A
2A Computerized Physician Order Entry (CPOE)	Latest 3 months prior to Survey submission	Latest 3 months prior to Survey submission
2B EHR Application Information	N/A	N/A
2C Bar Code Medication Administration (BCMA)	Latest 3 months prior to Survey submission	Latest 3 months prior to Survey submission
2D Medication Reconciliation	Latest 6 months prior to Survey submission	Latest 6 months prior to Survey submission
3A Hospital and Surgeon Volume	Volume: 12 months or 24-month annual average ending 12/31/2024	Volume: 12 months or 24-month annual average ending 06/30/2025
	STS MVRR Composite Score: Latest 36-month report	STS MVRR Composite Score: Latest 36-month report
3B Safe Surgery Checklist for Adult and Pediatric Complex Surgery	Latest 12 months prior to Survey submission	Latest 12 months prior to Survey submission
4A Maternity Care Volume and Services	Volume: 12 months ending 12/31/2024	Volume: 12 months ending 06/30/2025
	Services: N/A	Services: N/A
4B Cesarean Birth	12 months ending 12/31/2024	12 months ending 06/30/2025
	Cesarean Birth Stratified by Race/Ethnicity: 24 months ending 12/31/2024	Cesarean Birth Stratified by Race/Ethnicity: 24 months ending 06/30/2025
4C Episiotomy	12 months ending 12/31/2024	12 months ending 06/30/2025
4D Process Measures of Quality	12 months ending 12/31/2024	12 months ending 06/30/2025

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	Survey Submitted <u>Prior to</u> September 1	Survey (Re)Submitted <u>on or</u> <u>After</u> September 1
Survey Section/ Measure	Reporting Period	Reporting Period
4E High-Risk Deliveries*	Volume: 12 months ending 12/31/2024	Volume: 12 months ending 06/30/2025
	VON: 2023 report	VON: 2024 report
5A Adult ICU Physician Staffing	Latest 3 months prior to Survey submission	Latest 3 months prior to Survey submission
5B Pediatric ICU Physician Staffing	Latest 3 months prior to Survey submission	Latest 3 months prior to Survey submission
5C Nursing Workforce	Nurse Staffing and Skill Mix: 12 months ending 12/31/2024	Nurse Staffing and Skill Mix: 12 months ending 06/30/2025
	NQF Safe Practice #9: Latest 12 months prior to Survey submission	NQF Safe Practice #9: Latest 12 months prior to Survey submission
	Percentage of RNs who are BSN-Prepared: N/A	Percentage of RNs who are BSN-Prepared: N/A
6A NQF Safe Practice #1 – Culture of Safety Leadership Structures and Systems	Latest 12 months prior to Survey submission	Latest 12 months prior to Survey submission
6B NQF Safe Practice #2 – Culture Measurement, Feedback, and Intervention	Latest 12 or 24 months prior to Survey submission (see individual safe practice for specific reporting period)	Latest 12 or 24 months prior to Survey submission (see individual safe practice for specific reporting period)
6C Hand Hygiene	N/A	N/A
6D Diagnostic Excellence	CEO Commitment to Diagnostic Excellence, Patient Engagement, Risk Assessment and Mitigation, Convening a Multidisciplinary Team Focused on Diagnostic Excellence, Training and Education: N/A	CEO Commitment to Diagnostic Excellence, Patient Engagement, Risk Assessment and Mitigation, Convening a Multidisciplinary Team Focused on Diagnostic Excellence, Training and Education: N/A
	Closing the Loop on Cancer Diagnosis: 12 months ending 12/31/2024	Closing the Loop on Cancer Diagnosis: 12 months ending 06/30/2025
6E Hospital Boarding in the Emergency Department (ED)	12 months ending 12/31/2024	12 months ending 06/30/2025
7A Never Events	N/A	N/A
7B Healthcare-Associated Infections**	June and August Data Downloads: 01/01/2024 – 12/31/2024	October and December Data Downloads: 07/01/2024 – 06/30/2025

	Survey Submitted <u>Prior to</u> September 1	Survey (Re)Submitted <u>on or</u> <u>After</u> September 1
Survey Section/ Measure	Reporting Period	Reporting Period
8A Patient Experience (CAHPS Child Hospital Survey)	Latest 12 months prior to Survey submission	Latest 12 months prior to Survey submission
8B Pediatric Computed Tomography (CT) Radiation Dose	12 months ending 12/31/2024	12 months ending 06/30/2025
9A Basic Outpatient Department Information	12 months ending 12/31/2024	12 months ending 06/30/2025
9B Medical, Surgical, and Clinical Staff	Latest 3 months prior to Survey submission	Latest 3 months prior to Survey submission
9C Volume of Procedures	12 months ending 12/31/2024	
9D Safety of Procedures***	Patient Follow-up: Latest 24 months prior to Survey submission	Patient Follow-up: Latest 24 months prior to Survey submission
	Safe Surgery Checklist: Latest 12 months prior to Survey submission	Safe Surgery Checklist: Latest 12 months prior to Survey submission
9E Medication Safety for Outpatient Procedures	12 months ending 12/31/2024	12 months ending 06/30/2025
9F Patient Experience (OAS CAHPS)	Latest 12 months prior to Survey submission	Latest 12 months prior to Survey submission

*Leapfrog will update VON data 3 times per Survey Cycle for all hospitals that have provided an accurate VON Transfer Code in the Hospital Profile, submitted a [Data Sharing Authorization](#) letter to VON, selected "VON National Performance Measure" in Section 4E, and submitted the 2025 Leapfrog Hospital Survey.

**Adult and pediatric hospitals reporting on Section 7B: Healthcare-Associated Infections are required to join Leapfrog's NHSN Group. More information, including important deadlines, is available on the [Join NHSN Group webpage](#). Leapfrog will update data 4 times for all members of our NHSN group that have provided an accurate NHSN ID in the Hospital Profile and submitted the 2025 Leapfrog Hospital Survey.

***Adult and pediatric hospitals reporting on Section 9D: Patient Follow-up are required to provide an accurate CMS Certification Number (CCN) in the Hospital Profile. Leapfrog will update data 3 times per Survey Cycle for all hospitals that have provided an accurate CCN in the Hospital Profile and submitted Section 9: Outpatient Procedures.

Included Units by Survey Section

Note: Only include units that were open for the entire reporting period and that remain currently open.

Survey Section/ Measure	Units
1A Basic Hospital Information	• Acute-Care Units¹ (adult and/or pediatric) • General Medical, Surgical, Medical/Surgical and Neuro ICUs¹⁴ (adult and/or pediatric) • Specialty ICUs (adult and/or pediatric) • Neonatal ICUs¹⁷
1B Billing Ethics	N/A
1C Health Care Equity	N/A
1D Informed Consent	N/A
2A Computerized Physician Order Entry (CPOE)	N/A
2B EHR Application Information	N/A
2C Bar Code Medication Administration (BCMA)	• General Medical, Surgical, Medical/Surgical, and Neuro ICUs¹⁴ (adult and/or pediatric) • Neonatal ICUs¹⁷ • Specialty ICUs (adult and/or pediatric) • Medical, Surgical, and Medical/Surgical Units (including telemetry units)¹⁹ (adult and/or pediatric) • Step-down/Progressive Units²⁰ (adult and/or pediatric) • Labor and Delivery Units²¹ • Pre-operative and Post-anesthesia Care Units²² (adult and/or pediatric)
2D Medication Reconciliation	• Medical and Medical/Surgical Units (including telemetry units) (adult only) • Step-down/Progressive Units²⁰ (adult only)
3A Hospital and Surgeon Volume	N/A
3B Safe Surgery Checklist for Adult and Pediatric Complex Surgery	N/A
4A Maternity Care Volume and Services	N/A
4B Cesarean Birth	N/A
4C Episiotomy	N/A
4D Process Measures of Quality	N/A
4E High-Risk Deliveries	• Neonatal ICUs¹⁷

Survey Section/ Measure	Units
5A Adult ICU Physician Staffing	General Medical, Surgical, Medical/Surgical, and Neuro ICUs¹⁴ (adult)
5B Pediatric ICU Physician Staffing	General Medical, Surgical, Medical/Surgical, and Neuro ICUs¹⁴ (pediatric)
5C Nursing Workforce	Nurse Staffing and Skill Level: - Single Acuity Medical Units (adult and/or pediatric) - Single Acuity Surgical Units (adult and/or pediatric) - Single Acuity Med-Surg Combined Units (adult and/or pediatric) - Mixed Acuity Medical, Surgical and Med-Surg Units (adult and/or pediatric) Percentage of RNs who are BSN-Prepared: - N/A For more information, refer to the Section 5C: Nursing Workforce Measure Specifications.
6A NQF Safe Practice #1 – Culture of Safety Leadership Structures and Systems	N/A
6B NQF Safe Practice #2 – Culture Measurement, Feedback, and Intervention	N/A
6C Hand Hygiene	Medical, Surgical, and Medical/Surgical Units (including telemetry units)¹⁹ (adult and/or pediatric) Step-down/Progressive Units²⁰ (adult and/or pediatric) - Obstetrical Units (Labor and Delivery Units²¹, nursery, etc., excluding procedural areas) General Medical, Surgical, Medical/Surgical, and Neuro ICUs¹⁴ (adult and/or pediatric) Neonatal ICUs¹⁷ - Specialty ICUs (adult and/or pediatric) Pre-operative and Post-anesthesia Care Units²² (adult and/or pediatric) - Observation units (adult and/or pediatric) Dedicated Emergency Departments⁴⁷ (adult and/or pediatric)
6D Diagnostic Excellence	N/A
6E Hospital Boarding in the Emergency Department (ED)	Dedicated Emergency Departments⁴⁷ (adult and/or pediatric)
7A Never Events	N/A
7B Healthcare-Associated Infections	N/A

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Survey Section/ Measure	Units
8A Patient Experience (CAHPS Child Hospital Survey)	N/A
8B Pediatric Computed Tomography (CT) Radiation Dose	N/A
9A Basic Outpatient Department Information	N/A
9B Medical, Surgical, and Clinical Staff	N/A
9C Volume of Procedures	N/A
9D Safety of Procedures***	N/A
9E Medication Safety for Outpatient Procedures	N/A
9F Patient Experience (OAS CAHPS)	N/A

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HOSPITAL PROFILE

Hospitals must complete and submit a Hospital Profile via the Online Hospital Survey Tool before accessing the Hospital Survey Dashboard for the first time. The Profile is available year-round and should be updated as needed.

Hospital Profile

The Hospital Profile includes questions about demographic and contact information. The Profile can be accessed and updated anytime throughout the year after logging into the [Online Hospital Survey Tool](#).

The Hospital Profile must be completed and submitted before you can access Sections 1-9 and the CPOE Evaluation Tool on the Survey Dashboard.

Hospital Profile

Hospitals that share a CMS Certification Number are required to report by facility. Please carefully review [Leapfrog's Multi-Campus Reporting Policy](#).

Important Notes:

Note 1: Leapfrog uses an administration system that links contacts shared by hospitals (i.e., CEOs, Survey Contacts, System Contacts, and Public Relations Contacts). Only one phone number and email address will be maintained for each contact, meaning that if this shared contact's information is updated in one hospital's Profile, it will be updated for all hospitals associated with the contact.

Note 2: Following [Leapfrog's Extensive Monthly Data Verification](#), the Primary Survey Contact, Secondary Survey Contact, and System Survey Contact will receive an email from the Help Desk detailing potential reporting errors.

Hospital Information

Organization Name This is the name that will appear on Leapfrog's public reporting website.	<u>CMS Certification Number (CCN)</u> ² If the CCN displayed in the Online Hospital Survey Tool is not correct, contact the Leapfrog Help Desk immediately.
	Does your hospital share this CCN with another facility? ☐ Yes ☐ No
	<u>NHSN ID</u> ³
	<u>Vermont Oxford Network (VON) Transfer Code</u> ⁴
	<u>Federal Tax Identification Number (TIN)</u> ⁵
	<u>National Provider Identifier (NPI)</u> ⁶ If the NPI displayed in the Online Hospital Survey Tool is not correct, contact the Leapfrog Help Desk immediately.
	Does your hospital share this NPI with another facility? ☐ Yes ☐ No

Demographic Information

Physical Address (used for public reporting)	Mailing Address (used to send important communications)
Street Address	Street Address or P.O. Box
City	City
<u>State</u> ⁷	Country
Zip Code	State

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Hospital Profile

Zip Code Suffix	Zip Code
Main Phone Number	Zip Code Suffix
Hospital Website Address ⁸ (so consumers can learn more about your hospital's efforts in the area of patient safety and quality improvement)	

Contact Information

Chief Executive Officer (CEO)	Chairperson of the Board
Prefix (e.g., Mr., Ms., Mrs., Dr., etc.)	First Name
First Name	Last Name
Last Name	
Title (e.g. CEO, President, etc.)	
E-mail Address (required for emailing of security codes and Top Hospital notification)	

Primary Survey Contact	Secondary Survey Contact
First Name	First Name
Last Name	Last Name
Title	Title
Phone Number	Phone Number
Phone Number Extension	Phone Number Extension
E-mail Address	E-mail Address

Hospital Public Relations Contact (required so that Leapfrog may provide information on Leapfrog accolades, such as Top Hospital notification, and announcements)
First Name
Last Name
Phone Number

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Hospital Profile

Phone Number Extension
E-mail Address

Opt-Out Opt-out of having information in the “Contact Information” subsection shared with third parties.	☐ Opt-out
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Healthcare System Information
Name of Healthcare System or Integrated Delivery Network⁹ If the name displayed in the Online Hospital Survey Tool is not correct, contact the Leapfrog Help Desk immediately.
System Contact First Name Provide a System Contact for the IDN displayed. If no System Contact for the IDN displayed, enter a Contact for a larger parent system or re-enter your Primary or Secondary Survey Contact information.
System Contact Last Name
System Contact E-mail Address

System Public Relations Contact First Name (required so that Leapfrog may provide information on Leapfrog accolades, such as Top Hospital notification, and announcements)
System Public Relations Contact Last Name
System Public Relations Contact Phone Number
System Public Relations Contact Phone Number Extension
System Public Relations Contact E-mail Address

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SECTION 1: PATIENT RIGHTS AND ETHICS

This section includes questions and reference information for Section 1: Patient Rights and Ethics. Please carefully review the questions, endnotes, and reference information (e.g., measure specifications, notes, and frequently asked questions) before you begin. Failure to review the reference information could result in inaccurate responses.

Section 1: Patient Rights and Ethics

Billing Ethics Bibliography and Fact Sheet:

<https://ratings.leapfroggroup.org/measure/hospital/2025/billing-ethics>

Health Care Equity Bibliography and Fact Sheet:

<https://ratings.leapfroggroup.org/measure/hospital/2025/health-care-equity>

Informed Consent Bibliography and Fact Sheet:

<https://ratings.leapfroggroup.org/measure/hospital/2025/informed-consent>

Section 1 includes questions about your hospital's billing ethics, health care equity, and informed consent processes. This section also includes questions on your hospital bed size, admissions, ICUs, and teaching status.

Each hospital achieving the standard for Billing Ethics:

- 1) Provides every patient with a billing statement within 30 days after final claims adjudication that includes all 10 required elements listed in question #1, **and**
- 2) Gives patients instructions for contacting a billing representative with access to an interpretation service to communicate in the patient's preferred language and has the authority to do all three required elements in question #2 within ten business days, **and**
- 3) Does NOT take legal action against patients for late or insufficient payment.

Each hospital achieving the standard for Health Care Equity:

- 1) Collects patient self-identified race, ethnicity, and preferred written and/or spoken language data, **and**
- 2) Trains staff responsible for collecting self-identified demographic data from patients, **and**
- 3) Uses the patient self-identified demographic data to stratify at least one quality measure, **and**
- 4) If disparities were identified, has an updated or revised policy or procedure to address the disparity or has developed a written action plan, **and**
- 5) Shares information about efforts to identify and reduce health care disparities on its public website, **and**
- 6) Reports out and discusses efforts to identify and address health care disparities with the board.

Each hospital achieving the standard for Informed Consent:

- 1) Has a training program on informed consent that tailors different training topics to different staff roles and has made the training required for newly hired staff and existing staff who were not trained, **and**
- 2) Ensures that as part of the process for obtaining informed consent, clinicians explain expected difficulties, recovery time, pain management, and restrictions after a procedure, and give the patient an opportunity to ask questions, **and**
- 3) Ensures every applicable consent form used by the hospital includes the name of the clinician performing the procedure, whether the clinician is expected to be absent, and whether any assistants or trainees will be involved, **and**
- 4) Ensures every applicable consent form is written at a 6th-grade reading level or lower, **and**
- 5) Prior to conducting the informed consent discussion, identifies the patient/legal guardian's preferred language and provides a medical interpreter, and has a place in the consent form that indicates whether an interpreter was used, **and**
- 6) Requires clinicians at the hospital to use the "teach back method" with patients/legal guardians.

Download the 2025 Leapfrog Hospital Survey Scoring Algorithm on the [Scoring and Results webpage](#).

1A: Basic Hospital Information

Hospitals that share a CMS Certification Number are required to report by facility. Please carefully review [Leapfrog's Multi-Campus Reporting Policy](#).

Important Note: Only include units that were open for the entire reporting period and that remain currently open.

Specifications: See [Basic Hospital Information Measure Specifications](#) in the Reference Information beginning on page 50.

Reporting Period: 12 months

- Surveys submitted prior to September 1:
 - 01/01/2024 – 12/31/2024
- Surveys (re)submitted on or after September 1:
 - 07/01/2024 – 06/30/2025

Note: As a reminder, the [Corrections Period](#) (December 1-January 31) is reserved for corrections to previously submitted Surveys only. Any updates made to reflect a change in performance must be made prior to the November 30 Late Submission and Performance Update Deadline. Updates made to reflect a change in performance after November 30 will not be scored or publicly reported.

General Information

1) Reporting period used:	☐ 01/01/2024 – 12/31/2024 ☐ 07/01/2024 – 06/30/2025
2) Total number of licensed acute-care ¹⁰ beds.	_____
3) Total number of staffed acute-care ¹¹ beds.	_____
4) Total number of adult acute-care admissions ¹² to your hospital during the reporting period.	_____
5) Total number of pediatric acute-care admissions ¹³ to your hospital during the reporting period.	_____
6) Does your hospital operate any adult and/or pediatric general medical, surgical, medical/surgical, or neuro ICUs ¹⁴ ? <i>If "yes" to question #6, skip question #11 below.</i> <i>If "no" to question #6, skip questions #7-10 and continue to question #11.</i>	☐ Yes ☐ No
7) Total number of licensed ¹⁵ adult and pediatric general medical, surgical, medical/surgical, and neuro ICU beds.	_____
8) Total number of staffed ¹⁶ adult and pediatric general medical, surgical, medical/surgical, and neuro ICU beds.	_____
9) Total number of adult general medical, surgical, medical/surgical, and neuro ICU ¹⁴ admissions during the reporting period.	_____
10) Total number of pediatric general medical, surgical, medical/surgical, and neuro ICU ¹⁴ admissions during the reporting period.	_____
11) If your hospital does not operate dedicated adult or pediatric general medical, surgical, medical/surgical, or neuro ICUs, does your hospital admit adult and/or pediatric general medical, surgical, medical/surgical or neuro ICU patients to mixed acuity units?	☐ Yes ☐ No

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Section 1: Patient Rights and Ethics

12) Does your hospital operate any of the following specialty ICUs: medical cardiac, respiratory, surgical cardiothoracic, burn, trauma, pediatric cardiothoracic, oncology, or any level neonatal ICU? <i>If “no” to question #12, skip question #13 and continue to question #14.</i>	☐ Yes ☐ No
13) Total number of admissions to any level neonatal ICU ¹⁷ during the reporting period.	_____
14) Is your hospital a Major or Graduate teaching hospital (based on NHSN's definitions) for physicians and/or physicians-in-training or nursing students?	<i>No response required here. Determined automatically based on NHSN 2024 Patient Safety Component – Annual Hospital Survey.</i>

Reporting Period: Answer questions #15-18 based on the practices currently in place at the time you submit this section of the Survey.

Note: As a reminder, the [Corrections Period](#) (December 1-January 31) is reserved for corrections to previously submitted Surveys only. Any updates made to reflect a change in performance must be made prior to the November 30 Late Submission and Performance Update Deadline. Updates made to reflect a change in performance after November 30 will not be scored or publicly reported.

General Hospital Policies

15) To help ensure that patients are cared for by well-trained physicians and other providers (e.g., certified registered nurse anesthetists, certified midwives, or certified nurse-midwives, etc.), do your medical staff by-laws or hospital-wide policies require all physicians and providers who have privileges to provide care at your hospital to be board certified or board eligible?	☐ Yes ☐ No
16) Does your hospital include performance on the Leapfrog Hospital Survey, Leapfrog Hospital Safety Grade, or Leapfrog Top Hospital in performance reviews and/or compensation incentives for senior administrative leadership?	☐ Yes ☐ No
17) Does your hospital have a policy and protocol that empowers patients, or their family caregivers, to activate a rapid response team (RRT) to evaluate the patient for possible escalation of care, that includes all the following elements: • A process to notify patients and family caregivers, verbally or in writing, about how to activate the rapid response team; • A process to ensure clinicians are trained to recognize when a patient or family caregiver is asking for an evaluation by a rapid response team; and • A process to ensure clinicians are trained on how to conduct the evaluation if they are part of the rapid response team?	☐ Yes ☐ No
18) Does your hospital have a protocol to follow-up on patient-reported concerns about their care that includes all the following elements: • All patients and family caregivers are <u>notified</u> of at least one method to report concerns with their care, • All patients and family caregivers who report a concern are <u>contacted</u> by a hospital representative within 30 days of making the report, and • All concerns reported by patients and family caregivers are <u>logged</u> in an incident reporting system?	☐ Yes ☐ No

1B: Billing Ethics

Hospitals that share a CMS Certification Number are required to report by facility. Please carefully review [Leapfrog's Multi-Campus Reporting Policy](#).

Important Note: Hyperlinks throughout this subsection refer to the [Billing Ethics FAQs](#) beginning on page 50, not to endnotes. These hyperlinks are not included in the Online Survey Tool.

Reporting Period: Answer questions #1-3 based on the practices currently in place at the time you submit this section of the Survey.

Note: As a reminder, the [Corrections Period](#) (December 1-January 31) is reserved for corrections to previously submitted Surveys only. Any updates made to reflect a change in performance must be made prior to the November 30 Late Submission and Performance Update Deadline. Updates made to reflect a change in performance after November 30 will not be scored or publicly reported.

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

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Section 1: Patient Rights and Ethics

iii. offer a payment plan?	
3) Does your hospital take legal action against patients for late payment or insufficient payment of a medical bill? <i>This question does not include patients with whom your hospital has entered into a written agreement specifying a good faith estimate for a medical service.</i> <i>Only Military Treatment Facilities should respond “no, but required by federal law to transfer delinquent payments to the Department of Treasury for action.”</i>	☐ Yes ☐ No ☐ No, but required by federal law to transfer delinquent payments to the Department of Treasury for action

Additional Questions (Optional – Fact Finding Only)

4) Does your hospital screen ALL patients to determine if they are eligible for your hospital's financial assistance program, regardless of whether they apply for financial assistance? <i>If “no, we only screen uninsured patients for financial assistance eligibility” or “no, we only screen patients who have applied for financial assistance,” skip question #5 and continue to question #6.</i> <i>If “no, our hospital does not have a financial assistance program,” skip questions #5-7 and continue to the next subsection.</i>	☐ Yes, using a presumptive eligibility tool licensed from a third-party ☐ Yes, using our hospital's own approach to assessing financial assistance eligibility ☐ No, we only screen uninsured patients for financial assistance eligibility ☐ No, we only screen patients who have applied for financial assistance ☐ No, our hospital does not have a financial assistance program
5) Does your hospital notify ALL patients who were determined to be eligible for your hospital's financial assistance program that they have qualified for the program within 30 days of the determination?	☐ Yes ☐ No
6) Does your hospital's financial assistance program apply to ALL clinician fees, in addition to facility fees, for clinicians with privileges at your hospital?	☐ Yes ☐ No ☐ No, but we include a list of covered providers and services in our financial assistance application
7) Does your hospital's financial assistance application include notification that some services, including physician services, may be billed separately?	☐ Yes ☐ No

1C: Health Care Equity

Hospitals that share a CMS Certification Number are required to report by facility. Please carefully review [Leapfrog's Multi-Campus Reporting Policy](#).

Important Notes:

Note 1: Question #5 will not be used in scoring for hospitals that do not identify disparities or if there is inadequate data to determine if disparities exist in question #4. Additionally, question #7 is optional and will not be used in scoring or publicly reported. All other questions will be used in scoring and public reporting.

Note 2: Hyperlinks throughout this subsection refer to the [Health Care Equity FAQs](#) beginning on page 52, not to endnotes. These hyperlinks are not included in the Online Survey Tool.

Reporting Period: Answer questions #1-8 based on the practices currently in place at the time you submit this section of the Survey.

Note: As a reminder, the [Corrections Period](#) (December 1-January 31) is reserved for corrections to previously submitted Surveys only. Any updates made to reflect a change in performance must be made prior to the November 30 Late Submission and Performance Update Deadline. Updates made to reflect a change in performance after November 30 will not be scored or publicly reported.

1) Which of the following patient self-identified demographic data does your hospital collect directly from its patients (or patient's legal guardian) prior to or while registering a patient for a hospital visit? <i>Select all that apply.</i> <i>If "none of the above," skip the remaining questions in Section 1C and continue to the next subsection. The hospital will be scored as "Limited Achievement."</i>	☐ Race ☐ Ethnicity ☐ Spoken language preferred for health care (patient or legal guardian) ☐ Written language preferred for health care (patient or legal guardian) ☐ Sexual orientation ☐ Gender identity ☐ Ability status ☐ None of the above
2) Does your hospital train staff responsible for collecting the self-identified demographic data either in-person or over the phone from patients (or patient's legal guardian) in question #1 at both: - the time of onboarding, and - annually thereafter?	☐ Yes ☐ No
3) Does your hospital use the patient self-identified demographic data it collects directly from patients (or patient's legal guardian) in question #1 to stratify <u>any</u> quality measure(s) with the aim of identifying health care disparities? <i>If "no" to question #3, skip questions #4-5 and continue to question #6.</i>	☐ Yes ☐ No
4) By stratifying the quality measure(s) from question #3, has your hospital identified any health care disparities among its patients? <i>If "no, disparities were not identified" or "inadequate data available to determine if disparities exist" to question #4, skip question #5 and continue to question #6.</i>	☐ Yes, disparities were identified ☐ No, disparities were not identified ☐ Inadequate data available to determine if disparities exist

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Section 1: Patient Rights and Ethics

5) In the past 12 months, has your hospital used the data and information obtained through question #4 to update or revise its policies or procedures? OR In the past 12 months, has your hospital developed a written action plan that describes how it will address at least one of the health care disparities identified through question #4?	☐ Yes ☐ No
6) Does your hospital share information on its efforts to identify and reduce health care disparities and the impact of those efforts on its public website based on <i>race, ethnicity, spoken language preferred for health care (patient or legal guardian), written language preferred for health care (patient or legal guardian), sexual orientation, gender identity, or ability status</i>? <i>If “no” to question #6, skip question #7 and continue to question #8.</i>	☐ Yes ☐ No
7) Webpage⁸ URL where efforts to identify and reduce health care disparities and the impact of those efforts (based on the self-identified demographic data collected directly from patients or patient’s legal guardian) are displayed: <i>The http:// prefix needs to be included.</i> <i>This question is optional and response will not be scored or publicly reported in 2025.</i>	_____
8) Does your hospital report out and discuss efforts related to identifying and addressing disparities with the Board at least annually?	☐ Yes ☐ No

1D: Informed Consent

Hospitals that share a CMS Certification Number are required to report by facility. Please carefully review [Leapfrog's Multi-Campus Reporting Policy](#).

Important Notes:

Note 1: Question #2, while required, will not be scored or publicly reported.

Note 2: In this subsection, questions regarding the informed consent process and consent forms ONLY apply to those procedures where general anesthesia, regional anesthesia, or monitored anesthesia care is used. The questions do NOT apply to anesthesia care; they only apply to the consent process and consent forms for applicable procedures.

Note 3: Hyperlinks throughout this subsection refer to the [Informed Consent FAQs](#) beginning on page 54, not to endnotes. These hyperlinks are not included in the Online Survey Tool.

Reporting Period: Answer questions #1-7 based on the practices currently in place at the time you submit this section of the Survey.

Note: As a reminder, the [Corrections Period](#) (December 1-January 31) is reserved for corrections to previously submitted Surveys only. Any updates made to reflect a change in performance must be made prior to the November 30 Late Submission and Performance Update Deadline. Updates made to reflect a change in performance after November 30 will not be scored or publicly reported.

Policies and Training

1) Does your hospital train employed staff on informed consent and tailor different training topics to different staff roles , including hospital leaders, MD/NP/PA, nurses and other clinical staff, administrative staff, and interpreters, and has your hospital made the training: - a required component of onboarding for the appropriate newly hired staff, and - required for the appropriate existing staff who were not previously trained?	☐ Yes ☐ No
2) At least once a year, does your hospital solicit feedback from patients/legal guardians about your hospital's informed consent process to understand how it can be improved over time? <i>This question is required but response will not be scored or publicly reported in 2025.</i>	☐ Yes ☐ No

Content of Informed Consent Forms

3) As part of your hospital's process for obtaining informed consent, does: - the clinician explain expected difficulties, recovery time, pain management, and restrictions after a procedure that may be experienced by the patient either in the hospital or post-discharge, if applicable; - the patient have the opportunity to ask questions; and - the consent form document that these two elements of the process have taken place?	☐ Yes ☐ No
---	---

4) Do ALL applicable consent forms used by your hospital include: - the name(s) of the clinician(s) performing the procedure; - whether the clinician is expected to be absent from portions of the procedure (e.g., opening, closing), if applicable; and - whether any assistants or trainees will be involved in the procedure, if applicable?	☐ Yes ☐ No
5) Are ALL applicable consent forms used by your hospital written at a 6th-grade reading level or lower? <i>The procedure name and description, and any words accompanied by a plain language definition can be excluded from the reading level assessment.</i>	☐ Yes, all applicable forms are written at a 6th-grade reading level or lower ☐ No, but at least one form is written at a 6th-grade reading level or lower ☐ No forms are written at a 6th-grade reading level or lower ☐ No, all applicable forms are written at a 9th-grade reading level or lower

Process for Gaining Informed Consent

6) Prior to the informed consent discussion, does your hospital: - ask what the patient/legal guardian's preferred language for medical decision-making is; - where needed, provide the patient/legal guardian access to a qualified medical interpreter, NOT a family caregiver; - use a consent form or notation in the medical record to document whether a qualified medical interpreter was used to conduct the informed consent process; and - have the medical interpreter sign the consent form (either in-person, electronically, or by documenting the use of an interpreter in the medical record)?	☐ Yes ☐ No
7) As part of the informed consent discussion, do clinicians at your hospital use the "teach back method" with patients/legal guardians where patients/legal guardians are asked to describe in their own words what they understand will be performed, why it will be performed, and what are the primary risks?	☐ Yes ☐ No

As the hospital CEO or as an employee of the hospital to whom the hospital CEO has delegated responsibility, I have reviewed this information pertaining to the Patient Rights and Ethics Section at our hospital, and I hereby certify that this information is true, accurate, and reflects the current, normal operating circumstances at our hospital. I am authorized to make this certification on behalf of our hospital.

Affirmed by _____, the hospital's _____,
(first name and last name) (title)
on _____.
(date)

Section 1: Patient Rights and Ethics Reference Information***What's New in the 2025 Survey*****Section 1A: Basic Hospital Information**

In response to comments collected during the public comment period and through the national pilot, Leapfrog is making additional updates to Section 1A: Basic Hospital Information to ask hospitals that do not operate dedicated general medical, surgical, medical/surgical, or neuro ICUs if they admit adult and/or pediatric general medical, surgical, medical/surgical, or neuro ICU patients to mixed acuity units. The purpose of this new question is to identify hospitals without a dedicated ICU that are eligible to report on ICU Physician Staffing in Sections 5A: Adult ICU Physician Staffing and 5B: Pediatric ICU Physician Staffing. Leapfrog is also asking hospitals to report on adult and pediatric admissions to their general medical, surgical, medical/surgical, and neuro ICUs separately to help identify what types of ICUs hospitals are eligible to report on.

Additionally, Leapfrog is updating the unit description endnotes in Section 1A: Basic Hospital Information to add further clarification and alignment with reporting in other sections of the Survey. The endnotes defining licensed acute-care beds and licensed ICU beds are also being updated to instruct hospitals to report the number of staffed beds if beds are currently staffed higher than licensed. The endnote for acute-care beds will also instruct hospitals to include telemetry, as well as step-down/progressive beds, and exclude observation and swing beds. The endnote for licensed ICU beds will instruct hospitals to exclude beds used for step-down/progressive care.

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

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

Section 1B: Billing Ethics

In response to feedback from hospitals participating in the Survey, Leapfrog is making the following updates to Section 1B: Billing Ethics:

- Question #1, regarding the itemized billing statement, will continue to ask that the itemized billing statement be provided either by mail or electronically (via email or the patient portal), however, Leapfrog is no longer adding patient preference in 2025.

Additionally, Leapfrog is retaining the optional, fact-finding questions regarding presumptive screening of patients for financial assistance and patient notification when financial assistance has been applied, for a second year with plans to incorporate into the national Billing Ethics Standard in 2026, but is making the following updates:

- Question #4, regarding the presumptive screening of patients for financial assistance, is being updated to clarify that ALL patients should be included in the screening process. We are also adding a response option for hospitals that only screen uninsured patients.

Two additional fact-finding questions will also be added regarding whether all clinicians are included in the hospital's financial assistance program as well as a notification that some services may be billed separately. We are also adding a FAQ with further information

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

Section 1C: Health Care Equity

Leapfrog will continue to score and publicly report the Health Care Equity standard and will be making the following updates to Section 1C: Health Care Equity:

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

Leapfrog will add a new optional question asking hospitals to provide a link to where they publicly share their efforts to identify and reduce health care disparities. Only hospitals that answer “yes” to question #6 will be asked to provide the URL. This question, and the provided URL, will be used as part of Leapfrog’s [Data Verification Protocols](#). The URL will not be scored or publicly reported.

There are no changes to the scoring algorithm for Section 1C: Health Care Equity

Section 1D: Informed Consent

Based on the fact that health care facilities in Georgia and Texas have a statutory protection facilitated by using consent forms at a ninth-grade reading level, Leapfrog will maintain the current scoring algorithm giving hospitals the ability to earn “Considerable Achievement” by having all consent forms written at a ninth-grade reading level, when additional criteria in the section are met. However, since 54% of Americans between the ages of 16 and 74 read below the equivalent of a sixth-grade level, hospitals will continue to be required to have all applicable consent forms written at a sixth-grade reading level or lower to “Achieve the Standard.” In response to questions and feedback from hospitals participating in the Survey, Leapfrog is updating question #1 to clarify that the question about training only concerns individuals employed by the hospital.

We are also updating FAQ#22 to indicate that only administrative staff with a patient-facing role need to be trained on informed consent.

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

Change Summary Since Release

None. If substantive changes are made to this section of the Survey after release on April 1, 2025, they will be documented in this Change Summary section.

Section 1A: Basic Hospital Information Measure Specifications

Important Note: Hospitals that share a CMS Certification Number are required to report by facility. Please carefully review [Leapfrog's Multi-Campus Reporting Policy](#).

Teaching Status is obtained directly from CDC's National Healthcare Safety Network (NHSN) using a hospital's response to the following questions within the "Hospital Facility" section of the 2024 Patient Safety Component – Annual Hospital Survey:

Is your hospital a teaching hospital for physicians and/or physicians-in-training or nursing students? [Yes, No]

If Yes, what type: [Major, Graduate, Undergraduate]

NHSN Home

- Alerts
- Dashboard
- Reporting Plan
- Patient
- Event
- Procedure
- Summary Data
- COVID-19
- Import/Export
- Surveys**
- Analysis
- Users
- Facility

View Annual Survey

Mandatory fields marked with *

Facility ID: * The Leapfrog Group Test (ID 93395)

Survey Type: * FACSRV-PS - Hospital Survey Data

Survey Year: * 2024

In the previous calendar year, indicate: ☐ Facility was not operational in this survey year

Facility Characteristics (completed by Infection Preventionist)

Facility ownership: * GOV - Government

Hospital Facility:

Number of Patient Days: *

Number of Admissions: *

Is your hospital a teaching hospital for physicians and/or physicians-in-training or nursing students? * N - No

If Yes, what type: ☐ MAJOR ☐ GRADUATE ☐ UNDERGRADUATE

For the purposes of the 2025 Leapfrog Hospital Survey and Leapfrog's Top Hospital program, Leapfrog will consider the following types a "teaching hospital:" Major and Graduate. NHSN's definitions for types of teaching hospitals may be reviewed [here](#). This designation will also be used for the purposes of assigning hospitals to a teaching or non-teaching hospital cohort for the purposes of scoring the Total Nursing Care Hours per Patient Day, RN Hours per Patient Day, and Nursing Skill Mix measures in [Section 5C: Nursing Workforce](#).

In order for Leapfrog to obtain teaching status from NHSN, hospitals must complete the following steps:

- 1) Join Leapfrog's NHSN Group and review/accept Leapfrog's Data Rights Template by the published [deadlines](#)*,
- 2) Enter a valid NHSN ID in the Profile of their 2025 Leapfrog Hospital Survey, and
- 3) Submit a 2025 Leapfrog Hospital Survey by the published [deadlines](#).

*Hospitals are not required to "re-join" Leapfrog's NHSN Group if they joined and conferred rights in previous Leapfrog Hospital Survey Cycles. However, all hospitals in Leapfrog's NHSN Group must review their Rights Acceptance Report at least annually by the published [join-by deadlines](#).

Instructions for joining or verifying that you are in Leapfrog's NHSN Group are available [here](#) (See "NHSN Guidance: Join the Group, Data Rights Template, and Downloading Reports"). These instructions also include information for verifying the teaching status response to the 2024 Patient Safety Component – Annual Hospital Survey.

Section 1: Patient Rights and Ethics Frequently Asked Questions (FAQs)

Basic Hospital Information FAQs

1. How does Leapfrog define board certified and board eligible?

For physicians:

- **Board certified** means that the physician has been awarded certification from the American Board of Medical Specialties (ABMS) or the American Osteopathic Association (AOA).
- **Board eligible** indicates that the physician has completed their initial training/fellowship but has not yet passed an existing board-certifying exam in a specialty. Leapfrog adheres to the ABMS and AOA Board Eligibility Policy for all specialties, which may be reviewed here: <https://www.abms.org/board-certification/board-certification-requirements/board-eligibility/> and <https://certification.osteopathic.org/about/>, respectively. These eligibility periods provide the physician with an adequate window to take their boards and re-take if necessary.

For CRNAs, **board certified** means that the RN has been awarded certification from The National Board of Certification and Recertification for Nurse Anesthetists (NBCRNA).

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

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

3. What are some examples of a protocol to follow-up on patient-reported concerns? What kinds of concerns are we supposed to be capturing?

Leapfrog's goal is to capture how hospitals are encouraging the submission of, and following up on, issues or complaints from patients that are specific to the care they received at the hospital.

Examples of opportunities to report would include any of the following:

- Notifying patients on admission about their right to report concerns as part of their [rights and responsibilities](#);
- A patient experience department that can be contacted by telephone, e-mail, and in-person;
- A reporting system available to patients through the patient portal e.g. a specific function or message in the application that prompts patients to report concerns, including through messaging the provider directly;
- A patient survey administered to patients soliciting concerns with their care; or
- The free text fields of the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) Survey.

Billing Ethics FAQs

4. Can we consider information provided to patients at admission, or as part of the "conditions of admission" packet of material, as information that meets one or more of the elements of the billing statement in question #1?

No. Only information provided directly to the patient by mail or electronically (via email or the patient portal) can be considered.

5. To meet the criteria for item “i” in question #1, does our hospital have to translate the billing statement and/or master itemized bill to every language spoken by our patients?

Hospitals must provide instructions, in the patient’s preferred language, on how to obtain a written translation or oral interpretation of the bill if the language constitutes 5% (and at least 50 patients) or 1,000 patients (whichever is less) of the population eligible to be served or likely to receive care at the hospital.

6. As a SafetyNet hospital, our funding comes from taxpayers, grants, and government funding. A large portion of our patients are deemed indigent and do not receive a bill for any services. Only a small portion with insurance will receive a bill. Therefore, we do not send a bill to every patient. Can we respond “yes” to question #1?

Yes. Hospitals do not need to provide billing statements to patients with no balance due in order to respond “yes” to question #1. However, for those patients who are receiving a bill, all the criteria listed in the question must be included to respond “yes.”

7. What does Leapfrog mean by “legal action” in question #3?

Legal action can include, but is not limited to, a lawsuit, wage garnishment, filing to take a patient’s money out of their tax return, seizing or placing a lien on a patient’s personal property, and selling or transferring a patient’s debt to a debt collection agency that will take legal action against the patient. If, through their contract with the hospital, the debt collection agency is prevented from taking legal action against patients, selling or transferring a patient’s debt to that debt collection agency would not be considered legal action.

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

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

8. What are alternatives to legal action against patients?

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

9. What is a “good faith estimate” as referred to in question #3?

A good faith estimate includes an itemized list of expected charges for the primary item or service the patient will receive and any other items or services provided as part of the same scheduled episode of care. The final bill must be no more than \$400 over the amount of the good faith estimate. The Centers for Medicare and Medicaid Services have published an example template for providing good faith estimates: <https://www.cms.gov/files/document/good-faith-estimate-example.pdf>.

10. How and when should hospitals initiate the screening process for their financial assistance program?

Hospitals should initiate the eligibility screening process on all patients at the time of registration. Hospitals can do so by using presumptive eligibility software used to determine Medicaid eligibility to help determine if patients are eligible for the hospital’s own financial assistance programs (e.g., Waystar, FinThrive, RevCo, etc.). Hospitals can use tools such as Experian or paper applications to assess a patient’s ability to pay.

11. What does Leapfrog mean when asking if the hospital's financial assistance program includes ALL clinicians with privileges at the hospital?

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

Health Care Equity FAQs**12. Our hospital is just starting to explore the collection and use of demographic data. What are some resources or tools we can use to collect demographic data?**

Hospitals can refer to [the Toronto Measuring Health Equity website](#) which includes training videos, manuals, and presentations on how to collect demographic data from patients, including the modeling of interactions between health care staff and patients. Additionally, CMS also has some free tools available on their website at: <https://www.cms.gov/priorities/health-equity/minority-health/research-data/research-data/tools>.

13. What types of demographic data should hospitals be collecting?

At minimum, hospitals should collect ethnicity and race data from patients. While the Office of Management and Budget (OMB) has revised their Standards for maintaining, collecting, and presenting federal data on race and ethnicity, hospitals may not have implemented those updates. However, the following minimum categories should be used: American Indian or Alaska Native, Asian, Black or African American, Hispanic or Latino, Native Hawaiian or Pacific Islander, and White.

Regarding patient self-identified gender identity and sexual orientation, the Centers for Disease Control and Prevention has issued helpful guidance for providers and facilities, including guidance on the type of questions to ask patients. More information is available at <https://www.cdc.gov/hivnexus/hcp/sexual-history/index.html>.

14. To select any of the patient self-identified demographic data in question #1, does a hospital need to collect the data in a particular way?

Hospitals should be regularly collecting the information via registration or a nurse admission assessment directly from the patient or, for pediatric and other patients who cannot communicate the information themselves, the patient's legal guardian. Patients or their legal guardians should have the opportunity to provide the information either verbally (in-person or over the phone) or via a paper form or online patient portal. Information should NOT be collected through observation or other documents (e.g., state-issued ID). This information should be collected from inpatients and outpatients.

15. Does Leapfrog have an example of how to collect patient self-reported "sexual orientation" in question #1?

The CDC has helpful information available on their website at <https://www.cdc.gov/hivnexus/hcp/sexual-history/index.html>. This webpage includes guidance for discussing sexual health, sexual orientation, and gender identity. Additionally, they provide some helpful tips on what questions to ask to collect the data.

16. What does Leapfrog mean by "ability status"?

As described by the [CDC](#), a disability is any condition of the body or mind (impairment) that makes it more difficult for the person with the condition to do certain activities (activity limitation) and interact with the world around them (participation restrictions). More information is available on the CDC website at https://www.cdc.gov/disability-and-health/about/?CDC_AAref_Val=https://www.cdc.gov/ncbddd/disabilityandhealth/disability.html.

Examples of questions and ways to determine one's ability status can be found here:

- https://www.cdc.gov/dhds/datasets/?CDC_AAref_Val=https://www.cdc.gov/ncbddd/disabilityandhealth/datasets.html

- <https://torontohealthequity.ca/wp-content/uploads/2018/03/Measuring-Health-Equity-Participant-Manual-2018.pdf>
- [Short Set of question on Disability: Data Collection - Washington Group](#)
- [Video 2 - Collecting Disability Data](#)

17. How does Leapfrog define “health care disparities?”

Leapfrog defines health care disparities as differences in the quality of health care that are not due to access-related factors or clinical needs, preferences, and appropriateness of intervention. More information is available at <https://www.ihl.org/insights/words-matter-making-sense-health-equity-terminology>.

18. In question #4, what does Leapfrog mean by “inadequate data available to determine if disparities exist”?

Hospitals may find that they cannot determine if a health care disparity exists due to small sample sizes (e.g., fewer than 25 patients able to be measured).

19. Can we report on health system level data in question #4 if we do not have adequate data to determine if disparities exist?

Yes, individual hospitals that do not have enough data to identify disparities among their patients based on the demographic data selected in question #1 can respond “yes” to question #4 if they are aggregating their data for the purposes of analysis with other facilities that are part of their system.

20. In question #6, is Leapfrog asking whether our hospital is publicly reporting the measures we stratify from question #3 on our website?

No. We are trying to assess the extent to which hospitals are sharing any information on their efforts to identify and reduce health care disparities based on the self-identified demographic data collected directly from the patient or legal guardian present and the impact of those efforts. This may take the form of sharing quantitative or qualitative data. It may also include a description of the types of demographic data collected and the analyses performed, which in some cases demonstrated no apparent health care disparities. Please note that the information on your webpage should be easily accessible. If your hospital is part of a health system, you must provide a link to the system webpage from your hospital's individual website. Below are examples that meet the criteria for question #6.

- Henry Ford Health: <https://www.henryford.com/about/diversity/why-we-ask>
- NewYork-Presbyterian: <https://www.nyp.org/daliocenter/data-and-infrastructure>

Informed Consent FAQs

21. In cases where hospitals do not have information about informed consent processes that take place at a clinician’s (e.g., surgeon’s) office, or if informed consent processes are conducted by clinicians that are not employed by the hospital, or in other cases where the hospital does not have visibility into the informed consent process, how should hospitals respond to questions in this section?

Hospitals that do not have input over the consent form or visibility into the informed consent process for procedures performed at a hospital, should select “No” for the questions in this section.

If the hospital does have input over the consent form and visibility into the informed consent process for procedures performed at the hospital, such as through the privileging process to allow clinicians to practice at their facility, but the consent forms and the consent process are being completed at the clinician(s)'s office, the hospital can work with those offices to implement the requirements outlined in the questions and, via an annual audit, verify that the forms and process meet the criteria to respond “Yes” to the questions in this section. All documentation should be maintained throughout the Survey Cycle.

22. Are there any examples of patients for whom the informed consent questions would not apply?

When responding to the questions in this subsection, you can exclude patients who are unable to communicate and for whom no legal guardian or medical proxy has been identified at least one week prior to the procedure being performed.

23. Should we consider the term “legal guardian” to be equivalent to the term “legal surrogate decision-maker”?

Yes, for the purposes of the Leapfrog Hospital Survey, these terms are equivalent.

24. What roles and staff levels need to be included in the training program on informed consent included in question #1? What types of training can we use?

As described on page 98 of the [AHRQ's Making Informed Consent an Informed Choice – Training for Health Care Leaders](#), the appropriate roles for training include all the following: hospital leaders, physicians/independent nurse practitioners/independent physician assistants, nurses or other clinical staff, administrative staff in a patient-facing role, and interpreters. The training may be tailored to only include relevant materials based on the staff role. The goal is for each responsible staff person to be trained in their applicable domains. For example:

- For hospital leaders, training on the definition and principles of informed consent and specifics on the hospital's informed consent policy is appropriate.
- Clinical staff such as physicians and nurses should also be trained in strategies for clear communication, for presenting choices, and for documentation, if they are responsible for directly conducting the informed consent process.
- For administrative staff in a patient-facing role and interpreters, participating in the informed consent process should also be trained in reviewing and completing documentation.

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

Training does not need to be exclusive to informed consent and can be included as a component or module in other trainings. Examples of trainings include computer-based training, one-on-one precepting, webinars, and staff meeting presentations, as well as other modalities where learning can be assessed after the content is delivered to the trainee.

25. Regarding the process for soliciting patient feedback in question #2, what parameters should this process follow? Is there a specific patient feedback form that should be used?

Any method of soliciting feedback from patients who have gone through your informed consent process would be acceptable. One example would be surveying patients after discharge; another example would be asking the hospital's Patient and Family Caregiver Advisory Council (PFAC), if the PFAC includes at least one person who has experience with consenting to a procedure at the hospital in the past 24 months, either for themselves or on behalf of a patient as a caregiver. Asking about the specific verbiage used in the consent form, as well as more general questions about the consent process itself, would both be acceptable areas of inquiry. It is Leapfrog's goal to encourage hospitals to ensure their process is working well for patients by being as flexible as possible in allowing for differing methods.

For an example of a survey of patient's experience with the informed consent process, see: Hallock JL, Rios R, Handa VL. Patient satisfaction and informed consent for surgery. *Am J Obstet Gynecol*. 2017 Aug;217(2):181.e1-181.e7. doi: 10.1016/j.ajog.2017.03.020. Epub 2017 Mar 28. PMID: 28363439.

26. Should each consent form be customized to include patient- and procedure-specific details to explain expected difficulties and recovery time (question #3)?

No. Instead, the consent form must document that the conversation between the patient and the clinician took place, and that the patient had the opportunity to ask questions. For example, such language might read: “I confirm that the choices for my treatment were explained to me. I understand the risks I may face and the benefits that may happen. I also know about the issues I might face from having the procedure. I understand how long I will take to recover, how I can manage my pain, and any rules to follow while I am in the hospital and after I leave. I also understand why the procedure is being done.”

27. Does the consent form need to specifically name the assistants and trainees who will be involved in the procedure, the same way the consent form needs to name the clinician performing the procedure?

No. The consent form only needs to indicate that assistants or trainees may be involved, if this applies to the specific procedure the patient is signing the consent form for.

28. Why has Leapfrog selected a 6th-grade reading level target for consent forms, and what are some strategies we can use to meet this?

Just over half of U.S. adults have a reading level that permits them to understand and synthesize information from a complex text. According to [a Gallup analysis](#), 54% of Americans between the ages of 16 and 74 read below the equivalent of a sixth-grade level. A [more recent survey by the Organization for Economic Development and Cooperation \(OECD\)](#) indicates that literacy in the U.S. has gradually declined since that Gallup analysis, suggesting a still-greater proportion of the population reads below a sixth-grade level today.

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

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

29. How should the reading level of the consent form be assessed?

There are software tools available to assess reading level. For example, consent forms can be edited in Microsoft Word 365, where a readability tool can be used to make this assessment by: (1) on the "File" tab, click the "Options" button; (2) on the "Proofing" tab, under "When correcting spelling and grammar in Word," select the "Show readability statistics" check box. Exit the window. Then, under the Review tab in your Word document, click the "Editor" button in the far left corner of the ribbon, then click "Insights – Document Stats" on the "Editor" sidebar. Word displays a message box showing you the Flesch-Kincaid readability grade-level: any value less than or equal to 6.9 is considered a "sixth-grade" reading level. Reading level can also be assessed using online tools, such as those provided at Readable.com, provided those tools use either the Flesch-Kincaid or SMOG readability standard to evaluate the readability of written language.

30. What information on the consent form can be excluded from the reading level assessment?

The procedure name and description can be excluded from the reading level assessment. In addition, information intended to be read by the provider or administrative staff ONLY, such as instructions for signing and returning the consent form, and information that is written in by an individual provider to give that patient information specific to their condition, can also be excluded. Finally, any words where a sixth-grade reading level definition is included with the term can be excluded from the reading level assessment. For example, in the sentence "anesthesia (putting you to sleep)," only "putting you to sleep" needs to be considered in the reading level assessment.

31. What is a qualified medical interpreter?

In the [U.S. Department of Health and Human Services 2023 Language Access Plan](#), a qualified medical interpreter is defined as "A bilingual/multilingual person who has the appropriate training and experience or demonstrated ability to fully understand, analyze, and process and then faithfully render a spoken, written, or signed message in one language into a second language and who abides by a code of professional practice and ethics." Leapfrog adheres to this definition for the purposes of reporting on the Hospital Survey.

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SECTION 2: MEDICATION SAFETY

This section includes questions and reference information for Section 2: Medication Safety. Please carefully review the questions, endnotes, and reference information (e.g., measure specifications, notes, and frequently asked questions) before you begin. Failure to review the reference information could result in inaccurate responses.

Section 2: Medication Safety

Computerized Physician Order Entry (CPOE) Fact Sheet and Bibliography:

<https://ratings.leapfroggroup.org/measure/hospital/2025/safe-medication-ordering>

Bar Code Medication Administration (BCMA) Fact Sheet and Bibliography:

<https://ratings.leapfroggroup.org/measure/hospital/2025/safe-medication-administration>

Medication Reconciliation Fact Sheet:

<https://ratings.leapfroggroup.org/measure/hospital/2025/medication-reconciliation>

In Section 2, pediatric hospitals should only respond to questions in Sections 2A and 2C. Sections 2B and 2D do not apply to pediatric hospitals. Additionally, pediatric hospitals are not required to complete the CPOE Evaluation Tool.

Section 2 includes questions about your hospital's use of CPOE and BCMA, and (for adult and general hospitals) questions about your hospital's medication reconciliation process. The EHR application subsection (2B) is only applicable to adult and general hospitals and will not be scored or publicly reported. In 2025, three questions about Artificial Intelligence (AI) applications were added to subsection 2B – these questions are optional and will not be scored or publicly reported.

Each hospital achieving the standard for Computerized Physician Order Entry (CPOE):

1. Assures that prescribers enter at least 85% of inpatient medication orders via a computer system that includes decision support software to reduce prescribing errors, **and**
2. For adult and general hospitals, demonstrates, via a test, that its inpatient CPOE system can alert physicians to at least 60% of frequent serious medication errors known to cause harm to patients.

Each hospital achieving the standard for Bar Code Medication Administration:

1. Has implemented the use of BCMA at the bedside in 100% of applicable units; **and**
2. Has achieved at least 95% compliance with scanning patients and medications during administration in applicable units where BCMA is implemented; **and**
3. Has a BCMA system that includes all the following types of decision support: wrong patient, wrong medication, wrong dose, wrong time, and second nurse check needed; **and**
4. Has at least six of the following structures in place to monitor and reduce workarounds: has a formal committee that meets routinely to review data reports on BCMA system use, has back-up equipment for hardware failures, has a help desk that provides timely responses to urgent BCMA issues in real-time, conducting real-time observations of users using the BCMA system, and engages nursing leadership at the unit level on BCMA use. Additionally, information from these structures is used to implement quality improvement projects or monitor previous quality improvement projects focusing on the hospital's BCMA system. Results from the quality improvement projects are evaluated and demonstrate that these projects have resulted in higher adherence to standard medication administration processes. Finally, resolution of system deficiencies and/or problems that may have contributed to the workaround are communicated back to the end user.

Each hospital achieving the standard for Medication Reconciliation:

1. Uses a nationally endorsed protocol to collect data on the accuracy of its medication reconciliation process for at least 30 sampled patients and reported the data collected to Leapfrog, **and**
2. Has a rate of unintentional medication discrepancies that is lower than the 50th percentile (where lower performance is better).

Download the 2025 Leapfrog Hospital Survey Scoring Algorithm on the [Scoring and Results webpage](#).

2A: Computerized Physician Order Entry (CPOE)

Hospitals that share a CMS Certification Number are required to report by facility. Please carefully review [Leapfrog's Multi-Campus Reporting Policy](#).

Important Notes:

Note 1: "Prescribers" used throughout this subsection refers to all licensed clinicians who are authorized by the state in which the hospital is located to order medications for patients. This includes residents and interns who are authorized to order medications under their own authority.

Note 2: Adult and general hospitals must complete an Adult Inpatient Test at least once per Survey Cycle (April to November). Hospitals are encouraged to ensure that the Adult Inpatient CPOE Test is submitted along with the Survey to meet the deadlines for Leapfrog's Programs such as Top Hospital, Leapfrog Hospital Safety Grade, etc.

Note 3: Hospitals will have access to the CPOE Evaluation Tool immediately after completing the Hospital Profile in the Online Hospital Survey Tool.

Specifications: See [Computerized Physician Order Entry \(CPOE\) Measure Specifications](#) in the Reference Information beginning on page 72.

Reporting Period: 3 months

Answer questions #1-5 for the latest 3-month period prior to the submission of this section of the Survey.

Note: As a reminder, the [Corrections Period](#) (December 1-January 31) is reserved for corrections to previously submitted Surveys only. Any updates made to reflect a change in performance must be made prior to the November 30 Late Submission and Performance Update Deadline. Updates made to reflect a change in performance after November 30 will not be scored or publicly reported.

1) What is the latest 3-month reporting period for which your hospital is submitting responses to this section? 3-month reporting period ending:	<u> </u> <i>Format: Month/Year</i>
2) Does your hospital have a functioning CPOE system in one or more <u>inpatient</u> units of the hospital that: - includes decision support software to reduce prescribing errors; and - is linked¹⁸ to pharmacy, laboratory, and admitting-discharge-transfer (ADT) information in your hospital? <i>If "no" to question #2, skip the remaining questions in Section 2A and Section 2B, and continue to Section 2C. The hospital will be scored as "Limited Achievement."</i>	☐ Yes ☐ No
3) Total number of inpatient medication orders , including orders made in units that do NOT have a functioning CPOE system.	<u> </u>
4) Total number of inpatient medication orders in question #3 that licensed prescribers entered via a CPOE system that meets the criteria outlined in question #2.	<u> </u>

If "yes" to question #2 and you are an **adult or general hospital**, use the **Take CPOE Tool** button on the Survey Dashboard to access the **CPOE Evaluation Tool**. Question #5 does not apply to pediatric hospitals.

- 5) Hospital's score when it tested its CPOE system using the Leapfrog CPOE Evaluation Tool:

Adult Inpatient Test must be completed between April 1 and November 30, 2025.

*No response required here. Determined automatically based on **separately completing** a test using the Leapfrog CPOE Evaluation Tool.*

2B: EHR Application Information

This section is not applicable to pediatric hospitals.

Hospitals that share a CMS Certification Number are required to report by facility. Please carefully review [Leapfrog's Multi-Campus Reporting Policy](#).

Important Note: This subsection will not be scored or publicly reported. The information collected in this subsection is used by the CPOE Evaluation Tool developers for research and CPOE Evaluation Tool improvements.

Reporting Period: Answer questions #1-6 based on the EHR application currently in place at the time you submit this section of the Survey.

Note: As a reminder, the [Corrections Period](#) (December 1-January 31) is reserved for corrections to previously submitted Surveys only. Any updates made to reflect a change in performance must be made prior to the November 30 Late Submission and Performance Update Deadline. Updates made to reflect a change in performance after November 30 will not be scored or publicly reported.

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

Additional Questions (Optional – Fact Finding Only)

7) Does your hospital currently use any Artificial Intelligence (AI) applications as part of your medication ordering decision support system? <i>If “no” to question #7, skip the remaining questions in Section 2B, and continue to Section 2C.</i>	☐ Yes ☐ No
8) Which Artificial Intelligence (AI) vendor source is your hospital currently using as part of your medication ordering decision support system? <i>Select all that apply.</i> <i>If “Other AI Vendor” or “Other Homegrown AI Application” is selected, continue to question #9. Otherwise, skip question #9 and continue to the next subsection.</i>	EHR Vendors ☐ Epic ☐ Cerner ☐ Allscripts (Altera) ☐ Meditech ☐ Quadramed ☐ CPSI Medication Safety Vendors ☐ First Databank ☐ Medi-Span ☐ Multum ☐ Lexicomp ☐ Elsevier Other ☐ Other AI Vendor ☐ Other Homegrown AI Application
9) What are the names of the Other AI Vendors or Other Homegrown AI Applications that your hospital is currently using as part of your medication ordering decision support system? <i>If entering multiple Other AI Vendors or Other Homegrown AI Applications, separate each by a comma.</i>	_____

2C: Bar Code Medication Administration (BCMA)

Hospitals that share a CMS Certification Number are required to report by facility. Please carefully review [Leapfrog's Multi-Campus Reporting Policy](#).

Important Note: Only include units that were open for the entire reporting period and that remain currently open.

Specifications: See [Bar Code Medication Administration \(BCMA\) Measure Specifications](#) in the Reference Information beginning on page 73.

Reporting Period: 3 months

Answer questions #1-21 for the latest 3-month period prior to the submission of this section of the Survey.

Note: As a reminder, the [Corrections Period](#) (December 1-January 31) is reserved for corrections to previously submitted Surveys only. Any updates made to reflect a change in performance must be made prior to the November 30 Late Submission and Performance Update Deadline. Updates made to reflect a change in performance after November 30 will not be scored or publicly reported.

1) What is the latest 3-month reporting period for which your hospital is submitting responses to questions #2-21? 3-month reporting period ending:	_____ <i>Format: Month/Year</i>
2) Does your hospital use a Bar Code Medication Administration (BCMA) system that is linked to the electronic medication administration record (eMAR) when administering medications at the bedside in at least one of the following adult and/or pediatric units: • General Medical, Surgical, Medical/Surgical, Neuro¹⁴, Neonatal¹⁷, or Specialty ICUs; • Medical, Surgical, or Medical/Surgical Units (including telemetry units)¹⁹; • Step-down/Progressive Units²⁰; • Labor and Delivery Unit²¹; or • Pre-operative and Post-anesthesia Care Units²²? <i>If "no" to question #2, skip questions #3-21 and continue to the next subsection. The hospital will be scored as "Limited Achievement."</i>	☐ Yes ☐ No
3) Does your hospital operate adult and/or pediatric General Medical, Surgical, Medical/Surgical, Neuro ¹⁴ , Neonatal ¹⁷ , or Specialty ICUs? <i>If "no" to question #3, skip questions #4-5 and continue to question #6.</i>	☐ Yes ☐ No
4) If "yes," how many of this type of unit are open and staffed in the hospital?	_____
5) How many of the units in question #4 utilized the BCMA/eMAR system when administering medications at the bedside?	_____
6) Does your hospital operate adult and/or pediatric Medical, Surgical, or Medical/Surgical Units (including telemetry units) ¹⁹ ? <i>If "no" to question #6, skip questions #7-8 and continue to question #9.</i>	☐ Yes ☐ No
7) If "yes," how many of this type of unit were open and staffed in the hospital?	_____

8) How many of the units in question #7 utilized the BCMA/eMAR system when administering medications at the bedside?	_____
9) Does your hospital operate adult and/or pediatric Step-down/Progressive Units ²⁰ ? <i>If “no” to question #9, skip questions #10-11 and continue to question #12.</i>	☐ Yes ☐ No
10) If “yes,” how many of this type of unit were open and staffed in the hospital?	_____
11) How many of the units in question #10 utilized the BCMA/eMAR system when administering medications at the bedside?	_____
12) Does your hospital operate a Labor and Delivery Unit ²¹ ? <i>If “no” to question #12, skip questions #13-14 and continue to question #15.</i>	☐ Yes ☐ No
13) If “yes,” how many of this type of unit were open and staffed in the hospital?	_____
14) How many of the units in question #13 utilized the BCMA/eMAR system when administering medications at the bedside?	_____
15) Does your hospital operate adult and/or pediatric Pre-operative and Post-anesthesia Care Units ²² ? <i>If “no” to question #15, skip questions #16-17 and continue to question #18.</i>	☐ Yes ☐ No
16) If “yes,” how many of this type of unit are open and staffed in the hospital?	_____
17) How many of the units in question #16 utilized the BCMA/eMAR system when administering medications at the bedside?	_____

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

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

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

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

21) Which of the following mechanisms does your hospital use to reduce and understand potential BCMA system “workarounds?”		
a)	Has a formal committee that meets routinely to review data reports on BCMA system use	☐ Yes ☐ No
b)	Has back-up equipment (e.g., extra scanners, portable computers, batteries, and mice) for BCMA hardware failures	☐ Yes ☐ No
c)	Has a Help Desk that provides timely responses to urgent BCMA issues in real-time	☐ Yes ☐ No
d)	Conducts real-time observations of users at the unit level using the BCMA system	☐ Yes ☐ No
e)	Engages nursing leadership at the unit level on BCMA use	☐ Yes ☐ No
f)	In the past 12 months used the data and information obtained through items a-e to implement quality improvement projects that have focused on improving the hospital’s BCMA performance OR In the past 12 months used the data and information obtained through items a-e to monitor a previously implemented quality improvement project focused on improving the hospital’s BCMA performance <i>Cannot respond “yes” to this question, unless “yes” to either 21a, 21d or 21e.</i>	☐ Yes ☐ No
g)	In the past 12 months evaluated the results of the quality improvement projects (from f) and demonstrated that these projects have resulted in higher adherence to your hospital’s standard medication administration process OR In the past 12 months evaluated the results of the quality improvement projects (from f) and demonstrated continued adherence to your hospital’s standard medication administration process <i>Cannot respond “yes” to this question, unless “yes” to 21f.</i>	☐ Yes ☐ No
h)	Communicated back to end users the resolution of any system deficiencies and/or problems that may have contributed to workarounds <i>Cannot respond “yes” to this question, unless “yes” to either 21a, 21d or 21e.</i>	☐ Yes ☐ No

2D: Medication Reconciliation

This section is not applicable to pediatric hospitals.

Hospitals that share a CMS Certification Number are required to report by facility. Please carefully review [Leapfrog's Multi-Campus Reporting Policy](#).

Specifications: See [Medication Reconciliation Measure Specifications](#) in the Reference Information beginning on page 76.

Reporting Period: 6 months

Answer questions #1-8 for the latest 6-month period prior to the submission of this section of the Survey.

Note: As a reminder, the [Corrections Period](#) (December 1-January 31) is reserved for corrections to previously submitted Surveys only. Any updates made to reflect a change in performance must be made prior to the November 30 Late Submission and Performance Update Deadline. Updates made to reflect a change in performance after November 30 will not be scored or publicly reported.

Sufficient Sample: See [Medication Reconciliation Measure Specifications](#) for instructions on identifying a sufficient sample for question #3.

1) What is the latest 6-month reporting period for which your hospital is submitting responses to this section? 6-month reporting period ending:	_____ Format: Month/Year
2) During the 6-month reporting period, did your hospital conduct a random sample of adult patients and have a pharmacist or certified pharmacy technician²³ complete the following steps for each patient included in the sample: • Interview Patient and Obtain the Gold Standard Medication History (pharmacist or certified pharmacy technician²³); • Complete a Medication Reconciliation Worksheet for each sampled patient (pharmacist or certified pharmacy technician²³); • Compare Gold Standard Medication History to Admission Orders (pharmacist only); and • Compare Gold Standard Medication History to Discharge Orders (pharmacist only)? <i>If "no" to question #2, skip the remaining questions in Section 2D and go to the Affirmation of Accuracy. The hospital will be scored as "Did Not Measure."</i> <i>If "no, had fewer than 30 admissions to medical or med/surg units" to question #2, skip the remaining questions in Section 2D and go to the Affirmation of Accuracy. The hospital will be scored as "Does Not Apply."</i>	☐ Yes ☐ No ☐ No, had fewer than 30 admissions to medical or med/surg units

For questions #3-8, if the sample is less than 30 patients from the 6-month period, the hospital will be scored as "Limited Achievement" and the rate of unintentional discrepancies will not be publicly reported.

3) Number of adult patients that your hospital sampled ²⁴ .	_____ Max value 500
--	------------------------

4) Number of patients from question #3 who had zero (0) Gold Standard Medications. <i>If more than 10 out of 30 patients (or one-third) included in the sample had zero (0) Gold Standard Medications, the hospital will be scored as “Unable to Calculate Score.”</i>	_____
5) Total number of medications obtained by the pharmacist or certified pharmacy technician ²³ from the Gold Standard Medication History ²⁵ for the adult patients included in the sample.	_____
6) Total number of unintentional discrepancies in admission and discharge among the gold standard medications ²⁶ in question #5 identified by the pharmacist.	_____
7) Total number of unintentionally ordered additional medications ²⁷ for the adult patients included in the sample on admission and/or discharge identified by the pharmacist.	_____
8) Total number of discrepancies due to unintentionally ordered additional medications ²⁸ in question #7 identified by the pharmacist.	_____

As the hospital CEO or as an employee of the hospital to whom the hospital CEO has delegated responsibility, I have reviewed this information pertaining to the Medication Safety Section at our hospital, and I hereby certify that this information is true, accurate, and reflects the current, normal operating circumstances at our hospital. I am authorized to make this certification on behalf of our hospital.

Affirmed by _____, the hospital's _____,
(first name and last name) (title)
on _____.
(date)

Section 2: Medication Safety Reference Information

What's New in the 2025 Survey

CPOE Evaluation Tool

The CPOE Evaluation Tool developers will update the test medication scenarios to reflect changes to clinical guidelines and to address medications that hospitals frequently reported as not being in their medication formulary. Due to unforeseen operational challenges, the Test Patients PDF will not include the date of birth for each patient. Hospitals will need to calculate the date of birth based on the age provided. To make this easier for hospitals, Leapfrog will include a Date of Birth Calculator on the [Survey and CPOE Materials webpage](#) starting on April 1.

Additionally, patient allergies will not be removed, as the CPOE test is designed to simulate a real-life environment where allergy information is typically included in patient profiles.

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

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

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

Section 2A: Computerized Physician Order Entry (CPOE)

In response to comments collected during the public comment period and in consultation with Leapfrog's CPOE Expert Panel, Leapfrog is updating the measure specifications for question #3 to include medications ordered via a secure texting platform in the denominator only. Medications ordered via a secure texting platform should be excluded from question #4, the numerator, since these orders are not entered through the CPOE system.

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

Section 2B: EHR Application Information

Leapfrog is adding optional fact-finding questions about Artificial Intelligence (AI) vendors. The responses will be used to research AI vendor influence on a hospital's CPOE Test score. Additionally, we are adding an FAQ to define Artificial Intelligence.

These optional, fact-finding questions are not used in scoring or public reporting. Section 2B: EHR Application Information is not scored or publicly reported.

Section 2C: Bar Code Medication Administration (BCMA)

Leapfrog will continue to ask hospitals about their utilization of BCMA in the following adult and/or pediatric units: medical, surgical, and medical/surgical units; intensive care units (including neonatal); labor and delivery units; and pre-operative and post-anesthesia care units, but, we are updating the unit

definitions to further align with other sections of the Survey, including specifying the inclusion of both single and mixed acuity units when reporting on medical, surgical, and medical/surgical units. Previously, step-down/progressive units were included when reporting on medical, surgical, and medical/surgical units. For 2025, Leapfrog is adding new questions to assess the utilization of step-down/progressive units separately. Hospitals without a dedicated stepdown/progressive unit will continue to report on any medical, surgical, and medical/surgical units and include any medications administered to step-down/progressive patients in these units. This has been clarified in the corresponding endnote for medical, surgical, and medical/surgical units. Telemetry units will continue to be reported with medical, surgical, and medical/surgical units. These questions have been refined for more clarity based on comments collected during the public comment period and national pilot.

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

Leapfrog is making two updates to assist hospitals reporting on their mechanisms used to reduce and understand potential BCMA system “workarounds.” First, Leapfrog is updating one of the questions to ask about “back-up equipment (e.g., extra scanners, portable computers, batteries, and mice)” for BCMA hardware failures, instead of “back-up systems.” Second, we are adding a FAQ reminding hospitals that they should still implement or monitor a quality improvement program even if they are at 95% compliance to ensure that they can continue to improve and maintain high compliance.

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

Section 2D: Medication Reconciliation

There are no changes to this subsection.

Change Summary Since Release

None. If substantive changes are made to this section of the Survey after release on April 1, 2025, they will be documented in this Change Summary section.

Section 2: Medication Safety Measure Specifications

Computerized Physician Order Entry (CPOE) Measure Specifications

Important Notes:

Note 1: Hospitals that share a CMS Certification Number are required to report by facility. Please carefully review [Leapfrog's Multi-Campus Reporting Policy](#).

Note 2: "Licensed prescriber" refers to all licensed clinicians who are authorized by the state in which the hospital is located to order medications for patients. This includes residents and interns who are authorized to order medications under their own authority.

Source: The Leapfrog Group
Reporting Period: The latest 3-month period prior to the submission of this section of the Survey.
Medications: For the purposes of this measure, a medication is a substance that is taken into, or placed onto, the body of a person for one or more of the following reasons: • as a placebo • to prevent a disease (e.g., flu vaccine) • to make a diagnosis (e.g., contrast dye) • to test for the possibility of an adverse effect • to modify a physiological, biochemical, or anatomical function or abnormality (e.g., heparin/heparin flushes, statins, antihypertensives, etc.) • to replace a missing factor (e.g., blood product) • to ameliorate a symptom (e.g., aspirin) • to treat a disease or condition (including topicals, nasal sprays, eye drops, compounds, inhalants, injectables, patches, etc.) • to induce anesthesia • to stabilize or hydrate during medical treatment or procedures (e.g., IV fluids, normal saline, lactated ringers, etc.) • to provide nutrition (e.g., enteral nutrition products, parenteral nutrition products, breast milk [breast milk applies to BCMA measure only]) • as a supplement (e.g., iron for a patient with iron deficiency anemia or calcium/vitamin D for a patient with osteoporosis) For the purposes of this measure, the following are not considered medications: • Pre-filled saline flushes and pre-filled heparin flushes (i.e., saline and heparin flushes that come from the manufacturer already filled and are not filled by the hospital's pharmacy) • Chlorhexidine and alcohol preparation pads • Intra-op irrigation solutions
Question #3 (denominator): Total number of inpatient medication orders, including medication orders made in inpatients units that do NOT have a functioning CPOE system. Include: • Medications ordered for any patient with an inpatient status, including those with an inpatient status who may be in an outpatient unit during an overflow situation. • Medications ordered for any neonatal ICU patient. • Medications ordered by any individual, including nurses and pharmacists. • Medications ordered electronically, via a secure texting platform, verbally or via paper. • Medications ordered verbally during a rapid response (prevention of serious injury, cardiac arrest, and respiratory arrest). Exclude: • Medications ordered for any newborn in a nursery or mother's room.

- New medication orders that have been modified from the original order but maintain the intent of the original order (e.g., “new” medication orders generated when a dose, route, frequency, or brand are changed).
- Medications ordered verbally during a “code blue” (i.e., medications ordered verbally when a patient requires resuscitation or needs immediate medical attention, most often as the result of a respiratory arrest or cardiac arrest).
- Medications ordered in an operating room or procedural area.

Question #4 (numerator): Total number of inpatient medication orders in question #3 that licensed prescribers entered via a CPOE system that meets the criteria outlined in question #2.

Include:

- Medication orders entered into the CPOE system by a licensed prescriber
- In addition, the following types of medication orders entered in to a CPOE system by a non-licensed prescriber, such as a nurse or pharmacist, can also be included:
 - Per protocol medication orders (i.e., medication orders with detailed guidance on how to administer, dose or adjust a medication) approved by a medical committee where the implementation of the protocol was authorized by a licensed prescriber and orders were initiated in the CPOE system.
 - Standing medication orders (i.e., orders which can be initiated based on medical staff approval of a screening criteria and indication for all patients that meet the screening criteria) approved by a medical committee that were initiated in the CPOE system.
 - Medication orders entered into the CPOE system that required either verbal read back of alerts to the licensed prescriber or a co-signature by a licensed prescriber prior to administration to ensure that the licensed prescriber was made aware of all advice/information generated by the CPOE system.

Exclude:

- Medications ordered verbally, via a secure texting platform, or via paper.
- Medication orders entered into the CPOE system by a non-licensed prescriber, such as a nurse or pharmacist, that were NOT per protocol medication orders or standing medication orders.
- Medication orders entered into the CPOE system by a non-licensed prescriber, such as a nurse or pharmacist, that DID NOT require either verbal read back of alerts or a co-signature of a licensed prescriber prior to administration.

See [FAQs](#) for additional information about responding to the questions in this section.

Bar Code Medication Administration (BCMA) Measure Specifications

Important Note: Hospitals that share a CMS Certification Number are required to report by facility. Please carefully review [Leapfrog's Multi-Campus Reporting Policy](#).

Source: The Leapfrog Group
Reporting Period: The latest 3-month period prior to the submission of this section of the Survey.
Included Adult and/or Pediatric Units: • General Medical, Surgical, Medical/Surgical, Neuro¹⁴, Neonatal¹⁷, or Specialty ICUs • Medical, Surgical, or Medical/Surgical Units (including telemetry units)¹⁹, • Step-down/Progressive Units²⁰ • Labor and Delivery Unit²¹ • Pre-operative and Post-anesthesia Care Units²² Excluded Units: • Emergency departments • Operating rooms • Procedural and diagnostic areas, such as radiology units, endoscopy units, etc. ◦ Note: Pre-operative and post-anesthesia care areas in these units must be included • Units that were not open for the entire reporting period or that are not currently open Important Note: Hospitals should count units as they do internally (i.e., if units are considered separate units despite sharing a space, report the units as two; if they are considered a single combined unit, report the unit as one). Medications: For the purposes of this measure, a medication is a substance that is taken into, or placed onto, the body of a person for one or more of the following reasons: • as a placebo • to prevent a disease (e.g., flu vaccine) • to make a diagnosis (e.g., contrast dye) • to test for the possibility of an adverse effect • to modify a physiological, biochemical or anatomical function or abnormality (e.g., heparin/heparin flushes, statins, antihypertensives, etc.) • to replace a missing factor (e.g., blood product) • to ameliorate a symptom (e.g., aspirin) • to treat a disease or condition (including topicals, nasal sprays, eye drops, compounds, inhalants, injectables, patches, etc.) • to induce anesthesia • to stabilize or hydrate during medical treatment or procedures (e.g., IV fluids, normal saline, lactated ringers, etc.) • to provide nutrition (e.g., enteral nutrition products, parenteral nutrition products, breast milk [breast milk applies to BCMA measure only]) • as a supplement (e.g., iron for a patient with iron deficiency anemia or calcium/vitamin D for a patient with osteoporosis) For the purposes of this measure, the following are not considered medications: • Pre-filled saline flushes and pre-filled heparin flushes (i.e., saline and heparin flushes that come from the manufacturer already filled and are not filled by the hospital's pharmacy) • Chlorhexidine and alcohol preparation pads • Intra-op irrigation solutions Question #18 (denominator): Total number of scannable medication administrations during the reporting period in those units that utilize BCMA as indicated in questions #5, #8, #11, #14 and #17. Include all scannable medication administrations (regardless of patient's admission status and administering provider) in adult and/or pediatric general medical, surgical, medical/surgical, neuro, neonatal, and specialty ICUs; medical, surgical, and medical/surgical units (including telemetry units);

step-down/progressive units; labor and delivery units; and pre-operative and post-anesthesia care units that utilize a BCMA system that is linked to the electronic medication administration record (eMAR).

Include medication administrations during a procedure if the hospital combines their procedural areas with their pre-operative or post-anesthesia care units and is **unable** to distinguish between these medication administrations.

Exclude:

- Medication administrations in units that are not specified in question #5, #8, #11, #14 or #17
- Medication administrations in units that do not utilize a BCMA system that is linked to the eMAR
- Medication administrations in units that have not been open or staffed for the entire 3-month reporting period or in units that are not open currently
- Medication administrations during a procedure if the hospital combines their procedural areas with their pre-operative or post-anesthesia care units and is able to distinguish between these medication administrations
- Administrations of medications that are not “scannable,” i.e., medications that do not have a bar code and could not be scanned if BCMA were in use

Question #19 (numerator): Total number of medication administrations from question #18 that had both the patient and the medication scanned during administration with a BCMA system that is linked to the electronic medication administration record (eMAR).

Include medication administrations where both the patient and medication were scanned during administration with a BCMA system that is linked to the eMAR.

Exclude medication administrations where neither patient nor medication were scanned during administration or only the patient or only the medication were scanned with a BCMA system that is linked to the eMAR.

See [FAQs](#) for additional information about responding to the questions in this section.

Medication Reconciliation Measure Specifications**Important Notes:**

Note 1: This section does not apply to pediatric hospitals.

Note 2: Hospitals that share a CMS Certification Number are required to report by facility. Please carefully review [Leapfrog's Multi-Campus Reporting Policy](#).

Note 3: A hospital pharmacist or [certified pharmacy technician](#)²³ plays two important roles in data collection for this measure. First, the pharmacist or certified pharmacy technician is responsible for obtaining the Gold Standard Medication History from each sampled patient. Second, the pharmacist is responsible for identifying the unintentional discrepancies by comparing the Gold Standard Medication History to admission orders and discharge orders.

Source: Brigham and Women's Hospital (NQF #2456)
Reporting Period: The latest 6-month period prior to submission of this section of the Survey.
Materials for Data Collection: To complete the data collection for this subsection and respond to questions #3-8 hospitals should download four important tools: • The Medication Reconciliation Workbook (Excel) includes 3 tabs: Instructions, Sampling, and Data Entry. This can be used to identify patients to sample and collect data from, as well as calculate the responses to enter into the Online Hospital Survey Tool from the completed Worksheets. • The Medication Reconciliation Worksheet (Word) can be used by the pharmacist to identify the number of unintentional discrepancies at admission and/or discharge for each sampled patient (question #6). The Medication Reconciliation Worksheet can also be used to track additional medications that were ordered unintentionally at admission and/or discharge (questions #7-8). • The MARQUIS 2 Best Possible Medication History: Quick Tips tri-fold (PDF) includes important information on how the pharmacist or certified pharmacy technician²³ should obtain the Gold Standard Medication History • Identifying Discrepancies Flow Chart (PDF) includes important information on how the pharmacist should identify discrepancies between the Gold Standard Medication History and admission and discharge orders. All of these tools are available on the Survey and CPOE Materials webpage and should be used when reporting on this measure.

The intent of this measure is to calculate your hospital's rate of unintentional medication discrepancies per medication. Hospitals may perform data collection on a regular basis or just once for the purposes of reporting on this measure to Leapfrog.

1. Hospitals that collect these data on a regular basis and did so using the previous year's measure specifications can use those data when reporting on this section of the Survey. For example, if your hospital samples regularly on a quarterly basis and collected data January through March using the previous year's specifications, you can report those data on the current year's Survey. We do ask that you download and use the most recent measure specifications and materials when they are made available on April 1 each year.
2. Hospitals that do not sample patients on a regular basis (i.e., quarterly) should sample in real-time beginning April 1 and can collect data at any time during the Survey Cycle (April 1 – November 30). Sampling can be spread out over the entire 6-month reporting period (e.g., five patients per month), or within a shorter time period within those 6 months (e.g., 30 patients in a two-week period).

Follow the steps below to complete data collection for this measure:**Step 1: Identify Patients to Include in the Sample (Survey Coordinator)**

- a. To be scored on the rate of unintentional medication discrepancies, hospitals are required to sample at least 30 patients from a 6-month reporting period. Hospitals that sample fewer than 30 patients during the reporting period will be scored and publicly reported as “Some Achievement.”
- b. All hospitals should exclude patients under 18 years old, patients who were discharged or expired before the Gold Standard Medication History could be obtained, and patients that do not have discharge orders written during the reporting period.
- c. Hospitals should sample patients from medical, medical/surgical, and step-down/progressive units (adult only) to reduce the number of sampled patients with zero (0) Gold Standard Medications. However, hospitals may expand their sampling to patients in additional units of the hospitals.
- d. Hospitals should sample patients from different days of the week, including patients admitted on the weekend.
- e. On the day of data collection, obtain a list of patients that were admitted the day before to medical and/or medical/surgical units, in the order that they were admitted.
- f. Follow the instructions in the Medication Reconciliation Workbook to randomly sample admitted patients.
- g. Send the list of sampled patients to the pharmacist, pharmacy resident, or pharmacy technician so they can schedule an in-person, video, or phone interview with each patient to obtain their Gold Standard Medication History.

Step 2: Interview Patients and Obtain the Gold Standard Medication History (Pharmacist or Certified Pharmacy Technician²³)

- a. A trained pharmacist, pharmacy resident, or [certified pharmacy technician²³](#) must interview the patients from Step 1 and obtain the Gold Standard Medication History within 24 hours after admission, typically the morning after admission. Note that this is in addition to, and separate from, any pre-admission medication list that was created as part of normal care.
- b. The pharmacist, pharmacy resident, or [certified pharmacy technician²³](#) can customize the following script to explain to the patient the reason for the interview: “Hi, I’m (*pharmacist’s name*), a pharmacist at (*name of hospital*). I know (*care team member who may have collected a pre-admission medication list or PAML*) already asked you about the medications you were taking before you were admitted to the hospital. I’m here to ask you about these medications again. Our hospital has asked me to collect this information again so I can use it to measure how well we are doing in gathering medication histories. What we learn will help us improve our processes of care in the future and make sure we manage patients’ medications safely when they come into and after they leave the hospital.”
- c. The Gold Standard Medication History is the list of medications that the patient was taking prior to admission. Best practices for collecting the Gold Standard Medication History can be found in the “Other Supporting Materials” for Section 2 on the [Survey and CPOE Materials webpage](#).
 - i. Pharmacists, pharmacy residents, and [certified pharmacy technicians²³](#) should try to use two sources of information (see [MARQUIS 2 Best Possible Medication History: Quick Tips](#) and [Medication Reconciliation Implementation Toolkit](#) for examples) and explore any discrepancies (e.g., errors related to dose, route, timing, etc.) before finalizing the Gold Standard Medication History. Once the pharmacist, pharmacy resident, or [certified pharmacy technician²³](#) has completed the patient interview, they can utilize support from non-certified pharmacy technicians, medical assistants, or nurses to investigate second or third information sources (e.g., EHR list, pharmacy list, primary or specialty provider information, etc.). However, the pharmacist, pharmacy resident, or [certified pharmacy technician²³](#) must be the one to obtain and finalize the Gold Standard Medication History.
 - ii. Medications that a patient is completely non-adherent to, meaning the patient has not taken the medication for at least 30 days, should be excluded from the Gold Standard Medication History.
 - iii. If a patient has been taking a medication differently to how it was prescribed, then the Gold Standard Medication History should list the medication as the patient was taking it.
 - iv. Exclude PRN medications unless they are clinically relevant. This includes topical locations and creams, saline nasal spray and artificial tear eye drops, herbals and supplements, and

- vitamins. Two examples of clinically relevant medications that should not be excluded from the gold standard pre-admission medication list would be iron for a patient with iron-deficiency anemia or calcium/vitamin D for a patient with osteoporosis.
- v. Include PRN medications that are clinically relevant. This includes inhalers, nitroglycerin, analgesics (opioid and non-opioid), muscle relaxants, and sedatives, including medications where sedation is a common side effect (e.g., sedation occurs in more than 10% of individuals). This also includes topical medications with systemic actions (e.g., lidocaine, triamcinolone, sulfadiazine, etc.).
 - vi. Clinically relevant is defined as any PRN medication that treats a medical condition on the patient's problem list and/or condition they are being treated for during the visit (i.e., reason for the hospital stay).

Step 3: Complete a Medication Reconciliation Worksheet for each sampled patient (Pharmacist or Certified Pharmacy Technician²³)

- a. Once the Gold Standard Medication History is complete, print out the Medication Reconciliation Worksheet for each sampled patient.
- b. Page 1 needs to be printed out for each sampled patient. Page 2 needs to be printed for each Gold Standard Medication the patient was taking.
- c. Complete the "Gold Standard Medication" column highlighted in yellow for each Gold Standard Medication on the list:

Gold Standard Medication	
<u>Name:</u>	
<u>Dose/Route/ Frequency:</u>	
<u>Drug Class:</u>	
☐ PRN ☐ OTC	
<u>Pt Adherence:</u>	
☐ Completely non-adherent*	☐ Systematically non-adherent**
☐ Sporadically non-adherent^	☐ Adherent
<u>Comments:</u>	
<u>All Sources Used:</u>	
☐ Patient	☐ Patient's family/Caregiver
☐ Pill Bottles	☐ Patient's Own Med List
☐ Outpatient EMR	☐ Outpatient Provider(s)
☐ Transfer Records	☐ Past DC Summary
☐ Pharmacy(s)	☐ Pharmacy Database
☐ Other:	

- d. If possible, wait until after the patient has been discharged to complete the next steps.

Step 4: Compare Gold Standard Medication History to Admission Orders (Pharmacist Only)

- a. After the patient has been discharged, obtain the admission and discharge orders for the patient (instructions for comparing the discharge orders are in Step 5 below). Admission orders include all orders written from the time of admission until 8:00 a.m. the following morning or up until 12 hours after the time of admission, whichever comes first.
- b. Compare the admission orders to each Gold Standard Medication on the Medication Reconciliation Worksheet. Note any differences.
 - i. Review the records for the patient to determine if the differences were intentional or unintentional. Use the [Identifying Discrepancies Flow Charts](#) to help with this step.

- | Admission Comparison | |
|--|---------------------------------------|
| <u>Note Differences:</u>
(select all that apply) | |
| ☐ Dose | ☐ Route |
| ☐ Frequency | ☐ Substitution |
| ☐ Duplication | ☐ Formulation |
| ☐ Duration | ☐ Other: |
| ☐ Omission | |
| <u>Reason:</u> | |
| ☐ Unintentional (History or Reconciliation Error) | |
| ☐ Intentional (Clinical Reason) | |
| <p>Were there any <u>unintentional</u> discrepancies between the gold standard and the admission order?</p> <p>☐ Yes</p> <p>☐ No</p> <p><i>If "yes," count as 1</i></p> | |

- | Additional Medication: | Unintentionally Ordered on: | Comments: |
|--|--|-----------|
| <u>Name:</u>

<u>Dose/Route/Frequency:</u> | ☐ Admission (count as 1)
☐ Discharge (count as 1)
☐ Both (count as 2) | |
| <u>Name:</u>

<u>Dose/Route/Frequency:</u> | ☐ Admission (count as 1)
☐ Discharge (count as 1)
☐ Both (count as 2) | |
| <u>Name:</u>

<u>Dose/Route/Frequency:</u> | ☐ Admission (count as 1)
☐ Discharge (count as 1)
☐ Both (count as 2) | |

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- i. If an unintentionally ordered additional medication was only ordered on admission, then check the “Admission” box in the pink-highlighted column.
- ii. If an unintentionally ordered additional medication was only ordered on discharge, then check the “Discharge” box in the pink -highlighted column.
- iii. If the unintentionally ordered additional medication was ordered on both admission and discharge, then check the “Both” box in the pink-highlighted column.

Step 6: Sum the number of medications and discrepancies (Survey Coordinator)

- a. The top of the first page of the Medication Reconciliation Worksheet contains four spaces for you to list the data for the patient.

Total # Unintentional Additional Medications: _____

(Enter into column F in the Med Rec Excel Workbook)

Total # of admission and discharge discrepancies due to Unintentional Additional Meds: _____

(Number of medications that were ordered unintentionally at admission (count as 1), discharge (count as 1), or both admission and discharge (count as 2). Enter into column H in the Med Rec Excel Workbook.

Total Number of Gold Standard Meds: _____

(Enter into column B in the Med Rec Excel Workbook)

Total # of admission and discharge discrepancies in Gold Standard Meds: _____

(For each Gold Standard Med, count the number of ‘yes’ responses to the error question. Minimum number of discrepancies per med is zero. Maximum number of discrepancies per med is 2. Enter into column D in the Med Rec Excel Workbook)

- i. Find the number of unintentionally ordered additional medications from the blue highlighted column on the same page. Enter in the first space, also highlighted in blue.
- ii. Find the number of **discrepancies** due to unintentionally ordered additional medications from the pink highlighted column on the same page.
 1. If a medication was only ordered on admission or only ordered on discharge, then this counts as one discrepancy.
 2. If a medication was ordered on **both** admission and discharge, then this counts as two discrepancies.
 3. Sum the number of discrepancies across all unintentionally ordered additional medications and enter this number in the pink-highlighted space.
- iii. Find the number of Gold Standard Medications and enter this number in the yellow-highlighted space.
- iv. Find the number of discrepancies in the admission and discharge orders for the Gold Standard Medications
 1. Review the Medication Reconciliation Worksheet for each Gold Standard Medication.
 2. Sum the number of times the orange highlighted “Yes” box is checked, indicating an unintentional discrepancy in admission or discharge orders.
 3. Enter this sum into the orange-highlighted space on the first page of the Medication Reconciliation Worksheet.

Step 7: Contact providers if necessary (Pharmacist Only)

If you found any serious discrepancies that could cause the patient harm, you will need to contact the providers. The provider may need to reach out to the patient, PCP, or pharmacies to have the issue corrected.

Step 8: Enter data into Excel Workbook and Online Hospital Survey Tool (Survey Coordinator)

- a. Collect all the Medication Reconciliation Worksheets from the pharmacists. Open the Data Entry Tab of the Medication Reconciliation Excel Workbook.
 - i. Enter the numbers from the top of each Medication Reconciliation Worksheet into the corresponding columns of the Excel Workbook, for the sampled patient, one patient per row.

- ii. As you enter the data, Row 6 (in red) will automatically sum the values entered for each patient. Once you have entered the data for all sampled patients, you will have the final values to enter into the Online Hospital Survey Tool.
- iii. On the right, your hospital's rate of unintentional medication discrepancies per medication will automatically be calculated based on the data entered.

Step 9: Use your hospital's results in quality improvement (Survey Coordinator and Pharmacist)

The developer of this measure has two toolkits available for hospitals that wish to implement a medication reconciliation program:

- [Medication Reconciliation Implementation Toolkit](#) (free)
- [The MARQUIS Collaborative](#) (fee to participate)

See [FAQs](#) for additional information about responding to the questions in this section.

Section 2: Medication Safety Frequently Asked Questions (FAQs)

Computerized Physician Order Entry (CPOE) FAQs

Information specific to the CPOE Evaluation Tool, including instructions and FAQs, is available on the [Survey and CPOE Materials webpage](#) and the [Prepare for CPOE Tool webpage](#).

1. **What 3-month reporting period should be used when reporting on this section?**
When responding to the questions in Section 2A, hospitals should use the most recent three months prior to submitting the Survey for which they have complete data. For example, if submitting Section 2A in the month of June, the most recent 3-month reporting period for which you have complete data may be February, March, and April or March, April, and May. Hospitals cannot submit data collected for less than three full months.
2. **My hospital transitioned to a new CPOE system, and we have not been on the new system for a full 3 months. How should we respond to the questions in Section 2A-2B?**
When responding to questions #3 and #4 in Section 2A, hospitals can combine inpatient medication data from their old CPOE system with their new CPOE system to have three full months of data. However, hospitals should respond to the questions in Section 2B based on the new CPOE system and take the CPOE Evaluation Tool using the new CPOE system. When taking the CPOE Evaluation Tool, hospitals should select a licensed prescriber that is fully trained on the new system. All hospitals are urged to take a Sample Test before starting the Adult Inpatient Test.
3. **Should we include medications ordered verbally or via paper during system downtime when responding to question #3 (denominator)?**
Yes. Count medication orders entered during system downtime when responding to question #3. Exclude these orders when responding to question #4.
4. **We can't exclude medication orders that originated from an operating room or procedural area from the CPOE report that we are using to respond to questions #3 (denominator) and #4 (numerator). Can we include these medication orders?**
Yes, if you are unable to exclude medication orders for inpatients that were ordered from an operating room or procedural area, you can count these orders when responding to questions #3 and #4.
5. **What are examples of per protocol orders?**
Examples of per protocol orders include vancomycin dosing per protocol and heparin drip per protocol. Per protocol orders refer to orders that the medical staff has approved the use of, based on evidence-based guidance, in advance of its use. Per protocol orders are often identified by the Pharmacy and Therapeutics (P&T) committee and then recommended to the Medical Executive Committee (MEC) for approval. Once approved, per protocol orders are initiated by a [licensed prescriber](#), but then acted on by pharmacy, nursing, radiology, respiratory therapy, etc. Count per protocol orders when responding to questions #3 (denominator) and #4 (numerator).
6. **What are examples of standing orders?**
Examples of standing orders include influenza vaccine, pneumonia vaccine, hepatitis B vaccine, or erythromycin eye ointment. Standing orders are usually rare, limited use situations. Count standing orders when responding to questions #3 (denominator) and #4 (numerator).
7. **My hospital requires readback for all phone orders, but there is no way to document that the readback occurred. How can we include these orders when responding to question #4 (numerator)?**
If your hospital cannot document that verbal readback on phone orders occurred, you should develop a written policy that outlines training and implementation of this practice and perform a

random audit at least annually to ensure the policy is being followed. Maintain documentation of the audit that demonstrates compliance with the policy as Leapfrog performs monthly documentation requests starting with June 30 submissions and continuing until the Survey closes on January 31.

8. When should we take the CPOE Evaluation Tool?

The CPOE Evaluation Tool is a core element of Leapfrog's CPOE Standard. Hospitals are urged to ensure that the Adult Inpatient CPOE Test is submitted along with the Survey (i.e., in the same month) in order to meet the [deadlines](#) for the Leapfrog Hospital Survey and Leapfrog's other programs such as Top Hospital and the Leapfrog Hospital Safety Grade.

Hospitals that submit the Survey, but do not submit an Adult Inpatient Test via the CPOE Evaluation Tool, are scored and publicly reported as "Limited Achievement" on the CPOE measure.

Within a Survey Cycle (April 1 – November 30), a hospital cannot retake a CPOE Evaluation Tool until at least 120 days have passed since their last test.

9. Should hospitals take the CPOE Test more than once per Survey Cycle?

Not necessarily. Hospitals have the option of re-taking a test after 120 days, but if there were no changes made to your CPOE system after the first test there is likely no reason to retake the test. Hospitals that switch vendors, perform major upgrades, or make significant changes to their decision support settings and/or formulary (e.g., expanding from a limited formulary to a large formulary) should re-take the test to ensure the results reflect their current system.

10. If we update our responses to questions #3 and #4, do we need to re-take the CPOE Test?

No. Hospitals don't need to retake the CPOE Evaluation Tool after submitting updates to Section 2 via the Online Survey Tool. Retaking a test is only recommended for hospitals that switched vendors, performed major upgrades, or made significant changes to their decision support settings and/or formulary.

EHR Application Information FAQs

11. What is the definition of Artificial Intelligence?

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

Bar Code Medication Administration (BCMA) FAQs

General Questions

12. Why does the Bar Code Medication Administration system have to be connected to an electronic medication administration record (eMAR)?

An eMAR serves as the communication interface that automatically documents the administration of medication into certified Electronic Health Record (EHR) technology. By linking BCMA with the eMAR, information on medication administration is captured in a much timelier manner than a manual documentation process can accomplish.

Units

13. Should a unit that has only been open for part of the 3-month reporting period be included?

No. Only include those units that are currently open and have been opened and staffed for the entire 3-month reporting period. For example, if you open a new unit that has only been open and

staffed for 1-month out of the 3-month reporting period, you will not include that unit when responding to the questions in this section.

14. How should a hospital report if they had BCMA implemented in some units but not all during the reporting period?

To answer “yes” to question #2, your hospital must have a Bar Code Medication Administration (BCMA) system that is linked to the electronic medication administration record (eMAR) when administering medications at the bedside in *at least one* of the following adult and/or pediatric units: general medical, surgical, medical/surgical, neuro, neonatal, or specialty ICU; medical, surgical, or medical/surgical unit (including telemetry units); step-down/progressive unit; labor and delivery unit; or pre-operative unit and/or post-anesthesia care unit. You should only report on units that are currently open and have been in operation for the entire 3-month reporting period selected in question #1. For example, if you have 3 surgical units and are only using BCMA in 1 of the 3 units, you will respond 3 in question #7 and 1 in question #8. You should only include medication administrations that were ordered and scannable in the open and staffed units in which a BCMA system was implemented (as indicated in questions #5, #8, #11, and #14, and #17) when reporting on compliance in questions #18-19.

15. How should hospitals report if they have a combined pre-operative and post-anesthesia care unit (PACU)?

As noted in [endnote #22](#), hospitals must include combined pre-operative and post-anesthesia care units when reporting on questions #15-17. Therefore, hospitals should respond “yes” to question #15 and then report on how many of these units are open and staffed in question #16 and how many of the units utilize the BCMA/eMAR system in question #17. Medication administrations that occurred in these combined pre-operative and post-anesthesia care units must be included when reporting on compliance in question #18-19 provided these units utilize a BCMA system that is linked to the eMAR.

16. Should we include pre-operative and post-anesthesia care units that are located in our surgery centers or free-standing hospital outpatient departments that share our hospital’s license or CMS Certification Number (CCN) when reporting on questions #15-17?

No, for the purposes of reporting on Section 2C: BCMA, only include pre-operative and post-anesthesia care units (adult and/or pediatric) that are located in or [co-located](#)³¹ with your hospital.

17. Certain procedural units in our hospital (e.g., endoscopy, interventional radiology, cath lab, etc.) encompass the pre-op area, procedural area, and post-anesthesia care area – meaning the same area is used for all three aspects of care. As such, our data includes medications administered pre-operatively, post-operatively, and administered during the procedures. Should we include or exclude these procedural units?

Please include these units when responding to questions #15-17 regarding pre-op/PACUs. If you can separate out the medications that are being administered pre- and post- from those that are administered during a procedure, exclude medications administered during a procedure when reporting on compliance in questions #18-19. Otherwise, you can count these medication administrations when responding to questions #18-19.

Compliance

18. What is considered a “scannable” medication?

Any medication ([see measure specifications](#)) that has a bar code and could be scanned if BCMA were in use would be considered “scannable.” In question #18, hospitals should only include ordered and “scannable” medications from the units where they indicated a BCMA system was implemented.

19. Should we only include inpatient medication administrations when reporting on compliance in questions #18-19?

No, hospitals must include all scannable medication administrations (regardless of the patient's admission status) from the units in questions #5, #8, #11, #14 and #17 that were utilizing a BCMA system linked to the eMAR during the reporting period. This would include scannable medications administered to inpatients, outpatients, observation status patients, etc.

20. Should we exclude medications that were administered in units that are not currently implementing BCMA?

Yes. Question #18 is asking about medication administrations ordered and scannable in those units that are open and staffed and that have implemented a BCMA system. You should include all scannable medications ordered and administered to patients in the open and staffed units (from questions #5, #8, #11, #14 and #17) in which a BCMA system was implemented. Question #18 is used as the denominator to calculate the rate of compliance and should include administrations whether the medication and/or patient was scanned during the administration. Question #19 is used as the numerator and is where you would report the number of medication administrations from these units where the patient and medication were scanned during the administration. We would not expect these two responses to be the same.

21. Should we exclude medications that are given during emergencies when responding to questions #18-19?

No. If the medications are considered "scannable" e.g., any medication that has a bar code and could be scanned if BCMA were in use, they should be included in question #18 (the denominator) but would not be counted in question #19 (the numerator) if the patient and medication were not scanned during administration, even if due to an emergency. Leapfrog's target rate for compliance is 95% to allow for emergency cases such as these.

22. Should we exclude medications that are given during a system downtime when responding to questions #18-19?

No. Medications administered during a system downtime should be included in question #18 (the denominator) but would not be counted in questions #19 (the numerator) if the patient and medication were not scanned during administration because the hospital's BCMA system was down.

23. Our vendor report provides medication and patient scanning rates separately. How can we report on our compliance if our reports do not provide the number of administrations that had both the medication and patient scanned?

If your vendor's report only provides the percentage of patients scanned and the percentage of medications scanned separately but does not provide the rate of administrations where both the patient and medication were scanned, please report the lower of the two rates (supply the denominator in question #18 and numerator in question #19), as that would be the maximum possible rate of having both scanned.

Moving forward, we do ask that your hospital work with your vendor to report out the rate of administrations where both the patient and medication are scanned. It is only when both are scanned that safe medication administration can be ensured.

24. Is manual scanning (e.g., in lieu of scanning the patient's wristband, typing in the patient's number) something we can count in our BCMA scans?

No. The problem is that the user may type in the wrong patient number, negating the safety benefits. The best practice is to scan the wristband that is on the wrist of the patient.

25. Our process is to scan the patient once and then scan each medication. Question #19 seems to want each medication and patient scanned with each medication. Can you clarify?

Hospitals should report on the number of administrations where both the patient and the medication were scanned during the administration. During administrations where multiple

medications are administered sequentially, the patient should be scanned first, but does not need to be rescanned before each medication is administered.

- 26. In our hospital some medications are ordered and scheduled, but not administered. Should medications that are ordered and scheduled, but not administered be included when responding to questions #18-19?**

No, medications that are not administered should not be included in questions #18-19.

Decision Support

- 27. If an alert is part of the eMAR, but not the Bar Code Medication Administration system, should we respond “yes” to the decision support elements in question #20a - e?**

If the provider and pharmacist are notified or alerted (e.g., second nurse check), but the nurse or provider administering the medication does not receive an alert at the point of administration, then your hospital should answer “no” to these questions about decision support.

- 28. My hospital’s EHR workflow for medication administration is designed in such a way that our system will never generate a “wrong patient” alert. How should we answer the question in the Survey about whether we have that type of decision support?**

If your hospital’s EHR workflow is designed so that the nurse scans the patient first, and then the medications, such that the nurse would never receive a “wrong patient” alert, for purposes of the Survey, your hospital should indicate that it has ‘wrong patient’ decision support. The goal of including a “wrong patient” alert is to acknowledge that as a safe practice and to drive organizations to validate the “right patient” in the medication administration process. The workflow described helps ensure that a ‘wrong patient’ is not encountered.

- 29. Is the “second nurse check needed” decision support element required for all medications or just certain medication classes in order to answer “yes” to question #17e?**

No. An alert for “second nurse check needed” is only required for certain medications and it is up to each hospital to decide which medication classes require this alert during administration.

Workarounds

- 30. Must a hospital establish a separate committee to meet solely to review data reports on BCMA system use?**

While establishing a committee that has the sole purpose of reviewing data reports on BCMA system use is encouraged, it is not required. At a minimum, a pre-existing standing committee that meets on a regular basis could be given the responsibility of reviewing these reports. The committee chosen to review the reports must include individuals whose roles reflect each part of the BCMA process (e.g., pharmacists, nurses, IT personnel, etc.).

- 31. What are some examples of “back-up equipment” for hardware failures?**

Examples of “back-up equipment” include extra BCMA scanners, portable computers, batteries, and mice that are easily accessible to nurses experiencing equipment malfunctions. Quickly replacing malfunctioning equipment is essential to prevent workarounds.

- 32. What are some examples of “engaging nursing leadership at the unit level on BCMA use?”**

Engaging nursing leadership on BCMA use should be an active, ongoing process. An engaged leader would actively use BCMA data to coach staff towards safe or desired behaviors. Examples of activities in which nursing leadership could be engaged include, but are not limited to:

- Education sessions in units
- Review of policies regarding use and non-use of BCMA
- Investigating problems with BCMA specific to the unit
- Providing a forum for users to report BCMA problems and reasons for workarounds
- Providing suggestions for improvements to both technology and process

33. How often should hospitals conduct real-time observations and what do ‘best practices’ look like?

At a minimum, the observations should be conducted on each unit at least biannually (2x/year) and should be 30 minutes or 30 medication administrations in length, whichever is shorter. If a central team does observations, they should ensure each type of unit is observed within that 6-month period. More frequent observations are appropriate for hospitals that have recently introduced BCMA and/or when safety reports indicate a problem, where observations can be helpful in understanding the root cause of an incident or near miss.

The observations should be direct nurse-BCMA observations, watching how the nurse uses the BCMA system as part of the bedside medication administration process. The observer should note if nurses are using any workarounds to compensate for system issues. In addition to observing the nurse-BCMA interaction, the observer should also have conversations with the nurses, as their comments are often a good source for understanding the causes of workarounds. The observations collected from the different units should be aggregated together to understand trends across the hospital and where the hospital should place a priority for addressing BCMA system issues.

34. If our hospital meets the 95% compliance target, do we still need to implement or monitor a quality improvement project for question #21f?

Yes, the hospital should still implement or monitor a quality improvement project to ensure that they can continue to improve and maintain high compliance and the project should focus on those units included in the standard. For example, perhaps through reviewing compliance you have recognized that one or more units is lower performing, so you develop a project (training, observing, etc.) to improve. Another example is improving the timeliness of Help Desk responses for equipment failures etc.

35. What are some appropriate mechanisms for communicating back to end users for question #21h?

Appropriate mechanisms for communicating back to end users would include staff meetings, safety briefings or unit huddles, or sharing in a Nursing Informatics eNewsletter, through a Medication Safety Team, or Quality Committee newsletter/flyer.

Medication Reconciliation FAQs

Sampling

36. Are we required to use Leapfrog's random sampling methodology?

No. You may use a different sampling methodology from the methodology provided in the Medication Reconciliation Workbook. However, you should be sure to sample from different days of the week, including weekends.

37. If the first few patients included in the sample have zero gold standard medications, should we sample more than 30 patients?

Yes, hospitals can sample more than 30 patients to ensure their rate of unintentional discrepancies per medication is scored and publicly reported. While 30 is the minimum sample size, hospitals are welcome to sample more than this.

Gold Standard Medication History

38. A pharmacist, pharmacy resident, or certified pharmacy technician creates the pre-admission Medical List as part of normal care. Can this be used as the Gold Standard Medication List?

No, a different trained pharmacist, pharmacy resident, or [certified pharmacy technician](#)²³ should collect the Gold Standard Medication List when collecting data for this measure.

39. Does the same pharmacist, pharmacy resident, or certified pharmacy technician who obtains the Gold Standard Medication List also need to perform the review to identify unintentional medication discrepancies?

No, different pharmacists or pharmacy residents can play different roles in the data collection process. Only pharmacists and pharmacy residents can compare the Gold Standard Medication List to admission and discharge orders to identify unintentional medication discrepancies.

40. We have two differing records of what dose the patient was taking prior to admission, one from the patient and one from the outpatient pharmacy. What do we record as the correct dose for the Gold Standard Medication?

In cases where the medication history obtained from interviewing the patient does not match other written records, the pharmacist will need to go back to the patient with the pharmacy records in hand and figure out the source of the discrepancy (e.g., the patient systematically takes it differently than prescribed vs. the patient was just mistaken about the strength of the pill, etc.). If the discrepancy can't be resolved, then another source will be needed (e.g., caregiver, PCP).

Admission and Discharge Orders**41. Are there any types of admission orders that can or should be excluded?**

Yes, (a) Medication orders that are clearly related to the chief complaint (e.g., levofloxacin for pneumonia when pneumonia is the admitting diagnosis), (b) Medication orders that are clearly documented (e.g., Lovenox for DVT prophylaxis), and (c) Standard PRN orders at your hospital (e.g., Tylenol PM if that is in the standard order set at your hospital).

42. Should admission orders that are discontinued prior to discharge be included?

Yes. Some of these orders may end up being counted in question #7 (additional medications that were unintentionally ordered).

Identifying Discrepancies**43. If a dose and a route discrepancy are found for the same medication, does it count as one or two in the number of unintentional discrepancies?**

The number of unintentional discrepancies is a count of medication orders where an unintentional discrepancy occurred. A medication order may have several errors associated with it (e.g., dose, route, timing, etc.). You should not count the number of errors associated with the same medication order. However, discrepancies in admission orders and discharge orders are counted separately. For example, if a medication on the Gold Standard Medication List is ordered for a patient on admission with the incorrect dose, this counts as one discrepancy. If this medication is ordered on discharge with the same incorrect dose, this would count as a second discrepancy. But a medication with a dose and frequency discrepancy in admission orders counts as one discrepancy.

44. Do all the additional medications that were ordered unintentionally in question #7 count as unintentional discrepancies in #8?

Yes. If a medication is unintentionally ordered at admission, then this counts as one discrepancy. If the same medication is unintentionally ordered at discharge, then this counts as a second discrepancy. If an unintentionally ordered medication in question #7 was ordered on both admission and discharge, then this would count as **two** discrepancies in question #8 (but counts as one medication in question #7).

45. If there is no documentation of systematic or sporadic nonadherence, why does the pharmacist have to count unintentional discrepancies on admission and discharge?

Systematically non-adherent means the patient consistently takes the medication differently than prescribed. Lack of appropriate documentation of systematic non-adherence can lead to an adverse drug event. For example, if a patient is prescribed hydralazine 25mg three times a day, but always takes 25mg two times a day this must be documented in the clinical record so the care team can decide how to order the medication on admission and discharge (i.e., recorded on the Med Rec Worksheet as an intentional discrepancy). If the systematic non-adherence is not

documented and the care team is unaware of how the patient has been taking the medication, they could order and administer it as prescribed and cause, in this example, hypotension in the patient.

Sporadically non-adherent means that the patient takes the medication as prescribed but, on average, misses two or more doses per week. Lack of appropriate documentation of sporadic non-adherence can lead to an adverse drug event. For example, if a patient is prescribed four antihypertensives, but misses two or more doses per week, this must be documented in the clinical record so the care team can decide how to order the medication on admission and discharge (i.e., recorded on the Med Rec Worksheet as an intentional discrepancy). If the sporadic non-adherence is not documented and the care team is unaware of how the patient has been taking the medication, they could order and administer it as prescribed and cause, in this example, hypotension in the patient.

46. A patient had two medications that were not on our hospital's formulary. They were not substituted. Do these two medications count as errors of omission?

Yes. If a Gold Standard Medication was not ordered or appropriately substituted on admission and discharge, it would count as two unintentional medication discrepancies for each medication that was omitted.

Scoring

47. What questions are used to calculate the numerator and denominator that results in the rate of unintentional medication discrepancies per medication?

The rate of unintentional medication discrepancies per medication is calculated using the following formula:

$$\frac{(\text{Question \#6} + \text{Question \#8})}{(\text{Question \#5} + \text{Question \#7})} = \text{Rate of unintentional medication discrepancies per medication}$$

This rate is calculated for you in the Med Rec Workbook provided on the [Survey Materials webpage](#). This information is also available in the [Scoring Algorithms](#).

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SECTION 3: ADULT AND PEDIATRIC COMPLEX SURGERY

This section includes questions and reference information for Section 3: Adult and Pediatric Complex Surgery. Please carefully review the questions, endnotes, and reference information (e.g., measure specifications, notes, and frequently asked questions) before you begin. Failure to review the reference information could result in inaccurate responses.

Section 3: Adult and Pediatric Complex Surgery

Adult and Pediatric Complex Surgery Fact Sheet and Bibliography:

<https://ratings.leapfroggroup.org/measure/hospital/2025/complex-adult-and-pediatric-surgery>

Section 3 is applicable to all hospitals. Hospitals that do not perform the high-risk procedures included in Section 3A should select “None of the above” in question #2 and move on to the Affirmation of Accuracy. Your hospital’s results will be displayed as “Does Not Apply” on Leapfrog’s public reporting website. Pediatric hospitals should only report on the Norwood procedure, if applicable.

Section 3 includes questions about your hospital’s volume and process for privileging surgeons for eleven high-risk procedures, outcomes for mitral valve repair and replacement, and participation in The Society of Thoracic Surgeons’ Congenital Heart Surgery Database for hospitals that perform the Norwood procedure. This section also includes questions about the implementation of a safe surgery checklist.

Each hospital achieving the standard for each of the nine applicable high-risk procedures:

1. Meets the minimum hospital volume standard for the procedure, **and**
2. Has a process for privileging surgeons that includes the surgeon meeting or exceeding the minimum annual surgeon volume standard for the procedure.

Each hospital achieving the standard for mitral valve repair and replacement procedures:

1. Meets the minimum hospital volume standard for the procedure, **and**
2. Has a process for privileging surgeons that includes meeting or exceeding the minimum annual surgeon volume standard for the procedure, **and**
3. Participates in the Society of Thoracic Surgeons (STS) Adult Cardiac Surgery Database (ACSD), **and**
4. Has an STS Mitral Valve Repair/Replacement Composite Score of 3 Stars.

Each hospital achieving the standard for Norwood procedures:

1. Meets the minimum hospital volume standard for the procedure, **and**
2. Has a process for privileging surgeons that includes meeting or exceeding the minimum annual surgeon volume standard for the procedure, **and**
3. Participates in the Society of Thoracic Surgeons (STS) Congenital Heart Surgery Database (CHSD).

Each hospital achieving the standard for the safe surgery checklist:

1. Uses a safe surgery checklist on **all** patients undergoing an applicable procedure (reported on in Section 3A, if applicable) that includes **all** safe surgery checklist elements; **and**
2. Verbalizes **all** safe surgery checklist elements in the presence of the appropriate personnel; **and**
3. Completes an audit on a sufficient sample of patients to document adherence to the checklist; **and**
4. Has documented adherence to the checklist for at least 90% of the patients included in the audit.

Download the 2025 Leapfrog Hospital Survey Scoring Algorithm on the [Scoring and Results webpage](#).

3A: Hospital and Surgeon Volume

Hospitals that share a CMS Certification Number are required to report by facility. Please carefully review [Leapfrog's Multi-Campus Reporting Policy](#).

Important Notes:

Note 1: This subsection is applicable to all hospitals. Hospitals that do not perform the procedures included in this subsection should select “None of the above” in question #2 and move on to the Affirmation of Accuracy. Your hospital's results will be displayed as “Does Not Apply” on Leapfrog's public reporting website.

Note 2: Pediatric hospitals should only respond to questions regarding the Norwood procedure, if applicable. If the Norwood procedure is not applicable, select “None of the above” in question #2 and move on to the Affirmation of Accuracy. Your hospital's results will be displayed as “Does Not Apply” on Leapfrog's public reporting website.

Specifications: See [Hospital and Surgeon Volume Measure Specifications](#) in the Reference Information beginning on page 101.

Reporting Period: 12 months or *optionally* 24 months (annual average)

- Surveys submitted prior to September 1:
 - 01/01/2024 – 12/31/2024 (12-month count) or 01/01/2023 – 12/31/2024 (24-month annual average)
- Surveys (re)submitted on or after September 1:
 - 07/01/2024 – 06/30/2025 (12-month count) or 07/01/2023 – 06/30/2025 (24-month annual average)

Note: As a reminder, the [Corrections Period](#) (December 1-January 31) is reserved for corrections to previously submitted Surveys only. Any updates made to reflect a change in performance must be made prior to the November 30 Late Submission and Performance Update Deadline. Updates made to reflect a change in performance after November 30 will not be scored or publicly reported.

1) 12-month or 24-month reporting period used:	○ 01/01/2024 – 12/31/2024 (12-month count) ○ 01/01/2023 – 12/31/2024 (24-month annual average) ○ 07/01/2024 – 06/30/2025 (12-month count) ○ 07/01/2023 – 06/30/2025 (24-month annual average)
2) Check all procedures that your hospital performs as defined in the Adult and Pediatric Complex Surgery Reference Information. <i>Select all that apply.</i> <i>Do not check the box for a procedure if your hospital ONLY performs the procedure on an emergency basis or when a patient is too unstable for safe transfer.</i> <i>If “none of the above,” skip the remaining questions in Section 3 and go to the Affirmation of Accuracy. The hospital will be scored as “Does Not Apply.”</i>	☐ Carotid endarterectomy ☐ Mitral valve repair and replacement ☐ Open aortic procedures ☐ Lung resection for cancer ☐ Esophageal resection for cancer ☐ Pancreatic resection for cancer ☐ Rectal cancer surgery ☐ Bariatric surgery for weight loss ☐ Total knee replacement ☐ Total hip replacement ☐ Norwood procedure ☐ None of the above

Respond to questions #3-11 based on the procedures selected in question #2.

3) Total hospital volume for each selected procedure during the reporting period: <i>Volume should represent a 12-month count or 24-month annual average consistent with the reporting period selected in question #1.</i>		
<i>Procedure</i>	<i>Hospital Volume Standard</i>	<i>Total Hospital Volume (12-month count or 24-month annual average)</i>
Carotid endarterectomy	20	
Mitral valve repair and replacement	40	
Open aortic procedures	10	
Lung resection for cancer	40	
Esophageal resection for cancer	20	
Pancreatic resection for cancer	20	
Rectal cancer surgery	16	
Bariatric surgery for weight loss	50	
Total knee replacement	50	
Total hip replacement	50	
Norwood procedure	8	

4) Does the total hospital volume for total knee replacement, total hip replacement, and/or bariatric surgery for weight loss reported on in question #3 above include procedures performed on an inpatient basis, outpatient basis, or both?	
Total knee replacement	☐ Inpatient ☐ Outpatient ☐ Both (inpatient and outpatient)
Total hip replacement	☐ Inpatient ☐ Outpatient ☐ Both (inpatient and outpatient)
Bariatric surgery for weight loss	☐ Inpatient ☐ Outpatient ☐ Both (inpatient and outpatient)

5) Does your hospital's privileging process include the surgeon meeting or exceeding the minimum annual surgeon volume standard listed below?		
<i>Procedure</i>	<i>Annual Surgeon Volume Standard</i>	
Carotid endarterectomy	10	☐ Yes ☐ No
Mitral valve repair and replacement	20	☐ Yes ☐ No
Open aortic procedures	7	☐ Yes ☐ No
Lung resection for cancer	15	☐ Yes ☐ No
Esophageal resection for cancer	7	☐ Yes ☐ No
Pancreatic resection for cancer	10	☐ Yes ☐ No

Rectal cancer surgery	6	☐ Yes ☐ No
Bariatric surgery for weight loss	20	☐ Yes ☐ No
Total knee replacement	25	☐ Yes ☐ No
Total hip replacement	25	☐ Yes ☐ No
Norwood procedure	5	☐ Yes ☐ No

If your hospital performs mitral valve repair and replacement (selected the checkbox in question #2), continue to question #6. Otherwise, skip questions #6-9 and continue to question #10.

Reporting Period: Base your responses on the latest **36-month** report received from the [Society of Thoracic Surgeons \(STS\)](#) Adult Cardiac Surgery Database (ACSD) for the **Mitral Valve Repair/Replacement Composite Score**.

Note: As a reminder, the [Corrections Period](#) (December 1-January 31) is reserved for corrections to previously submitted Surveys only. Any updates made to reflect a change in performance must be made prior to the November 30 Late Submission and Performance Update Deadline. Updates made to reflect a change in performance after November 30 will not be scored or publicly reported.

6) Does your hospital participate in the Society of Thoracic Surgeons (STS) Adult Cardiac Surgery Database (ACSD) and submit data for all applicable procedures during the most recent 36-month period for which performance reports are available? <i>If “no” to question #6, skip questions #7-9 and continue to question #10.</i>	☐ Yes ☐ No
7) What is the most recent 36-month reporting period for which STS performance reports are available? Reporting period ending:	_____ Format: Month/Year
8) Does your hospital have a Mitral Valve Repair/Replacement Composite Score publicly reported on the STS website and do you choose to report data from the most recent performance report to this Survey? <i>If “no” or “yes, but did not meet the STS Data Completeness Requirement”²⁹ during the reporting period,” skip question #9 and continue to question #10.</i>	☐ Yes ☐ No ☐ Yes, but did not meet the STS Data Completeness Requirement during the reporting period
9) What is your hospital's Mitral Valve Repair/Replacement Composite Score?	☐ 1 star – lower-than-expected performance ☐ 2 stars – as-expected performance ☐ 3 stars – higher-than-expected performance

If your hospital performs the Norwood procedure (selected the checkbox in question #2), continue to question #10. Otherwise, skip questions #10-11 and continue to the next subsection.

10) Does your hospital participate in the Society of Thoracic Surgeons (STS) Congenital Heart Surgery Database (CHSD) and did your hospital submit data for the Norwood procedure during the most recent 48-month period for which performance reports are available? <i>If “no” to question #10, skip question #11 and continue to the next subsection.</i>	☐ Yes ☐ No
11) What is the most recent 48-month reporting period for which STS performance reports are available? Reporting period ending:	_____ <i>Format: Month/Year</i>

3B: Safe Surgery Checklist for Adult and Pediatric Complex Surgery

Hospitals that share a CMS Certification Number are required to report by facility. Please carefully review [Leapfrog's Multi-Campus Reporting Policy](#).

Important Notes:

Note 1: The elements required for each stage of the safe surgery checklist are adapted from the [WHO Surgical Safety Checklist](#) and the [AHRQ Endoscopy Checklist](#).

Note 2: Question #7 will not be used in scoring or public reporting.

Note 3: Hyperlinks throughout this subsection refer to the [Safe Surgery Checklist for Adult and Pediatric Complex Surgery FAQs](#) beginning on page 143, not to endnotes. These hyperlinks are not included in the Online Survey Tool.

Specifications: See [Safe Surgery Checklist for Adult and Pediatric Complex Surgery Measure Specifications](#) in the Reference Information beginning on page 141.

Reporting Period: 12 months

Answer questions #1-9 for the latest 12-month period prior to submission of this section of the Survey.

Note: As a reminder, the [Corrections Period](#) (December 1-January 31) is reserved for corrections to previously submitted Surveys only. Any updates made to reflect a change in performance must be made prior to the November 30 Late Submission and Performance Update Deadline. Updates made to reflect a change in performance after November 30 will not be scored or publicly reported.

Sufficient Sample: See [Safe Surgery Checklist for Adult and Pediatric Complex Surgery Measure Specifications](#) for instructions on identifying a sufficient sample for questions #6-9.

1) What is the latest 12-month reporting period for which your hospital is submitting responses to questions #2-9? 12-month reporting period ending:	<u> </u> Format: Month/Year
2) Does your hospital utilize a safe surgery checklist on <u>every</u> patient <u>every</u> time one of the applicable procedures in Section 3A is performed? <i>If "no" to question #2, skip the remaining questions in Section 3B and go to the Affirmation of Accuracy. The hospital will be scored as "Limited Achievement."</i>	☐ Yes ☐ No
3) Before the induction of anesthesia , is a safe surgery checklist that includes <u>all</u> the following elements <u>read aloud</u> in the presence of the <u>anesthesia professional and nursing personnel</u> : • Patient ID; • Confirmation of procedure; • Patient consent; • Site marked, if applicable; • Anesthesia/medication check; • Allergies assessed; • Difficult airway/aspiration risk; • Risk of blood loss (only applicable if risk of blood loss is >500ml for adults or >7ml/kg for children); and • Availability of devices (applicable to endoscopy procedures only)?	☐ Yes ☐ No

4) Before the skin incision and/or before the procedure begins, is a safe surgery checklist that includes <u>all</u> the following elements <u>read aloud</u> in the presence of the <u>whole surgical team</u>: • <u>Clinical team introduction</u>; • Confirmation of patient name, procedure, and, if applicable, surgical/incision site; • Antibiotic prophylaxis, if applicable; • Anticipated Critical Events (i.e., non-routine steps, length of procedure, blood loss, patient-specific concerns, sterility); • Equipment check/concerns; and • Essential imaging available, if applicable?	☐ Yes ☐ No
5) Before the patient leaves the operating room and/or procedure room, is a safe surgery checklist that includes <u>all</u> the following elements <u>read aloud</u> in the presence of the <u>whole surgical team</u>: • Confirmation of procedure performed; • Instrument/supply counts; • Specimen labeling, if applicable; • Equipment concerns; and • Patient recovery/management concerns?	☐ Yes ☐ No

If “no” to question #3, #4, or #5, skip the remaining questions in Section 3B and go to the Affirmation of Accuracy. The hospital will be scored as “Limited Achievement.”

Hospitals performing the audit in Section 3B question #6 and the audit in Section 9D question #6 should audit 15 cases who underwent a procedure included in Section 3A and 15 cases who underwent a procedure included in Section 9C. Hospitals only performing the audit in Section 3B question #6 and not in Section 9D question #6 should audit 30 cases who underwent a procedure included in Section 3A.

6) Did your hospital perform an audit (either in-person or via the medical record or other EHR data) on a sufficient sample of patients who underwent a procedure included in Section 3A and measure adherence to the safe surgery checklist? <i>Free-standing pediatric hospitals that perform the Norwood Procedure and hospitals that reported a combined total hospital volume of less than the sufficient sample for all the procedures in Section 3A can sample any patients that had a procedure performed under general anesthesia.</i> <i>If “no” to question #6, skip the remaining questions in Section 3B and go to the Affirmation of Accuracy. The hospital will be scored as “Limited Achievement.”</i> <i>If “no, performed fewer than 30 total inpatient procedures under general anesthesia” to question #6, skip the remaining questions in Section 3B and go to the Affirmation of Accuracy. The hospital will be scored as “Unable to Calculate Score.”</i>	☐ Yes ☐ No ☐ No, performed fewer than 30 total inpatient procedures under general anesthesia
7) How many cases were included in the audit from question #6?	<u>Max value 100</u>

8) Which method was used to perform the audit on a sufficient sample in question #6?	○ In-person observational audit ○ Retrospective audit of medical records or EHR data ○ Both
9) Based on your hospital's audit (either in-person or via the medical record or other EHR data) on a sufficient sample of patients who underwent a procedure included in Section 3A, what was your hospital's documented rate of adherence to the safe surgery checklist (i.e., what percentage of the sampled cases had all elements in questions #3, #4, and #5 completed)?	○ 90%-100% ○ 75%-89% ○ 50%-74% ○ Less than 50%

Affirmation of Accuracy

As the hospital CEO or as an employee of the hospital to whom the hospital CEO has delegated responsibility, I have reviewed this information pertaining to the Adult and Pediatric Complex Surgery Section at our hospital, and I hereby certify that this information is true, accurate, and reflects the current, normal operating circumstances at our hospital. I am authorized to make this certification on behalf of our hospital.

The hospital and I understand that The Leapfrog Group, its members, the public and entities and persons who contract or have other business dealings with The Leapfrog Group are relying on the truth and accuracy of this information. The hospital and I also understand that The Leapfrog Group will make this information and/or analyses of this information public through the Survey Results public reporting website, The Leapfrog Group's Hospital Safety Grade, and/or other Leapfrog Group products and services. This information and/or analyses and all intellectual property rights therein shall be and remain the sole and exclusive property of The Leapfrog Group in which The Leapfrog Group retains exclusive ownership. This information does not infringe upon any third-party intellectual property rights or any other third-party rights whatsoever and is free and clear of all encumbrances and liens of any kind. The hospital and I acknowledge that The Leapfrog Group may use this information in a commercial manner for profit. The hospital shall be liable for and shall hold harmless and indemnify The Leapfrog Group from any and all damages, demands, costs, or causes of action resulting from any inaccuracies in the information or any misrepresentations in this Affirmation of Accuracy. The Leapfrog Group and its members and entities and persons who contract or have other business dealings with The Leapfrog Group reserve the right to omit or disclaim information that is not current, accurate or truthful.

Affirmed by _____, the hospital's _____,
(first name and last name) (title)
on _____.
(date)

Section 3: Adult and Pediatric Complex Surgery Reference Information

What's New in the 2025 Survey

Section 3A: Hospital and Surgeon Volume

For mitral valve repair and replacement, Leapfrog is updating the questions and measure specifications to clarify that hospitals can only report on their Mitral Valve Repair/Replacement Composite Score if the score is publicly reported on the STS website at <https://publicreporting.sts.org/search/acsd>. For Bariatric Surgery for Weight Loss, Leapfrog is making two updates:

- First, we are removing three procedure codes from the list of CPT codes used to count same-day bariatric procedures as they do not meet the criteria for inclusion in our volume standards since they are used for the placement of gastric banding rather than bypass of the stomach.
- Second, we are adding several ICD-10-CM procedure codes that bring greater alignment with the Centers for Medicare and Medicaid's payment policies for bariatric surgery. These additional codes expand on the current procedure code list, with a continued focus on the bypass of the stomach but reflect additional tissue types and approach types. The additions can be reviewed in the [Section 3A: Hospital and Surgeon Volume Measure Specifications](#).

Section 3B: Safe Surgery Checklist for Adult and Pediatric Complex Surgery

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

Change Summary Since Release

May 1, 2025 – Added four ICD-10 Morbid Obesity Diagnosis Codes for Bariatric Surgery for Weight Loss for Adult and Pediatric Complex Surgery. Hospitals are not required to make updates to data already collected and/or reported but have the option to include the additional codes if they wish.

The additional codes were added to the Complex Surgery ICD 10 Codes Workbook (available on the Survey Materials [webpage](#)) and CPT Code workbook (available on the [Survey Dashboard](#)). Please review the updated codes on page 131 of the Survey.

Section 3: Adult and Pediatric Complex Surgery Measure Specifications

Hospital and Surgeon Volume Measure Specifications

Important Notes:

Note 1: Hospitals that share a CMS Certification Number are required to report by facility. Please carefully review [Leapfrog's Multi-Campus Reporting Policy](#).

Note 2: For each of the eleven high-risk procedures included in Section 3A: Hospital and Surgeon Volume, Leapfrog has provided a set of ICD-10 procedure codes, and in some cases an additional set of CPT codes (for Total Hip Replacement, Total Knee Replacement, and Bariatric Surgery for Weight Loss) or ICD-10 diagnosis codes, for counting **patient discharges**. Please carefully review the measure specifications for each individual procedure to ensure you have the complete list of codes needed. ICD-10 codes are provided below and are also available in an Excel document on the [Survey Materials webpage](#). See Note 3 below for instructions on downloading CPT codes.

Note 3: CPT Codes are provided in downloadable Excel files on the Survey Dashboard. To access the files, click the CPT Code Workbook button next to Section 9. You will be required to complete the American Medical Association's Terms of Use before downloading the Excel file and using the individual CPT codes to query your EHR or billing system. You are only required to complete the Terms of Use once per Survey Cycle (April 1 – November 30).

The CPT Code Workbooks (Excel files) are labeled for Section 3A: Total Hip Replacement, Total Knee Replacement, and Bariatric Surgery for Weight Loss and Section 9C: Volume of Procedures. Please note, if you are part of a hospital system, each hospital will need to complete the Terms of Use. This is a requirement of the American Medical Association.

Source: The Leapfrog Group, American Medical Association
Reporting Period: 12 months or <i>optionally</i> 24 months (annual average) - Surveys submitted prior to September 1: 01/01/2024 – 12/31/2024 (12-month count) or 01/01/2023 – 12/31/2024 (24-month annual average) - Surveys (re)submitted on or after September 1: 07/01/2024 – 06/30/2025 (12-month count) or 07/01/2023 – 06/30/2025 (24-month annual average)
Question #2: Check all procedures that your hospital performs as defined in the Adult and Pediatric Complex Surgery Reference Information (listed below): - Carotid endarterectomy - Mitral valve repair and replacement - Open aortic procedures - Lung resection for cancer - Esophageal resection for cancer - Pancreatic resection for cancer - Rectal cancer surgery - Bariatric surgery for weight loss - Total knee replacement - Total hip replacement - Norwood procedure Free-standing pediatric hospitals should only report on the Norwood procedure, if applicable. <u>Do not</u> check the box for the procedure if: - Your hospital does not perform the procedure or ONLY performs the procedure on an emergency basis or when a patient is too unstable for safe transfer.

- Your hospital has started to perform the procedure in the last 18 months. Leapfrog gives hospitals an 18-month grace period before having to report on hospital volume and process for privileging surgeons for new service lines.

Do check the box for the procedure if:

- Your hospital would perform the procedure but had zero cases during the reporting period. Select the procedure and indicate a hospital volume of zero in question #3. Please note that hospitals can elect to report on a 24-month annual average.
- Your hospital has reached the end of the 18-month grace period for a new service line. You will now have to report on both hospital volume and your process for privileging surgeons for this procedure.

Question #3: Total **hospital volume** for each selected procedure (from question #2) during the reporting period:

- [Carotid endarterectomy](#) (Hospital Volume Standard: 20)
- [Mitral valve repair and replacement](#) (Hospital Volume Standard: 40)
- [Open aortic procedures](#) (Hospital Volume Standard: 10)
- [Lung resection for cancer](#) (Hospital Volume Standard: 40)
- [Esophageal resection for cancer](#) (Hospital Volume Standard: 20)
- [Pancreatic resection for cancer](#) (Hospital Volume Standard: 20)
- [Rectal cancer surgery](#) (Hospital Volume Standard: 16)
- [Bariatric surgery for weight loss](#) (Hospital Volume Standard: 50)
- [Total knee replacement](#) (Hospital Volume Standard: 50)
- [Total hip replacement](#) (Hospital Volume Standard: 50)
- [Norwood procedure](#) (Hospital Volume Standard: 8)

When calculating total **hospital volume** count the number of **patients** discharged from your hospital within the reporting period with any one or more of the ICD-10 codes or CPT codes (for Total Hip Replacement, Total Knee Replacement, and Bariatric Surgery for Weight Loss) specified for each procedure, subject to the inclusion criteria below:

- Only the ICD-10 procedure, CPT, and diagnosis codes provided by Leapfrog should be used to report on the questions in Section 3A: Hospital and Surgeon Volume. ICD-10 codes are provided below and are also available in an Excel document on the [Survey Materials webpage](#). See Note 3 above for instructions on downloading CPT codes.
- For procedures that include TWO sets of codes (one set of procedure codes and one set of diagnosis codes), both sets of codes must be used for counting patient discharges (e.g., at least one procedure code AND one diagnosis code must be present).
- Except for bariatric surgery for weight loss (where the ICD-10 diagnosis code must be the primary diagnosis) and total knee replacement and total hip replacement (where the procedure code must be the primary procedure), ICD-10 codes for the other procedures can appear in ANY procedure field and ANY diagnosis field.
- Age restrictions apply – For the Norwood procedure only include discharges for pediatric patients (ages 17 years and younger). For the remaining ten procedures, only include discharges for adult patients (ages 18 years and older).

Question #4: Does the total hospital volume for total knee replacement, total hip replacement, and/or bariatric surgery for weight loss reported on in question #3 above include procedures performed on an inpatient basis, outpatient basis, or both?

- If your hospital only performs total knee replacement, total hip replacement, and/or bariatric surgery for weight loss on an inpatient basis, select inpatient.
- If your hospital only performs total knee replacement, total hip replacement, and/or bariatric surgery for weight loss on an outpatient basis, select outpatient.
- If your hospital performs total knee replacement, total hip replacement, and/or bariatric surgery for weight loss on both an inpatient and outpatient basis, select both (inpatient and outpatient).

Question #5: Does your hospital's privileging process include the surgeon meeting or exceeding the minimum annual surgeon volume standard listed below?

- Carotid endarterectomy: 10
- Mitral valve repair and replacement: 20
- Open aortic procedures: 7
- Lung resection for cancer: 15
- Esophageal resection for cancer: 7
- Pancreatic resection for cancer: 10
- Rectal cancer surgery: 6
- Bariatric surgery for weight loss: 20
- Total knee replacement: 25
- Total hip replacement: 25
- Norwood procedure: 5

When determining whether surgeons have met or exceeded Leapfrog's minimum annual surgeon volume standards for the purposes of privileging, only refer to the ICD-10 procedure codes and CPT codes (for Total Hip Replacement, Total Knee Replacement, and Bariatric Surgery for Weight Loss) – **diagnosis** codes can be ignored.

Source: The Society of Thoracic Surgeons (STS)

Reporting Period: Latest **36-month** report from Society of Thoracic Surgeons (STS) Adult Cardiac Surgery Database (ACSD) for the **Mitral Valve Repair/Replacement Composite Score**.

Question #6: Does your hospital participate in the [Society of Thoracic Surgeons \(STS\)](#) Adult Cardiac Surgery Database (ACSD), submit data for all applicable procedures during the most recent 36-month period for which performance reports are available?

Select "yes" if your hospital participates in the [Society of Thoracic Surgeons \(STS\)](#) Adult Cardiac Surgery Database (ACSD) and has submitted data for all applicable procedures during the most recent 36-month period.

Question #7: What is the most recent 36-month reporting period for which STS performance reports are available? Reporting period ending:

Select the most recent 36-month reporting period for which STS performance reports are available. The reporting period is displayed when reviewing your "MVRR Composite Quality Ratings" at <https://publicreporting.sts.org/search/acsd>. See screenshot provided for question #9 [below](#).

Question #8: Does your hospital have a Mitral Valve Repair/Replacement Composite Score publicly reported on the STS website and do you choose to report data from the most recent performance report to this Survey?

Select "yes" if your hospital elects to share the MVRR data from your most recent performance report with Leapfrog.

Question #9: What is your hospital's Mitral Valve Repair/Replacement Composite Score?

Report your Mitral Valve Repair/Replacement Overall Composite Score from the STS Public Reporting website: <https://publicreporting.sts.org/search/acsd>.

Click on "Search All Groups." Then search for your hospital name/surgery group name in the "Participant Surgery Group Name" field and click your hospital name/surgery group name. On the next page find your "MVRR Composite Quality Rating" and your "Overall Composite Score." Report the number of stars displayed for "Overall Composite Score" represented in the screenshot below.



Source: The Society of Thoracic Surgeons (STS)

Question #10: Does your hospital participate in the [Society of Thoracic Surgeons \(STS\)](#) Congenital Heart Surgery Database (CHSD) and did your hospital submit data for the Norwood procedure during the most recent 48-month period for which performance reports are available?

Select "yes" if your hospital participates in the [Society of Thoracic Surgeons \(STS\)](#) Congenital Heart Surgery Database (CHSD) and has submitted data for the Norwood procedure during the most recent 48-month period.

Question #11: What is the most recent 48-month reporting period for which STS performance reports are available? Reporting period ending:

Select the most recent 48-month reporting period for which STS performance reports are available. The reporting period should appear at the top of your STS performance report.

See [FAQs](#) for additional information about responding to the questions in this section.

Carotid Endarterectomy Measure Specifications

For carotid endarterectomy, there are two sets of ICD-10 codes for counting patient discharges. The first set of codes is to identify patients who have had the procedure. The second set of codes is to identify patients with a specific diagnosis.

Count the number of patients, ages 18 years and older, discharged with the following ICD-10 codes in any procedure field AND any of the following ICD-10 codes in any diagnosis field.

ICD-10 Carotid Endarterectomy Procedure Codes

ICD-10 Procedure Code	Code Description
03CH0ZZ	Extirpation of Matter from Right Common Carotid Artery, Open Approach
03CJ0ZZ	Extirpation of Matter from Left Common Carotid Artery, Open Approach
03CK0ZZ	Extirpation of Matter from Right Internal Carotid Artery, Open Approach
03CL0ZZ	Extirpation of Matter from Left Internal Carotid Artery, Open Approach
03CM0ZZ	Extirpation of Matter from Right External Carotid Artery, Open Approach
03CN0ZZ	Extirpation of Matter from Left External Carotid Artery, Open Approach

ICD-10 Occlusion and Stenosis and Cerebral Infarction Diagnosis Codes

ICD-10 Diagnosis Code	Code Description
I63.031	Cerebral infarction due to thrombosis of right carotid artery
I63.032	Cerebral infarction due to thrombosis of left carotid artery
I63.033	Cerebral infarction due to thrombosis of bilateral carotid arteries
I63.039	Cerebral infarction due to thrombosis of unspecified carotid artery
I63.131	Cerebral infarction due to embolism of right carotid artery
I63.132	Cerebral infarction due to embolism of left carotid artery
I63.133	Cerebral infarction due to embolism of bilateral carotid arteries
I63.139	Cerebral infarction due to embolism of unspecified carotid artery
I63.231	Cerebral infarction due to unspecified occlusion or stenosis of right carotid arteries
I63.232	Cerebral infarction due to unspecified occlusion or stenosis of left carotid arteries
I63.233	Cerebral infarction due to unspecified occlusion or stenosis of bilateral carotid arteries
I63.239	Cerebral infarction due to unspecified occlusion or stenosis of unspecified carotid arteries
I65.21	Occlusion and stenosis of right carotid artery
I65.22	Occlusion and stenosis of left carotid artery
I65.23	Occlusion and stenosis of bilateral carotid arteries
I65.29	Occlusion and stenosis of unspecified carotid artery
I65.8	Occlusion and stenosis of other precerebral arteries
I65.9	Occlusion and stenosis of unspecified precerebral artery

Mitral Valve Repair and Replacement Measure Specifications

For mitral valve repair and replacement, there is only one set of ICD-10 codes for counting patient discharges. The set of codes is to identify patients who have had the procedure.

Count the number of patients, ages 18 years and older, discharged with the following ICD-10 codes in any procedure field.

ICD-10 Mitral Valve Repair and Replacement Procedure Codes

ICD-10 Procedure Code	Code Description
027G04Z	Dilation of Mitral Valve with Drug-eluting Intraluminal Device, Open Approach
027G0DZ	Dilation of Mitral Valve with Intraluminal Device, Open Approach
027G0ZZ	Dilation of Mitral Valve, Open Approach
02CG0ZZ	Extirpation of Matter from Mitral Valve, Open Approach
02NG0ZZ	Release Mitral Valve, Open Approach
02QG0ZE	Repair Mitral Valve created from Left Atrioventricular Valve, Open Approach
02QG0ZZ	Repair Mitral Valve, Open Approach
02RG07Z	Replacement of Mitral Valve with Autologous Tissue Substitute, Open Approach
02RG08Z	Replacement of Mitral Valve with Zooplasic Tissue, Open Approach
02RG0JZ	Replacement of Mitral Valve with Synthetic Substitute, Open Approach
02RG0KZ	Replacement of Mitral Valve with Nonautologous Tissue Substitute, Open Approach
02UG07E	Supplement Mitral Valve created from Left Atrioventricular Valve with Autologous Tissue Substitute, Open Approach
02UG07Z	Supplement Mitral Valve with Autologous Tissue Substitute, Open Approach
02UG08E	Supplement Mitral Valve created from Left Atrioventricular Valve with Zooplasic Tissue, Open Approach
02UG08Z	Supplement Mitral Valve with Zooplasic Tissue, Open Approach
02UG0JE	Supplement Mitral Valve created from Left Atrioventricular Valve with Synthetic Substitute, Open Approach
02UG0JZ	Supplement Mitral Valve with Synthetic Substitute, Open Approach
02UG0KE	Supplement Mitral Valve created from Left Atrioventricular Valve with Nonautologous Tissue Substitute, Open Approach
02UG0KZ	Supplement Mitral Valve with Nonautologous Tissue Substitute, Open Approach
02VG0ZZ	Restriction of Mitral Valve, Open Approach

Open Aortic Procedures Measure Specifications

For open aortic procedures, there is only one set of ICD-10 codes for counting patient discharges. The set of codes is to identify patients who have had the procedure.

Count the number of patients, ages 18 years and older, discharged with the following ICD-10 codes in any procedure field.

ICD-10 Open Aortic Procedure Codes

ICD-10 Procedure Code	Code Description
0410090	Bypass Abdominal Aorta to Abdominal Aorta with Autologous Venous Tissue, Open Approach
0410091	Bypass Abdominal Aorta to Celiac Artery with Autologous Venous Tissue, Open Approach
0410092	Bypass Abdominal Aorta to Mesenteric Artery with Autologous Venous Tissue, Open Approach
0410093	Bypass Abdominal Aorta to Right Renal Artery with Autologous Venous Tissue, Open Approach
0410094	Bypass Abdominal Aorta to Left Renal Artery with Autologous Venous Tissue, Open Approach
0410095	Bypass Abdominal Aorta to Bilateral Renal Artery with Autologous Venous Tissue, Open Approach
0410096	Bypass Abdominal Aorta to Right Common Iliac Artery with Autologous Venous Tissue, Open Approach
0410097	Bypass Abdominal Aorta to Left Common Iliac Artery with Autologous Venous Tissue, Open Approach
0410098	Bypass Abdominal Aorta to Bilateral Common Iliac Arteries with Autologous Venous Tissue, Open Approach
0410099	Bypass Abdominal Aorta to Right Internal Iliac Artery with Autologous Venous Tissue, Open Approach
021K0ZW	Bypass Right Ventricle to Aorta, Open Approach
021L0ZW	Bypass Left Ventricle to Aorta, Open Approach
021W08A	Bypass Thoracic Aorta, Descending to Innominate Artery with Zooplastic Tissue, Open Approach
021W08B	Bypass Thoracic Aorta, Descending to Subclavian with Zooplastic Tissue, Open Approach
021W08D	Bypass Thoracic Aorta, Descending to Carotid with Zooplastic Tissue, Open Approach
021W08F	Bypass Thoracic Aorta, Descending to Abdominal Artery with Zooplastic Tissue, Open Approach
021W08G	Bypass Thoracic Aorta, Descending to Axillary Artery with Zooplastic Tissue, Open Approach
021W08H	Bypass Thoracic Aorta, Descending to Brachial Artery with Zooplastic Tissue, Open Approach
021W08P	Bypass Thoracic Aorta, Descending to Pulmonary Trunk with Zooplastic Tissue, Open Approach
021W08Q	Bypass Thoracic Aorta, Descending to Right Pulmonary Artery with Zooplastic Tissue, Open Approach
021W08R	Bypass Thoracic Aorta, Descending to Left Pulmonary Artery with Zooplastic Tissue, Open Approach
021W08V	Bypass Thoracic Aorta, Descending to Lower Extremity Artery with Zooplastic Tissue, Open Approach

ICD-10 Procedure Code	Code Description
021W09B	Bypass Thoracic Aorta, Descending to Subclavian with Autologous Venous Tissue, Open Approach
021W09A	Bypass Thoracic Aorta, Descending to Innominate Artery with Autologous Venous Tissue, Open Approach
021W09D	Bypass Thoracic Aorta, Descending to Carotid with Autologous Venous Tissue, Open Approach
021W09F	Bypass Thoracic Aorta, Descending to Abdominal Artery with Autologous Venous Tissue, Open Approach
021W09G	Bypass Thoracic Aorta, Descending to Axillary Artery with Autologous Venous Tissue, Open Approach
021W09H	Bypass Thoracic Aorta, Descending to Brachial Artery with Autologous Venous Tissue, Open Approach
021W09P	Bypass Thoracic Aorta, Descending to Pulmonary Trunk with Autologous Venous Tissue, Open Approach
021W09Q	Bypass Thoracic Aorta, Descending to Right Pulmonary Artery with Autologous Venous Tissue, Open Approach
021W09R	Bypass Thoracic Aorta, Descending to Left Pulmonary Artery with Autologous Venous Tissue, Open Approach
021W09V	Bypass Thoracic Aorta, Descending to Lower Extremity Artery with Autologous Venous Tissue, Open Approach
021W0AA	Bypass Thoracic Aorta, Descending to Innominate Artery with Autologous Arterial Tissue, Open Approach
021W0AB	Bypass Thoracic Aorta, Descending to Subclavian with Autologous Arterial Tissue, Open Approach
021W0AD	Bypass Thoracic Aorta, Descending to Carotid with Autologous Arterial Tissue, Open Approach
021W0AF	Bypass Thoracic Aorta, Descending to Abdominal Artery with Autologous Arterial Tissue, Open Approach
021W0AG	Bypass Thoracic Aorta, Descending to Axillary Artery with Autologous Arterial Tissue, Open Approach
021W0AH	Bypass Thoracic Aorta, Descending to Brachial Artery with Autologous Arterial Tissue, Open Approach
021W0AP	Bypass Thoracic Aorta, Descending to Pulmonary Trunk with Autologous Arterial Tissue, Open Approach
021W0AQ	Bypass Thoracic Aorta, Descending to Right Pulmonary Artery with Autologous Arterial Tissue, Open Approach
021W0AR	Bypass Thoracic Aorta, Descending to Left Pulmonary Artery with Autologous Arterial Tissue, Open Approach
021W0AV	Bypass Thoracic Aorta, Descending to Lower Extremity Artery with Autologous Arterial Tissue, Open Approach
021W0JA	Bypass Thoracic Aorta, Descending to Innominate Artery with Synthetic Substitute, Open Approach
021W0JB	Bypass Thoracic Aorta, Descending to Subclavian with Synthetic Substitute, Open Approach
021W0JD	Bypass Thoracic Aorta, Descending to Carotid with Synthetic Substitute, Open Approach
021W0JF	Bypass Thoracic Aorta, Descending to Abdominal Artery with Synthetic Substitute, Open Approach
021W0JG	Bypass Thoracic Aorta, Descending to Axillary Artery with Synthetic Substitute, Open Approach
021W0JH	Bypass Thoracic Aorta, Descending to Brachial Artery with Synthetic Substitute, Open Approach
021W0JP	Bypass Thoracic Aorta, Descending to Pulmonary Trunk with Synthetic Substitute, Open Approach

ICD-10 Procedure Code	Code Description
021W0JQ	Bypass Thoracic Aorta, Descending to Right Pulmonary Artery with Synthetic Substitute, Open Approach
021W0JR	Bypass Thoracic Aorta, Descending to Left Pulmonary Artery with Synthetic Substitute, Open Approach
021W0JV	Bypass Thoracic Aorta, Descending to Lower Extremity Artery with Synthetic Substitute, Open Approach
021W0KA	Bypass Thoracic Aorta, Descending to Innominate Artery with Nonautologous Tissue Substitute, Open Approach
021W0KB	Bypass Thoracic Aorta, Descending to Subclavian with Nonautologous Tissue Substitute, Open Approach
021W0KD	Bypass Thoracic Aorta, Descending to Carotid with Nonautologous Tissue Substitute, Open Approach
021W0KF	Bypass Thoracic Aorta, Descending to Abdominal Artery with Nonautologous Tissue Substitute, Open Approach
021W0KG	Bypass Thoracic Aorta, Descending to Axillary Artery with Nonautologous Tissue Substitute, Open Approach
021W0KH	Bypass Thoracic Aorta, Descending to Brachial Artery with Nonautologous Tissue Substitute, Open Approach
021W0KP	Bypass Thoracic Aorta, Descending to Pulmonary Trunk with Nonautologous Tissue Substitute, Open Approach
021W0KQ	Bypass Thoracic Aorta, Descending to Right Pulmonary Artery with Nonautologous Tissue Substitute, Open Approach
021W0KR	Bypass Thoracic Aorta, Descending to Left Pulmonary Artery with Nonautologous Tissue Substitute, Open Approach
021W0KV	Bypass Thoracic Aorta, Descending to Lower Extremity Artery with Nonautologous Tissue Substitute, Open Approach
021W0ZA	Bypass Thoracic Aorta, Descending to Innominate Artery, Open Approach
021W0ZB	Bypass Thoracic Aorta, Descending to Subclavian, Open Approach
021W0ZD	Bypass Thoracic Aorta, Descending to Carotid, Open Approach
021W0ZP	Bypass Thoracic Aorta, Descending to Pulmonary Trunk, Open Approach
021W0ZQ	Bypass Thoracic Aorta, Descending to Right Pulmonary Artery, Open Approach
021W0ZR	Bypass Thoracic Aorta, Descending to Left Pulmonary Artery, Open Approach
021X08A	Bypass Thoracic Aorta, Ascending/Arch to Innominate Artery with Zooplastic Tissue, Open Approach
021X08B	Bypass Thoracic Aorta, Ascending/Arch to Subclavian with Zooplastic Tissue, Open Approach
021X08D	Bypass Thoracic Aorta, Ascending/Arch to Carotid with Zooplastic Tissue, Open Approach
021X08P	Bypass Thoracic Aorta, Ascending/Arch to Pulmonary Trunk with Zooplastic Tissue, Open Approach
021X08Q	Bypass Thoracic Aorta, Ascending/Arch to Right Pulmonary Artery with Zooplastic Tissue, Open Approach
021X08R	Bypass Thoracic Aorta, Ascending/Arch to Left Pulmonary Artery with Zooplastic Tissue, Open Approach
021X09A	Bypass Thoracic Aorta, Ascending/Arch to Innominate Artery with Autologous Venous Tissue, Open Approach
021X09B	Bypass Thoracic Aorta, Ascending/Arch to Subclavian with Autologous Venous Tissue, Open Approach
021X09D	Bypass Thoracic Aorta, Ascending/Arch to Carotid with Autologous Venous Tissue, Open Approach

ICD-10 Procedure Code	Code Description
021X09P	Bypass Thoracic Aorta, Ascending/Arch to Pulmonary Trunk with Autologous Venous Tissue, Open Approach
021X09Q	Bypass Thoracic Aorta, Ascending/Arch to Right Pulmonary Artery with Autologous Venous Tissue, Open Approach
021X09R	Bypass Thoracic Aorta, Ascending/Arch to Left Pulmonary Artery with Autologous Venous Tissue, Open Approach
021X0AA	Bypass Thoracic Aorta, Ascending/Arch to Innominate Artery with Autologous Arterial Tissue, Open Approach
021X0AB	Bypass Thoracic Aorta, Ascending/Arch to Subclavian with Autologous Arterial Tissue, Open Approach
021X0AD	Bypass Thoracic Aorta, Ascending/Arch to Carotid with Autologous Arterial Tissue, Open Approach
021X0AP	Bypass Thoracic Aorta, Ascending/Arch to Pulmonary Trunk with Autologous Arterial Tissue, Open Approach
021X0AQ	Bypass Thoracic Aorta, Ascending/Arch to Right Pulmonary Artery with Autologous Arterial Tissue, Open Approach
021X0AR	Bypass Thoracic Aorta, Ascending/Arch to Left Pulmonary Artery with Autologous Arterial Tissue, Open Approach
021X0JA	Bypass Thoracic Aorta, Ascending/Arch to Innominate Artery with Synthetic Substitute, Open Approach
021X0JB	Bypass Thoracic Aorta, Ascending/Arch to Subclavian with Synthetic Substitute, Open Approach
021X0JD	Bypass Thoracic Aorta, Ascending/Arch to Carotid with Synthetic Substitute, Open Approach
021X0JP	Bypass Thoracic Aorta, Ascending/Arch to Pulmonary Trunk with Synthetic Substitute, Open Approach
021X0JQ	Bypass Thoracic Aorta, Ascending/Arch to Right Pulmonary Artery with Synthetic Substitute, Open Approach
021X0JR	Bypass Thoracic Aorta, Ascending/Arch to Left Pulmonary Artery with Synthetic Substitute, Open Approach
021X0KA	Bypass Thoracic Aorta, Ascending/Arch to Innominate Artery with Nonautologous Tissue Substitute, Open Approach
021X0KB	Bypass Thoracic Aorta, Ascending/Arch to Subclavian with Nonautologous Tissue Substitute, Open Approach
021X0KD	Bypass Thoracic Aorta, Ascending/Arch to Carotid with Nonautologous Tissue Substitute, Open Approach
021X0KP	Bypass Thoracic Aorta, Ascending/Arch to Pulmonary Trunk with Nonautologous Tissue Substitute, Open Approach
021X0KQ	Bypass Thoracic Aorta, Ascending/Arch to Right Pulmonary Artery with Nonautologous Tissue Substitute, Open Approach
021X0KR	Bypass Thoracic Aorta, Ascending/Arch to Left Pulmonary Artery with Nonautologous Tissue Substitute, Open Approach
021X0ZA	Bypass Thoracic Aorta, Ascending/Arch to Innominate Artery, Open Approach
021X0ZB	Bypass Thoracic Aorta, Ascending/Arch to Subclavian, Open Approach
021X0ZD	Bypass Thoracic Aorta, Ascending/Arch to Carotid, Open Approach
021X0ZP	Bypass Thoracic Aorta, Ascending/Arch to Pulmonary Trunk, Open Approach
021X0ZQ	Bypass Thoracic Aorta, Ascending/Arch to Right Pulmonary Artery, Open Approach
021X0ZR	Bypass Thoracic Aorta, Ascending/Arch to Left Pulmonary Artery, Open Approach
02BW0ZX	Excision of Thoracic Aorta, Descending, Open Approach, Diagnostic
02BW0ZZ	Excision of Thoracic Aorta, Descending, Open Approach

ICD-10 Procedure Code	Code Description
02BX0ZX	Excision of Thoracic Aorta, Ascending/Arch, Open Approach, Diagnostic
02BX0ZZ	Excision of Thoracic Aorta, Ascending/Arch, Open Approach
02QW0ZZ	Repair Thoracic Aorta, Descending, Open Approach
02QX0ZZ	Repair Thoracic Aorta, Ascending/Arch, Open Approach
02RW07Z	Replacement of Thoracic Aorta, Descending with Autologous Tissue Substitute, Open Approach
02RW08Z	Replacement of Thoracic Aorta, Descending with Zooplastic Tissue, Open Approach
02RW0JZ	Replacement of Thoracic Aorta, Descending with Synthetic Substitute, Open Approach
02RW0KZ	Replacement of Thoracic Aorta, Descending with Nonautologous Tissue Substitute, Open Approach
02RX07Z	Replacement of Thoracic Aorta, Ascending/Arch with Autologous Tissue Substitute, Open Approach
02RX08Z	Replacement of Thoracic Aorta, Ascending/Arch with Zooplastic Tissue, Open Approach
02RX0JZ	Replacement of Thoracic Aorta, Ascending/Arch with Synthetic Substitute, Open Approach
02RX0KZ	Replacement of Thoracic Aorta, Ascending/Arch with Nonautologous Tissue Substitute, Open Approach
02SW0ZZ	Reposition Thoracic Aorta, Descending, Open Approach
02SX0ZZ	Reposition Thoracic Aorta, Ascending/Arch, Open Approach
02UW07Z	Supplement Thoracic Aorta, Descending with Autologous Tissue Substitute, Open Approach
02UW08Z	Supplement Thoracic Aorta, Descending with Zooplastic Tissue, Open Approach
02UW0JZ	Supplement Thoracic Aorta, Descending with Synthetic Substitute, Open Approach
02UW0KZ	Supplement Thoracic Aorta, Descending with Nonautologous Tissue Substitute, Open Approach
02UX08Z	Supplement Thoracic Aorta, Ascending/Arch with Zooplastic Tissue, Open Approach
041009B	Bypass Abdominal Aorta to Left Internal Iliac Artery with Autologous Venous Tissue, Open Approach
041009C	Bypass Abdominal Aorta to Bilateral Internal Iliac Arteries with Autologous Venous Tissue, Open Approach
041009D	Bypass Abdominal Aorta to Right External Iliac Artery with Autologous Venous Tissue, Open Approach
041009F	Bypass Abdominal Aorta to Left External Iliac Artery with Autologous Venous Tissue, Open Approach
041009G	Bypass Abdominal Aorta to Bilateral External Iliac Arteries with Autologous Venous Tissue, Open Approach
041009H	Bypass Abdominal Aorta to Right Femoral Artery with Autologous Venous Tissue, Open Approach
041009J	Bypass Abdominal Aorta to Left Femoral Artery with Autologous Venous Tissue, Open Approach
041009K	Bypass Abdominal Aorta to Bilateral Femoral Arteries with Autologous Venous Tissue, Open Approach
041009Q	Bypass Abdominal Aorta to Lower Extremity Artery with Autologous Venous Tissue, Open Approach
041009R	Bypass Abdominal Aorta to Lower Artery with Autologous Venous Tissue, Open Approach
04100A0	Bypass Abdominal Aorta to Abdominal Aorta with Autologous Arterial Tissue, Open Approach

ICD-10 Procedure Code	Code Description
04100A1	Bypass Abdominal Aorta to Celiac Artery with Autologous Arterial Tissue, Open Approach
04100A2	Bypass Abdominal Aorta to Mesenteric Artery with Autologous Arterial Tissue, Open Approach
04100A3	Bypass Abdominal Aorta to Right Renal Artery with Autologous Arterial Tissue, Open Approach
04100A4	Bypass Abdominal Aorta to Left Renal Artery with Autologous Arterial Tissue, Open Approach
04100A5	Bypass Abdominal Aorta to Bilateral Renal Artery with Autologous Arterial Tissue, Open Approach
04100A6	Bypass Abdominal Aorta to Right Common Iliac Artery with Autologous Arterial Tissue, Open Approach
04100A7	Bypass Abdominal Aorta to Left Common Iliac Artery with Autologous Arterial Tissue, Open Approach
04100A8	Bypass Abdominal Aorta to Bilateral Common Iliac Arteries with Autologous Arterial Tissue, Open Approach
04100A9	Bypass Abdominal Aorta to Right Internal Iliac Artery with Autologous Arterial Tissue, Open Approach
04100AB	Bypass Abdominal Aorta to Left Internal Iliac Artery with Autologous Arterial Tissue, Open Approach
04100AC	Bypass Abdominal Aorta to Bilateral Internal Iliac Arteries with Autologous Arterial Tissue, Open Approach
04100AD	Bypass Abdominal Aorta to Right External Iliac Artery with Autologous Arterial Tissue, Open Approach
04100AF	Bypass Abdominal Aorta to Left External Iliac Artery with Autologous Arterial Tissue, Open Approach
04100AG	Bypass Abdominal Aorta to Bilateral External Iliac Arteries with Autologous Arterial Tissue, Open Approach
04100AH	Bypass Abdominal Aorta to Right Femoral Artery with Autologous Arterial Tissue, Open Approach
04100AJ	Bypass Abdominal Aorta to Left Femoral Artery with Autologous Arterial Tissue, Open Approach
04100AK	Bypass Abdominal Aorta to Bilateral Femoral Arteries with Autologous Arterial Tissue, Open Approach
04100AQ	Bypass Abdominal Aorta to Lower Extremity Artery with Autologous Arterial Tissue, Open Approach
04100AR	Bypass Abdominal Aorta to Lower Artery with Autologous Arterial Tissue, Open Approach
04100J0	Bypass Abdominal Aorta to Abdominal Aorta with Synthetic Substitute, Open Approach
04100J1	Bypass Abdominal Aorta to Celiac Artery with Synthetic Substitute, Open Approach
04100J2	Bypass Abdominal Aorta to Mesenteric Artery with Synthetic Substitute, Open Approach
04100J3	Bypass Abdominal Aorta to Right Renal Artery with Synthetic Substitute, Open Approach
04100J4	Bypass Abdominal Aorta to Left Renal Artery with Synthetic Substitute, Open Approach
04100J5	Bypass Abdominal Aorta to Bilateral Renal Artery with Synthetic Substitute, Open Approach
04100J6	Bypass Abdominal Aorta to Right Common Iliac Artery with Synthetic Substitute, Open Approach
04100J7	Bypass Abdominal Aorta to Left Common Iliac Artery with Synthetic Substitute, Open Approach
04100J8	Bypass Abdominal Aorta to Bilateral Common Iliac Arteries with Synthetic Substitute, Open Approach

ICD-10 Procedure Code	Code Description
04100J9	Bypass Abdominal Aorta to Right Internal Iliac Artery with Synthetic Substitute, Open Approach
04100JB	Bypass Abdominal Aorta to Left Internal Iliac Artery with Synthetic Substitute, Open Approach
04100JC	Bypass Abdominal Aorta to Bilateral Internal Iliac Arteries with Synthetic Substitute, Open Approach
04100JD	Bypass Abdominal Aorta to Right External Iliac Artery with Synthetic Substitute, Open Approach
04100JF	Bypass Abdominal Aorta to Left External Iliac Artery with Synthetic Substitute, Open Approach
04100JG	Bypass Abdominal Aorta to Bilateral External Iliac Arteries with Synthetic Substitute, Open Approach
04100JH	Bypass Abdominal Aorta to Right Femoral Artery with Synthetic Substitute, Open Approach
04100JJ	Bypass Abdominal Aorta to Left Femoral Artery with Synthetic Substitute, Open Approach
04100JK	Bypass Abdominal Aorta to Bilateral Femoral Arteries with Synthetic Substitute, Open Approach
04100JQ	Bypass Abdominal Aorta to Lower Extremity Artery with Synthetic Substitute, Open Approach
04100JR	Bypass Abdominal Aorta to Lower Artery with Synthetic Substitute, Open Approach
04100K0	Bypass Abdominal Aorta to Abdominal Aorta with Nonautologous Tissue Substitute, Open Approach
04100K1	Bypass Abdominal Aorta to Celiac Artery with Nonautologous Tissue Substitute, Open Approach
04100K2	Bypass Abdominal Aorta to Mesenteric Artery with Nonautologous Tissue Substitute, Open Approach
04100K3	Bypass Abdominal Aorta to Right Renal Artery with Nonautologous Tissue Substitute, Open Approach
04100K4	Bypass Abdominal Aorta to Left Renal Artery with Nonautologous Tissue Substitute, Open Approach
04100K5	Bypass Abdominal Aorta to Bilateral Renal Artery with Nonautologous Tissue Substitute, Open Approach
04100K6	Bypass Abdominal Aorta to Right Common Iliac Artery with Nonautologous Tissue Substitute, Open Approach
04100K7	Bypass Abdominal Aorta to Left Common Iliac Artery with Nonautologous Tissue Substitute, Open Approach
04100K8	Bypass Abdominal Aorta to Bilateral Common Iliac Arteries with Nonautologous Tissue Substitute, Open Approach
04100K9	Bypass Abdominal Aorta to Right Internal Iliac Artery with Nonautologous Tissue Substitute, Open Approach
04100KB	Bypass Abdominal Aorta to Left Internal Iliac Artery with Nonautologous Tissue Substitute, Open Approach
04100KC	Bypass Abdominal Aorta to Bilateral Internal Iliac Arteries with Nonautologous Tissue Substitute, Open Approach
04100KD	Bypass Abdominal Aorta to Right External Iliac Artery with Nonautologous Tissue Substitute, Open Approach
04100KF	Bypass Abdominal Aorta to Left External Iliac Artery with Nonautologous Tissue Substitute, Open Approach
04100KG	Bypass Abdominal Aorta to Bilateral External Iliac Arteries with Nonautologous Tissue Substitute, Open Approach
04100KH	Bypass Abdominal Aorta to Right Femoral Artery with Nonautologous Tissue Substitute, Open Approach

ICD-10 Procedure Code	Code Description
04100KJ	Bypass Abdominal Aorta to Left Femoral Artery with Nonautologous Tissue Substitute, Open Approach
04100KK	Bypass Abdominal Aorta to Bilateral Femoral Arteries with Nonautologous Tissue Substitute, Open Approach
04100KQ	Bypass Abdominal Aorta to Lower Extremity Artery with Nonautologous Tissue Substitute, Open Approach
04100KR	Bypass Abdominal Aorta to Lower Artery with Nonautologous Tissue Substitute, Open Approach
04100Z0	Bypass Abdominal Aorta to Abdominal Aorta, Open Approach
04100Z1	Bypass Abdominal Aorta to Celiac Artery, Open Approach
04100Z2	Bypass Abdominal Aorta to Mesenteric Artery, Open Approach
04100Z3	Bypass Abdominal Aorta to Right Renal Artery, Open Approach
04100Z4	Bypass Abdominal Aorta to Left Renal Artery, Open Approach
04100Z5	Bypass Abdominal Aorta to Bilateral Renal Artery, Open Approach
04100Z6	Bypass Abdominal Aorta to Right Common Iliac Artery, Open Approach
04100Z7	Bypass Abdominal Aorta to Left Common Iliac Artery, Open Approach
04100Z8	Bypass Abdominal Aorta to Bilateral Common Iliac Arteries, Open Approach
04100Z9	Bypass Abdominal Aorta to Right Internal Iliac Artery, Open Approach
04100ZB	Bypass Abdominal Aorta to Left Internal Iliac Artery, Open Approach
04100ZC	Bypass Abdominal Aorta to Bilateral Internal Iliac Arteries, Open Approach
04100ZD	Bypass Abdominal Aorta to Right External Iliac Artery, Open Approach
04100ZF	Bypass Abdominal Aorta to Left External Iliac Artery, Open Approach
04100ZG	Bypass Abdominal Aorta to Bilateral External Iliac Arteries, Open Approach
04100ZH	Bypass Abdominal Aorta to Right Femoral Artery, Open Approach
04100ZJ	Bypass Abdominal Aorta to Left Femoral Artery, Open Approach
04100ZK	Bypass Abdominal Aorta to Bilateral Femoral Arteries, Open Approach
04100ZQ	Bypass Abdominal Aorta to Lower Extremity Artery, Open Approach
04100ZR	Bypass Abdominal Aorta to Lower Artery, Open Approach
041C090	Bypass Right Common Iliac Artery to Abdominal Aorta with Autologous Venous Tissue, Open Approach
041C0A0	Bypass Right Common Iliac Artery to Abdominal Aorta with Autologous Arterial Tissue, Open Approach
041C0J0	Bypass Right Common Iliac Artery to Abdominal Aorta with Synthetic Substitute, Open Approach
041C0K0	Bypass Right Common Iliac Artery to Abdominal Aorta with Nonautologous Tissue Substitute, Open Approach
041C0Z0	Bypass Right Common Iliac Artery to Abdominal Aorta, Open Approach
041D090	Bypass Left Common Iliac Artery to Abdominal Aorta with Autologous Venous Tissue, Open Approach
041D0A0	Bypass Left Common Iliac Artery to Abdominal Aorta with Autologous Arterial Tissue, Open Approach
041D0J0	Bypass Left Common Iliac Artery to Abdominal Aorta with Synthetic Substitute, Open Approach
041D0K0	Bypass Left Common Iliac Artery to Abdominal Aorta with Nonautologous Tissue Substitute, Open Approach
041D0Z0	Bypass Left Common Iliac Artery to Abdominal Aorta, Open Approach

ICD-10 Procedure Code	Code Description
04B00ZX	Excision of Abdominal Aorta, Open Approach, Diagnostic
04B00ZZ	Excision of Abdominal Aorta, Open Approach
04Q00ZZ	Repair Abdominal Aorta, Open Approach
04R007Z	Replacement of Abdominal Aorta with Autologous Tissue Substitute, Open Approach
04R00JZ	Replacement of Abdominal Aorta with Synthetic Substitute, Open Approach
04R00KZ	Replacement of Abdominal Aorta with Nonautologous Tissue Substitute, Open Approach
04S00ZZ	Reposition Abdominal Aorta, Open Approach
04U007Z	Supplement Abdominal Aorta with Autologous Tissue Substitute, Open Approach
04U00JZ	Supplement Abdominal Aorta with Synthetic Substitute, Open Approach
04U00KZ	Supplement Abdominal Aorta with Nonautologous Tissue Substitute, Open Approach
X2RX0N7	Replacement of Thoracic Aorta, Arch using Branched Synthetic Substitute with Intraluminal Device, Open Approach, New Technology Group 7

Lung Resection for Cancer Measure Specifications

For lung resection for cancer, there are two sets of ICD-10 codes for counting patient discharges. The first set of codes is to identify patients who have had the procedure. The second set of codes is to identify patients with a specific diagnosis.

Count the number of patients, ages 18 years and older, discharged with the following ICD-10 codes in any procedure field AND any of the following ICD-10 codes in any diagnosis field.

ICD-10 Lung Resection for Cancer Procedure Codes

ICD-10 Procedure Code	Code Description
0BBC0ZZ	Excision of Right Upper Lung Lobe, Open Approach
0BBC3ZZ	Excision of Right Upper Lung Lobe, Percutaneous Approach
0BBC4ZZ	Excision of Right Upper Lung Lobe, Percutaneous Endoscopic Approach
0BBD0ZZ	Excision of Right Middle Lung Lobe, Open Approach
0BBD3ZZ	Excision of Right Middle Lung Lobe, Percutaneous Approach
0BBD4ZZ	Excision of Right Middle Lung Lobe, Percutaneous Endoscopic Approach
0BBF0ZZ	Excision of Right Lower Lung Lobe, Open Approach
0BBF3ZZ	Excision of Right Lower Lung Lobe, Percutaneous Approach
0BBF4ZZ	Excision of Right Lower Lung Lobe, Percutaneous Endoscopic Approach
0BBG0ZZ	Excision of Left Upper Lung Lobe, Open Approach
0BBG3ZZ	Excision of Left Upper Lung Lobe, Percutaneous Approach
0BBG4ZZ	Excision of Left Upper Lung Lobe, Percutaneous Endoscopic Approach
0BBH0ZZ	Excision of Lung Lingula, Open Approach
0BBH3ZZ	Excision of Lung Lingula, Percutaneous Approach
0BBH4ZZ	Excision of Lung Lingula, Percutaneous Endoscopic Approach
0BBJ0ZZ	Excision of Left Lower Lung Lobe, Open Approach
0BBJ3ZZ	Excision of Left Lower Lung Lobe, Percutaneous Approach
0BBJ4ZZ	Excision of Left Lower Lung Lobe, Percutaneous Endoscopic Approach
0BBK0ZZ	Excision of Right Lung, Open Approach
0BBK3ZZ	Excision of Right Lung, Percutaneous Approach
0BBK4ZZ	Excision of Right Lung, Percutaneous Endoscopic Approach
0BBL0ZZ	Excision of Left Lung, Open Approach
0BBL3ZZ	Excision of Left Lung, Percutaneous Approach
0BBL4ZZ	Excision of Left Lung, Percutaneous Endoscopic Approach
0BBL7ZZ	Excision of Left Lung, Via Natural or Artificial Opening
0BTC0ZZ	Resection of Right Upper Lung Lobe, Open Approach
0BTC4ZZ	Resection of Right Upper Lung Lobe, Percutaneous Endoscopic Approach
0BTD0ZZ	Resection of Right Middle Lung Lobe, Open Approach
0BTD4ZZ	Resection of Right Middle Lung Lobe, Percutaneous Endoscopic Approach
0BTF0ZZ	Resection of Right Lower Lung Lobe, Open Approach
0BTF4ZZ	Resection of Right Lower Lung Lobe, Percutaneous Endoscopic Approach
0BTG0ZZ	Resection of Left Upper Lung Lobe, Open Approach
0BTG4ZZ	Resection of Left Upper Lung Lobe, Percutaneous Endoscopic Approach

ICD-10 Procedure Code	Code Description
0BTH0ZZ	Resection of Lung Lingula, Open Approach
0BTH4ZZ	Resection of Lung Lingula, Percutaneous Endoscopic Approach
0BTJ0ZZ	Resection of Left Lower Lung Lobe, Open Approach
0BTJ4ZZ	Resection of Left Lower Lung Lobe, Percutaneous Endoscopic Approach
0BTK0ZZ	Resection of Right Lung, Open Approach
0BTK4ZZ	Resection of Right Lung, Percutaneous Endoscopic Approach
0BTL0ZZ	Resection of Left Lung, Open Approach
0BTL4ZZ	Resection of Left Lung, Percutaneous Endoscopic Approach

ICD-10 Malignant Tumor and Cancer in Situ Diagnosis Codes

ICD-10 Diagnosis Code	Code Description
C7A.090	Malignant carcinoid tumor of the bronchus and lung
C7A.1	Malignant poorly differentiated neuroendocrine tumors
C7A.8	Other malignant neuroendocrine tumors
C34.00	Malignant neoplasm of main bronchus
C34.01	Malignant neoplasm of right main bronchus
C34.02	Malignant neoplasm of left main bronchus
C34.10	Malignant neoplasm of upper lobe, unspecified bronchus or lung
C34.11	Malignant neoplasm of upper lobe, right bronchus or lung
C34.12	Malignant neoplasm of upper lobe, left bronchus or lung
C34.2	Malignant neoplasm of middle lobe, bronchus or lung
C34.30	Malignant neoplasm of lower lobe, unspecified bronchus or lung
C34.31	Malignant neoplasm of lower lobe, right bronchus or lung
C34.32	Malignant neoplasm of lower lobe, left bronchus or lung
C34.80	Malignant neoplasm of overlapping sites of unspecified bronchus and lung
C34.81	Malignant neoplasm of overlapping sites of right bronchus and lung
C34.82	Malignant neoplasm of overlapping sites of left bronchus and lung
C34.90	Malignant neoplasm of unspecified part of unspecified bronchus or lung
C34.91	Malignant neoplasm of unspecified part of right bronchus or lung
C34.92	Malignant neoplasm of unspecified part of left bronchus or lung
D02.20	Carcinoma in situ of unspecified bronchus and lung
D02.21	Carcinoma in situ of right bronchus and lung
D02.22	Carcinoma in situ of left bronchus and lung

Esophageal Resection for Cancer Measure Specifications

For esophageal resection for cancer, there are two sets of ICD-10 codes for counting patient discharges. The first set of codes is to identify patients who have had the procedure. The second set of codes is to identify patients with a specific diagnosis.

Count the number of patients, ages 18 years and older, discharged with the following ICD-10 codes in any procedure field AND any of the following ICD-10 codes in any diagnosis field.

ICD-10 Esophageal Resection for Cancer Procedure Codes

ICD-10 Procedure Code	Code Description
0D11074	Bypass Upper Esophagus to Cutaneous with Autologous Tissue Substitute, Open Approach
0D11076	Bypass Upper Esophagus to Stomach with Autologous Tissue Substitute, Open Approach
0D11079	Bypass Upper Esophagus to Duodenum with Autologous Tissue Substitute, Open Approach
0D1107A	Bypass Upper Esophagus to Jejunum with Autologous Tissue Substitute, Open Approach
0D1107B	Bypass Upper Esophagus to Ileum with Autologous Tissue Substitute, Open Approach
0D110J4	Bypass Upper Esophagus to Cutaneous with Synthetic Substitute, Open Approach
0D110J6	Bypass Upper Esophagus to Stomach with Synthetic Substitute, Open Approach
0D110J9	Bypass Upper Esophagus to Duodenum with Synthetic Substitute, Open Approach
0D110JA	Bypass Upper Esophagus to Jejunum with Synthetic Substitute, Open Approach
0D110JB	Bypass Upper Esophagus to Ileum with Synthetic Substitute, Open Approach
0D110K4	Bypass Upper Esophagus to Cutaneous with Nonautologous Tissue Substitute, Open Approach
0D110K6	Bypass Upper Esophagus to Stomach with Nonautologous Tissue Substitute, Open Approach
0D110K9	Bypass Upper Esophagus to Duodenum with Nonautologous Tissue Substitute, Open Approach
0D110KA	Bypass Upper Esophagus to Jejunum with Nonautologous Tissue Substitute, Open Approach
0D110KB	Bypass Upper Esophagus to Ileum with Nonautologous Tissue Substitute, Open Approach
0D110Z4	Bypass Upper Esophagus to Cutaneous, Open Approach
0D110Z6	Bypass Upper Esophagus to Stomach, Open Approach
0D110Z9	Bypass Upper Esophagus to Duodenum, Open Approach
0D110ZA	Bypass Upper Esophagus to Jejunum, Open Approach
0D110ZB	Bypass Upper Esophagus to Ileum, Open Approach
0D113J4	Bypass Upper Esophagus to Cutaneous with Synthetic Substitute, Percutaneous Approach
0D11474	Bypass Upper Esophagus to Cutaneous with Autologous Tissue Substitute, Percutaneous Endoscopic Approach
0D11476	Bypass Upper Esophagus to Stomach with Autologous Tissue Substitute, Percutaneous Endoscopic Approach
0D11479	Bypass Upper Esophagus to Duodenum with Autologous Tissue Substitute, Percutaneous Endoscopic Approach
0D1147A	Bypass Upper Esophagus to Jejunum with Autologous Tissue Substitute, Percutaneous Endoscopic Approach

ICD-10 Procedure Code	Code Description
0D1147B	Bypass Upper Esophagus to Ileum with Autologous Tissue Substitute, Percutaneous Endoscopic Approach
0D114J4	Bypass Upper Esophagus to Cutaneous with Synthetic Substitute, Percutaneous Endoscopic Approach
0D114J6	Bypass Upper Esophagus to Stomach with Synthetic Substitute, Percutaneous Endoscopic Approach
0D114J9	Bypass Upper Esophagus to Duodenum with Synthetic Substitute, Percutaneous Endoscopic Approach
0D114JA	Bypass Upper Esophagus to Jejunum with Synthetic Substitute, Percutaneous Endoscopic Approach
0D114JB	Bypass Upper Esophagus to Ileum with Synthetic Substitute, Percutaneous Endoscopic Approach
0D114K4	Bypass Upper Esophagus to Cutaneous with Nonautologous Tissue Substitute, Percutaneous Endoscopic Approach
0D114K6	Bypass Upper Esophagus to Stomach with Nonautologous Tissue Substitute, Percutaneous Endoscopic Approach
0D114K9	Bypass Upper Esophagus to Duodenum with Nonautologous Tissue Substitute, Percutaneous Endoscopic Approach
0D114KA	Bypass Upper Esophagus to Jejunum with Nonautologous Tissue Substitute, Percutaneous Endoscopic Approach
0D114KB	Bypass Upper Esophagus to Ileum with Nonautologous Tissue Substitute, Percutaneous Endoscopic Approach
0D114Z4	Bypass Upper Esophagus to Cutaneous, Percutaneous Endoscopic Approach
0D114Z6	Bypass Upper Esophagus to Stomach, Percutaneous Endoscopic Approach
0D114Z9	Bypass Upper Esophagus to Duodenum, Percutaneous Endoscopic Approach
0D114ZA	Bypass Upper Esophagus to Jejunum, Percutaneous Endoscopic Approach
0D114ZB	Bypass Upper Esophagus to Ileum, Percutaneous Endoscopic Approach
0D11874	Bypass Upper Esophagus to Cutaneous with Autologous Tissue Substitute, Via Natural or Artificial Opening Endoscopic
0D11876	Bypass Upper Esophagus to Stomach with Autologous Tissue Substitute, Via Natural or Artificial Opening Endoscopic
0D11879	Bypass Upper Esophagus to Duodenum with Autologous Tissue Substitute, Via Natural or Artificial Opening Endoscopic
0D1187A	Bypass Upper Esophagus to Jejunum with Autologous Tissue Substitute, Via Natural or Artificial Opening Endoscopic
0D1187B	Bypass Upper Esophagus to Ileum with Autologous Tissue Substitute, Via Natural or Artificial Opening Endoscopic
0D118J4	Bypass Upper Esophagus to Cutaneous with Synthetic Substitute, Via Natural or Artificial Opening Endoscopic
0D118J6	Bypass Upper Esophagus to Stomach with Synthetic Substitute, Via Natural or Artificial Opening Endoscopic
0D118J9	Bypass Upper Esophagus to Duodenum with Synthetic Substitute, Via Natural or Artificial Opening Endoscopic
0D118JA	Bypass Upper Esophagus to Jejunum with Synthetic Substitute, Via Natural or Artificial Opening Endoscopic
0D118JB	Bypass Upper Esophagus to Ileum with Synthetic Substitute, Via Natural or Artificial Opening Endoscopic
0D118K4	Bypass Upper Esophagus to Cutaneous with Nonautologous Tissue Substitute, Via Natural or Artificial Opening Endoscopic
0D118K6	Bypass Upper Esophagus to Stomach with Nonautologous Tissue Substitute, Via Natural or Artificial Opening Endoscopic

ICD-10 Procedure Code	Code Description
0D118K9	Bypass Upper Esophagus to Duodenum with Nonautologous Tissue Substitute, Via Natural or Artificial Opening Endoscopic
0D118KA	Bypass Upper Esophagus to Jejunum with Nonautologous Tissue Substitute, Via Natural or Artificial Opening Endoscopic
0D118KB	Bypass Upper Esophagus to Ileum with Nonautologous Tissue Substitute, Via Natural or Artificial Opening Endoscopic
0D118Z4	Bypass Upper Esophagus to Cutaneous, Via Natural or Artificial Opening Endoscopic
0D118Z6	Bypass Upper Esophagus to Stomach, Via Natural or Artificial Opening Endoscopic
0D118Z9	Bypass Upper Esophagus to Duodenum, Via Natural or Artificial Opening Endoscopic
0D118ZA	Bypass Upper Esophagus to Jejunum, Via Natural or Artificial Opening Endoscopic
0D118ZB	Bypass Upper Esophagus to Ileum, Via Natural or Artificial Opening Endoscopic
0D12074	Bypass Middle Esophagus to Cutaneous with Autologous Tissue Substitute, Open Approach
0D12076	Bypass Middle Esophagus to Stomach with Autologous Tissue Substitute, Open Approach
0D12079	Bypass Middle Esophagus to Duodenum with Autologous Tissue Substitute, Open Approach
0D1207A	Bypass Middle Esophagus to Jejunum with Autologous Tissue Substitute, Open Approach
0D1207B	Bypass Middle Esophagus to Ileum with Autologous Tissue Substitute, Open Approach
0D120J4	Bypass Middle Esophagus to Cutaneous with Synthetic Substitute, Open Approach
0D120J6	Bypass Middle Esophagus to Stomach with Synthetic Substitute, Open Approach
0D120J9	Bypass Middle Esophagus to Duodenum with Synthetic Substitute, Open Approach
0D120JA	Bypass Middle Esophagus to Jejunum with Synthetic Substitute, Open Approach
0D120JB	Bypass Middle Esophagus to Ileum with Synthetic Substitute, Open Approach
0D120K4	Bypass Middle Esophagus to Cutaneous with Nonautologous Tissue Substitute, Open Approach
0D120K6	Bypass Middle Esophagus to Stomach with Nonautologous Tissue Substitute, Open Approach
0D120K9	Bypass Middle Esophagus to Duodenum with Nonautologous Tissue Substitute, Open Approach
0D120KA	Bypass Middle Esophagus to Jejunum with Nonautologous Tissue Substitute, Open Approach
0D120KB	Bypass Middle Esophagus to Ileum with Nonautologous Tissue Substitute, Open Approach
0D120Z4	Bypass Middle Esophagus to Cutaneous, Open Approach
0D120Z6	Bypass Middle Esophagus to Stomach, Open Approach
0D120Z9	Bypass Middle Esophagus to Duodenum, Open Approach
0D120ZA	Bypass Middle Esophagus to Jejunum, Open Approach
0D120ZB	Bypass Middle Esophagus to Ileum, Open Approach
0D123J4	Bypass Middle Esophagus to Cutaneous with Synthetic Substitute, Percutaneous Approach
0D12474	Bypass Middle Esophagus to Cutaneous with Autologous Tissue Substitute, Percutaneous Endoscopic Approach

ICD-10 Procedure Code	Code Description
0D12476	Bypass Middle Esophagus to Stomach with Autologous Tissue Substitute, Percutaneous Endoscopic Approach
0D12479	Bypass Middle Esophagus to Duodenum with Autologous Tissue Substitute, Percutaneous Endoscopic Approach
0D1247A	Bypass Middle Esophagus to Jejunum with Autologous Tissue Substitute, Percutaneous Endoscopic Approach
0D1247B	Bypass Middle Esophagus to Ileum with Autologous Tissue Substitute, Percutaneous Endoscopic Approach
0D124J4	Bypass Middle Esophagus to Cutaneous with Synthetic Substitute, Percutaneous Endoscopic Approach
0D124J6	Bypass Middle Esophagus to Stomach with Synthetic Substitute, Percutaneous Endoscopic Approach
0D124J9	Bypass Middle Esophagus to Duodenum with Synthetic Substitute, Percutaneous Endoscopic Approach
0D124JA	Bypass Middle Esophagus to Jejunum with Synthetic Substitute, Percutaneous Endoscopic Approach
0D124JB	Bypass Middle Esophagus to Ileum with Synthetic Substitute, Percutaneous Endoscopic Approach
0D124K4	Bypass Middle Esophagus to Cutaneous with Nonautologous Tissue Substitute, Percutaneous Endoscopic Approach
0D124K6	Bypass Middle Esophagus to Stomach with Nonautologous Tissue Substitute, Percutaneous Endoscopic Approach
0D124K9	Bypass Middle Esophagus to Duodenum with Nonautologous Tissue Substitute, Percutaneous Endoscopic Approach
0D124KA	Bypass Middle Esophagus to Jejunum with Nonautologous Tissue Substitute, Percutaneous Endoscopic Approach
0D124KB	Bypass Middle Esophagus to Ileum with Nonautologous Tissue Substitute, Percutaneous Endoscopic Approach
0D124Z4	Bypass Middle Esophagus to Cutaneous, Percutaneous Endoscopic Approach
0D124Z6	Bypass Middle Esophagus to Stomach, Percutaneous Endoscopic Approach
0D124Z9	Bypass Middle Esophagus to Duodenum, Percutaneous Endoscopic Approach
0D124ZA	Bypass Middle Esophagus to Jejunum, Percutaneous Endoscopic Approach
0D124ZB	Bypass Middle Esophagus to Ileum, Percutaneous Endoscopic Approach
0D12874	Bypass Middle Esophagus to Cutaneous with Autologous Tissue Substitute, Via Natural or Artificial Opening Endoscopic
0D12876	Bypass Middle Esophagus to Stomach with Autologous Tissue Substitute, Via Natural or Artificial Opening Endoscopic
0D12879	Bypass Middle Esophagus to Duodenum with Autologous Tissue Substitute, Via Natural or Artificial Opening Endoscopic
0D1287A	Bypass Middle Esophagus to Jejunum with Autologous Tissue Substitute, Via Natural or Artificial Opening Endoscopic
0D1287B	Bypass Middle Esophagus to Ileum with Autologous Tissue Substitute, Via Natural or Artificial Opening Endoscopic
0D128J4	Bypass Middle Esophagus to Cutaneous with Synthetic Substitute, Via Natural or Artificial Opening Endoscopic
0D128J6	Bypass Middle Esophagus to Stomach with Synthetic Substitute, Via Natural or Artificial Opening Endoscopic
0D128J9	Bypass Middle Esophagus to Duodenum with Synthetic Substitute, Via Natural or Artificial Opening Endoscopic
0D128JA	Bypass Middle Esophagus to Jejunum with Synthetic Substitute, Via Natural or Artificial Opening Endoscopic

ICD-10 Procedure Code	Code Description
0D128JB	Bypass Middle Esophagus to Ileum with Synthetic Substitute, Via Natural or Artificial Opening Endoscopic
0D128K4	Bypass Middle Esophagus to Cutaneous with Nonautologous Tissue Substitute, Via Natural or Artificial Opening Endoscopic
0D128K6	Bypass Middle Esophagus to Stomach with Nonautologous Tissue Substitute, Via Natural or Artificial Opening Endoscopic
0D128K9	Bypass Middle Esophagus to Duodenum with Nonautologous Tissue Substitute, Via Natural or Artificial Opening Endoscopic
0D128KA	Bypass Middle Esophagus to Jejunum with Nonautologous Tissue Substitute, Via Natural or Artificial Opening Endoscopic
0D128KB	Bypass Middle Esophagus to Ileum with Nonautologous Tissue Substitute, Via Natural or Artificial Opening Endoscopic
0D128Z4	Bypass Middle Esophagus to Cutaneous, Via Natural or Artificial Opening Endoscopic
0D128Z6	Bypass Middle Esophagus to Stomach, Via Natural or Artificial Opening Endoscopic
0D128Z9	Bypass Middle Esophagus to Duodenum, Via Natural or Artificial Opening Endoscopic
0D128ZA	Bypass Middle Esophagus to Jejunum, Via Natural or Artificial Opening Endoscopic
0D128ZB	Bypass Middle Esophagus to Ileum, Via Natural or Artificial Opening Endoscopic
0D13074	Bypass Lower Esophagus to Cutaneous with Autologous Tissue Substitute, Open Approach
0D13076	Bypass Lower Esophagus to Stomach with Autologous Tissue Substitute, Open Approach
0D13079	Bypass Lower Esophagus to Duodenum with Autologous Tissue Substitute, Open Approach
0D1307A	Bypass Lower Esophagus to Jejunum with Autologous Tissue Substitute, Open Approach
0D1307B	Bypass Lower Esophagus to Ileum with Autologous Tissue Substitute, Open Approach
0D130J4	Bypass Lower Esophagus to Cutaneous with Synthetic Substitute, Open Approach
0D130J6	Bypass Lower Esophagus to Stomach with Synthetic Substitute, Open Approach
0D130J9	Bypass Lower Esophagus to Duodenum with Synthetic Substitute, Open Approach
0D130JA	Bypass Lower Esophagus to Jejunum with Synthetic Substitute, Open Approach
0D130JB	Bypass Lower Esophagus to Ileum with Synthetic Substitute, Open Approach
0D130K4	Bypass Lower Esophagus to Cutaneous with Nonautologous Tissue Substitute, Open Approach
0D130K6	Bypass Lower Esophagus to Stomach with Nonautologous Tissue Substitute, Open Approach
0D130K9	Bypass Lower Esophagus to Duodenum with Nonautologous Tissue Substitute, Open Approach
0D130KA	Bypass Lower Esophagus to Jejunum with Nonautologous Tissue Substitute, Open Approach
0D130KB	Bypass Lower Esophagus to Ileum with Nonautologous Tissue Substitute, Open Approach
0D130Z4	Bypass Lower Esophagus to Cutaneous, Open Approach
0D130Z6	Bypass Lower Esophagus to Stomach, Open Approach
0D130Z9	Bypass Lower Esophagus to Duodenum, Open Approach
0D130ZA	Bypass Lower Esophagus to Jejunum, Open Approach
0D130ZB	Bypass Lower Esophagus to Ileum, Open Approach

ICD-10 Procedure Code	Code Description
0D133J4	Bypass Lower Esophagus to Cutaneous with Synthetic Substitute, Percutaneous Approach
0D13474	Bypass Lower Esophagus to Cutaneous with Autologous Tissue Substitute, Percutaneous Endoscopic Approach
0D13476	Bypass Lower Esophagus to Stomach with Autologous Tissue Substitute, Percutaneous Endoscopic Approach
0D13479	Bypass Lower Esophagus to Duodenum with Autologous Tissue Substitute, Percutaneous Endoscopic Approach
0D1347A	Bypass Lower Esophagus to Jejunum with Autologous Tissue Substitute, Percutaneous Endoscopic Approach
0D1347B	Bypass Lower Esophagus to Ileum with Autologous Tissue Substitute, Percutaneous Endoscopic Approach
0D134J4	Bypass Lower Esophagus to Cutaneous with Synthetic Substitute, Percutaneous Endoscopic Approach
0D134J6	Bypass Lower Esophagus to Stomach with Synthetic Substitute, Percutaneous Endoscopic Approach
0D134J9	Bypass Lower Esophagus to Duodenum with Synthetic Substitute, Percutaneous Endoscopic Approach
0D134JA	Bypass Lower Esophagus to Jejunum with Synthetic Substitute, Percutaneous Endoscopic Approach
0D134JB	Bypass Lower Esophagus to Ileum with Synthetic Substitute, Percutaneous Endoscopic Approach
0D134K4	Bypass Lower Esophagus to Cutaneous with Nonautologous Tissue Substitute, Percutaneous Endoscopic Approach
0D134K6	Bypass Lower Esophagus to Stomach with Nonautologous Tissue Substitute, Percutaneous Endoscopic Approach
0D134K9	Bypass Lower Esophagus to Duodenum with Nonautologous Tissue Substitute, Percutaneous Endoscopic Approach
0D134KA	Bypass Lower Esophagus to Jejunum with Nonautologous Tissue Substitute, Percutaneous Endoscopic Approach
0D134KB	Bypass Lower Esophagus to Ileum with Nonautologous Tissue Substitute, Percutaneous Endoscopic Approach
0D134Z4	Bypass Lower Esophagus to Cutaneous, Percutaneous Endoscopic Approach
0D134Z6	Bypass Lower Esophagus to Stomach, Percutaneous Endoscopic Approach
0D134Z9	Bypass Lower Esophagus to Duodenum, Percutaneous Endoscopic Approach
0D134ZA	Bypass Lower Esophagus to Jejunum, Percutaneous Endoscopic Approach
0D134ZB	Bypass Lower Esophagus to Ileum, Percutaneous Endoscopic Approach
0D13874	Bypass Lower Esophagus to Cutaneous with Autologous Tissue Substitute, Via Natural or Artificial Opening Endoscopic
0D13876	Bypass Lower Esophagus to Stomach with Autologous Tissue Substitute, Via Natural or Artificial Opening Endoscopic
0D13879	Bypass Lower Esophagus to Duodenum with Autologous Tissue Substitute, Via Natural or Artificial Opening Endoscopic
0D1387A	Bypass Lower Esophagus to Jejunum with Autologous Tissue Substitute, Via Natural or Artificial Opening Endoscopic
0D1387B	Bypass Lower Esophagus to Ileum with Autologous Tissue Substitute, Via Natural or Artificial Opening Endoscopic
0D138J4	Bypass Lower Esophagus to Cutaneous with Synthetic Substitute, Via Natural or Artificial Opening Endoscopic
0D138J6	Bypass Lower Esophagus to Stomach with Synthetic Substitute, Via Natural or Artificial Opening Endoscopic

ICD-10 Procedure Code	Code Description
0D138J9	Bypass Lower Esophagus to Duodenum with Synthetic Substitute, Via Natural or Artificial Opening Endoscopic
0D138JA	Bypass Lower Esophagus to Jejunum with Synthetic Substitute, Via Natural or Artificial Opening Endoscopic
0D138JB	Bypass Lower Esophagus to Ileum with Synthetic Substitute, Via Natural or Artificial Opening Endoscopic
0D138K4	Bypass Lower Esophagus to Cutaneous with Nonautologous Tissue Substitute, Via Natural or Artificial Opening Endoscopic
0D138K6	Bypass Lower Esophagus to Stomach with Nonautologous Tissue Substitute, Via Natural or Artificial Opening Endoscopic
0D138K9	Bypass Lower Esophagus to Duodenum with Nonautologous Tissue Substitute, Via Natural or Artificial Opening Endoscopic
0D138KA	Bypass Lower Esophagus to Jejunum with Nonautologous Tissue Substitute, Via Natural or Artificial Opening Endoscopic
0D138KB	Bypass Lower Esophagus to Ileum with Nonautologous Tissue Substitute, Via Natural or Artificial Opening Endoscopic
0D138Z4	Bypass Lower Esophagus to Cutaneous, Via Natural or Artificial Opening Endoscopic
0D138Z6	Bypass Lower Esophagus to Stomach, Via Natural or Artificial Opening Endoscopic
0D138Z9	Bypass Lower Esophagus to Duodenum, Via Natural or Artificial Opening Endoscopic
0D138ZA	Bypass Lower Esophagus to Jejunum, Via Natural or Artificial Opening Endoscopic
0D138ZB	Bypass Lower Esophagus to Ileum, Via Natural or Artificial Opening Endoscopic
0D15074	Bypass Esophagus to Cutaneous with Autologous Tissue Substitute, Open Approach
0D15076	Bypass Esophagus to Stomach with Autologous Tissue Substitute, Open Approach
0D15079	Bypass Esophagus to Duodenum with Autologous Tissue Substitute, Open Approach
0D1507A	Bypass Esophagus to Jejunum with Autologous Tissue Substitute, Open Approach
0D1507B	Bypass Esophagus to Ileum with Autologous Tissue Substitute, Open Approach
0D150J4	Bypass Esophagus to Cutaneous with Synthetic Substitute, Open Approach
0D150J6	Bypass Esophagus to Stomach with Synthetic Substitute, Open Approach
0D150J9	Bypass Esophagus to Duodenum with Synthetic Substitute, Open Approach
0D150JA	Bypass Esophagus to Jejunum with Synthetic Substitute, Open Approach
0D150JB	Bypass Esophagus to Ileum with Synthetic Substitute, Open Approach
0D150K4	Bypass Esophagus to Cutaneous with Nonautologous Tissue Substitute, Open Approach
0D150K6	Bypass Esophagus to Stomach with Nonautologous Tissue Substitute, Open Approach
0D150K9	Bypass Esophagus to Duodenum with Nonautologous Tissue Substitute, Open Approach
0D150KA	Bypass Esophagus to Jejunum with Nonautologous Tissue Substitute, Open Approach
0D150KB	Bypass Esophagus to Ileum with Nonautologous Tissue Substitute, Open Approach
0D150Z4	Bypass Esophagus to Cutaneous, Open Approach
0D150Z6	Bypass Esophagus to Stomach, Open Approach
0D150Z9	Bypass Esophagus to Duodenum, Open Approach

ICD-10 Procedure Code	Code Description
0D150ZA	Bypass Esophagus to Jejunum, Open Approach
0D150ZB	Bypass Esophagus to Ileum, Open Approach
0D153J4	Bypass Esophagus to Cutaneous with Synthetic Substitute, Percutaneous Approach
0D15474	Bypass Esophagus to Cutaneous with Autologous Tissue Substitute, Percutaneous Endoscopic Approach
0D15476	Bypass Esophagus to Stomach with Autologous Tissue Substitute, Percutaneous Endoscopic Approach
0D15479	Bypass Esophagus to Duodenum with Autologous Tissue Substitute, Percutaneous Endoscopic Approach
0D1547A	Bypass Esophagus to Jejunum with Autologous Tissue Substitute, Percutaneous Endoscopic Approach
0D1547B	Bypass Esophagus to Ileum with Autologous Tissue Substitute, Percutaneous Endoscopic Approach
0D154J4	Bypass Esophagus to Cutaneous with Synthetic Substitute, Percutaneous Endoscopic Approach
0D154J6	Bypass Esophagus to Stomach with Synthetic Substitute, Percutaneous Endoscopic Approach
0D154J9	Bypass Esophagus to Duodenum with Synthetic Substitute, Percutaneous Endoscopic Approach
0D154JA	Bypass Esophagus to Jejunum with Synthetic Substitute, Percutaneous Endoscopic Approach
0D154JB	Bypass Esophagus to Ileum with Synthetic Substitute, Percutaneous Endoscopic Approach
0D154K4	Bypass Esophagus to Cutaneous with Nonautologous Tissue Substitute, Percutaneous Endoscopic Approach
0D154K6	Bypass Esophagus to Stomach with Nonautologous Tissue Substitute, Percutaneous Endoscopic Approach
0D154K9	Bypass Esophagus to Duodenum with Nonautologous Tissue Substitute, Percutaneous Endoscopic Approach
0D154KA	Bypass Esophagus to Jejunum with Nonautologous Tissue Substitute, Percutaneous Endoscopic Approach
0D154KB	Bypass Esophagus to Ileum with Nonautologous Tissue Substitute, Percutaneous Endoscopic Approach
0D154Z4	Bypass Esophagus to Cutaneous, Percutaneous Endoscopic Approach
0D154Z6	Bypass Esophagus to Stomach, Percutaneous Endoscopic Approach
0D154Z9	Bypass Esophagus to Duodenum, Percutaneous Endoscopic Approach
0D154ZA	Bypass Esophagus to Jejunum, Percutaneous Endoscopic Approach
0D154ZB	Bypass Esophagus to Ileum, Percutaneous Endoscopic Approach
0D15874	Bypass Esophagus to Cutaneous with Autologous Tissue Substitute, Via Natural or Artificial Opening Endoscopic
0D15876	Bypass Esophagus to Stomach with Autologous Tissue Substitute, Via Natural or Artificial Opening Endoscopic
0D15879	Bypass Esophagus to Duodenum with Autologous Tissue Substitute, Via Natural or Artificial Opening Endoscopic
0D1587A	Bypass Esophagus to Jejunum with Autologous Tissue Substitute, Via Natural or Artificial Opening Endoscopic
0D1587B	Bypass Esophagus to Ileum with Autologous Tissue Substitute, Via Natural or Artificial Opening Endoscopic
0D158J4	Bypass Esophagus to Cutaneous with Synthetic Substitute, Via Natural or Artificial Opening Endoscopic

ICD-10 Procedure Code	Code Description
0D158J6	Bypass Esophagus to Stomach with Synthetic Substitute, Via Natural or Artificial Opening Endoscopic
0D158J9	Bypass Esophagus to Duodenum with Synthetic Substitute, Via Natural or Artificial Opening Endoscopic
0D158JA	Bypass Esophagus to Jejunum with Synthetic Substitute, Via Natural or Artificial Opening Endoscopic
0D158JB	Bypass Esophagus to Ileum with Synthetic Substitute, Via Natural or Artificial Opening Endoscopic
0D158K4	Bypass Esophagus to Cutaneous with Nonautologous Tissue Substitute, Via Natural or Artificial Opening Endoscopic
0D158K6	Bypass Esophagus to Stomach with Nonautologous Tissue Substitute, Via Natural or Artificial Opening Endoscopic
0D158K9	Bypass Esophagus to Duodenum with Nonautologous Tissue Substitute, Via Natural or Artificial Opening Endoscopic
0D158KA	Bypass Esophagus to Jejunum with Nonautologous Tissue Substitute, Via Natural or Artificial Opening Endoscopic
0D158KB	Bypass Esophagus to Ileum with Nonautologous Tissue Substitute, Via Natural or Artificial Opening Endoscopic
0D158Z4	Bypass Esophagus to Cutaneous, Via Natural or Artificial Opening Endoscopic
0D158Z6	Bypass Esophagus to Stomach, Via Natural or Artificial Opening Endoscopic
0D158Z9	Bypass Esophagus to Duodenum, Via Natural or Artificial Opening Endoscopic
0D158ZA	Bypass Esophagus to Jejunum, Via Natural or Artificial Opening Endoscopic
0D158ZB	Bypass Esophagus to Ileum, Via Natural or Artificial Opening Endoscopic
0DB10ZZ	Excision of Upper Esophagus, Open Approach
0DB13ZZ	Excision of Upper Esophagus, Percutaneous Approach
0DB14ZZ	Excision of Upper Esophagus, Percutaneous Endoscopic Approach
0DB17ZZ	Excision of Upper Esophagus, Via Natural or Artificial Opening
0DB18ZZ	Excision of Upper Esophagus, Via Natural or Artificial Opening Endoscopic
0DB20ZZ	Excision of Middle Esophagus, Open Approach
0DB23ZZ	Excision of Middle Esophagus, Percutaneous Approach
0DB24ZZ	Excision of Middle Esophagus, Percutaneous Endoscopic Approach
0DB27ZZ	Excision of Middle Esophagus, Via Natural or Artificial Opening
0DB28ZZ	Excision of Middle Esophagus, Via Natural or Artificial Opening Endoscopic
0DB30ZZ	Excision of Lower Esophagus, Open Approach
0DB33ZZ	Excision of Lower Esophagus, Percutaneous Approach
0DB34ZZ	Excision of Lower Esophagus, Percutaneous Endoscopic Approach
0DB37ZZ	Excision of Lower Esophagus, Via Natural or Artificial Opening
0DB38ZZ	Excision of Lower Esophagus, Via Natural or Artificial Opening Endoscopic
0DB50ZZ	Excision of Esophagus, Open Approach
0DB53ZZ	Excision of Esophagus, Percutaneous Approach
0DB54ZZ	Excision of Esophagus, Percutaneous Endoscopic Approach
0DB57ZZ	Excision of Esophagus, Via Natural or Artificial Opening
0DB58ZZ	Excision of Esophagus, Via Natural or Artificial Opening Endoscopic
0DT10ZZ	Resection of Upper Esophagus, Open Approach
0DT14ZZ	Resection of Upper Esophagus, Percutaneous Endoscopic Approach

ICD-10 Procedure Code	Code Description
0DT17ZZ	Resection of Upper Esophagus, Via Natural or Artificial Opening
0DT18ZZ	Resection of Upper Esophagus, Via Natural or Artificial Opening Endoscopic
0DT20ZZ	Resection of Middle Esophagus, Open Approach
0DT24ZZ	Resection of Middle Esophagus, Percutaneous Endoscopic Approach
0DT27ZZ	Resection of Middle Esophagus, Via Natural or Artificial Opening
0DT28ZZ	Resection of Middle Esophagus, Via Natural or Artificial Opening Endoscopic
0DT30ZZ	Resection of Lower Esophagus, Open Approach
0DT34ZZ	Resection of Lower Esophagus, Percutaneous Endoscopic Approach
0DT37ZZ	Resection of Lower Esophagus, Via Natural or Artificial Opening
0DT38ZZ	Resection of Lower Esophagus, Via Natural or Artificial Opening Endoscopic
0DT44ZZ	Resection of Esophagogastric Junction, Percutaneous Endoscopic Approach
0DT50ZZ	Resection of Esophagus, Open Approach
0DT54ZZ	Resection of Esophagus, Percutaneous Endoscopic Approach
0DT57ZZ	Resection of Esophagus, Via Natural or Artificial Opening
0DT58ZZ	Resection of Esophagus, Via Natural or Artificial Opening Endoscopic
0DT60ZZ	Resection of Stomach, Open Approach
0DT64ZZ	Resection of Stomach, Percutaneous Endoscopic Approach
0DT67ZZ	Resection of Stomach, Via Natural or Artificial Opening
0DT68ZZ	Resection of Stomach, Via Natural or Artificial Opening Endoscopic
0DX60Z5	Transfer Stomach to Esophagus, Open Approach
0DX64Z5	Transfer Stomach to Esophagus, Percutaneous Endoscopic Approach
0DX80Z5	Transfer Small Intestine to Esophagus, Open Approach
0DX84Z5	Transfer Small Intestine to Esophagus, Percutaneous Endoscopic Approach
0DXE0Z5	Transfer Large Intestine to Esophagus, Open Approach
0DXE4Z5	Transfer Large Intestine to Esophagus, Percutaneous End

ICD-10 Malignant Tumor and Carcinoma in Situ Diagnosis Codes

ICD-10 Diagnosis Code	Code Description
C15.3	Malignant neoplasm of upper third of esophagus
C15.4	Malignant neoplasm of middle third of esophagus
C15.5	Malignant neoplasm of lower third of esophagus
C15.8	Malignant neoplasm of overlapping sites of esophagus
C15.9	Malignant neoplasm of esophagus, unspecified
C16.0	Malignancy of the cardio-esophageal junction
D00.1	Carcinoma in situ of esophagus

Pancreatic Resection for Cancer Measure Specifications

For pancreatic resection for cancer, there are two sets of ICD-10 codes for counting patient discharges. The first set of codes is to identify patients who have had the procedure. The second set of codes is to identify patients with a specific diagnosis.

Count the number of patients, ages 18 years and older, discharged with the following ICD-10 codes in any procedure field AND any of the following ICD-10 codes in any diagnosis field.

ICD-10 Pancreatic Resection for Cancer Procedure Codes

ICD-10 Procedure Code	Code Description
0DB90ZZ	Excision of Duodenum, Open Approach
0DB93ZZ	Excision of Duodenum, Percutaneous Approach
0DB94ZZ	Excision of Duodenum, Percutaneous Endoscopic Approach
0DB97ZZ	Excision of Duodenum, Via Natural or Artificial Opening
0DB98ZZ	Excision of Duodenum, Via Natural or Artificial Opening Endoscopic
0DT90ZZ	Resection of Duodenum, Open Approach
0DT94ZZ	Resection of Duodenum, Percutaneous Endoscopic Approach
0DT97ZZ	Resection of Duodenum, Via Natural or Artificial Opening
0DT98ZZ	Resection of Duodenum, Via Natural or Artificial Opening Endoscopic
0FBG0ZZ	Excision of Pancreas, Open Approach
0FBG3ZZ	Excision of Pancreas, Percutaneous Approach
0FBG4ZZ	Excision of Pancreas, Percutaneous Endoscopic Approach
0FBG8ZZ	Excision of Pancreas, Via Natural or Artificial Opening Endoscopic
0FTG0ZZ	Resection of Pancreas, Open Approach
0FTG4ZZ	Resection of Pancreas, Percutaneous Endoscopic Approach

ICD-10 Malignant Tumor Diagnosis Codes

ICD-10 Diagnosis Code	Code Description
C7A.1	Malignant poorly differentiated neuroendocrine tumors
C7A.8	Other malignant neuroendocrine tumors
C17.0	Malignant neoplasm of duodenum
C24.0	Malignant neoplasm of extrahepatic bile duct
C24.1	Malignant neoplasm of ampulla of Vater
C24.8	Malignant neoplasm of overlapping sites of biliary tract
C24.9	Malignant neoplasm of biliary tract, unspecified
C25.0	Malignant neoplasm of head of pancreas
C25.1	Malignant neoplasm of body of pancreas
C25.2	Malignant neoplasm of tail of pancreas
C25.3	Malignant neoplasm of pancreatic duct
C25.4	Malignant neoplasm of endocrine pancreas
C25.7	Malignant neoplasm of other parts of pancreas
C25.8	Malignant neoplasm of overlapping sites of pancreas
C25.9	Malignant neoplasm of pancreas, unspecified

Rectal Cancer Surgery Measure Specifications

For rectal cancer surgery, there are two sets of ICD-10 codes for counting patient discharges. The first set of codes is to identify patients who have had the procedure. The second set of codes is to identify patients with a specific diagnosis.

Count the number of patients, ages 18 years and older, discharged with the following ICD-10 codes in any procedure field AND any of the following ICD-10 codes in any diagnosis field.

ICD-10 Rectal Cancer Surgery Procedure Codes

ICD-10 Procedure Code	Code Description
0DBP0ZZ	Excision of Rectum, Open Approach
0DBP3ZZ	Excision of Rectum, Percutaneous Approach
0DBP4ZZ	Excision of Rectum, Percutaneous Endoscopic Approach
0DBP7ZZ	Excision of Rectum, Via Natural or Artificial Opening
0DBP8ZZ	Excision of rectum, via natural or artificial opening endoscopic
0DTP0ZZ	Resection of Rectum, Open Approach
0DTP4ZZ	Resection of Rectum, Percutaneous Endoscopic Approach
0DTP7ZZ	Resection of Rectum, Via Natural or Artificial Opening
0DTP8ZZ	Resection of Rectum, Via Natural or Artificial Opening Endoscopic

ICD-10 Malignant Tumor and Carcinoma in Situ Diagnosis Codes

ICD-10 Diagnosis Code	Code Description
C19	Malignant neoplasm of rectosigmoid junction
C20	Malignant neoplasm of rectum
C21.0	Malignant neoplasm of anus, unspecified
C21.1	Malignant neoplasm of anal canal
C21.2	Malignant neoplasm of cloacogenic zone
C21.8	Malignant neoplasm of overlapping sites of rectum, anus and anal canal
C78.5	Secondary malignant neoplasm of large intestine and rectum
D01.1	Carcinoma in situ of rectosigmoid junction
D01.2	Carcinoma in situ of rectum
D01.3	Carcinoma in situ of anus and anal canal

Bariatric Surgery for Weight Loss Measure Specifications

For bariatric surgery for weight loss, there are three sets of codes. One set of ICD-10 codes for counting inpatient discharges and one set of CPT codes for counting outpatient discharges. The first two sets of codes are to identify patients who have had the procedure. The third set of codes (ICD-10 diagnosis codes) is to identify patients with a specific diagnosis.

To determine the number of patients, ages 18 years and older, discharged for this procedure, hospitals have two options:

1. Count the number of patients, ages 18 years and older, discharged with the following ICD-10 codes or the CPT Codes in any procedure field AND any of the following ICD-10 codes in the **primary** diagnosis field. This method does not require chart review.
2. Count the number of patients, ages 18 years and older, discharged with the following ICD-10 codes or the CPT Codes in any procedure field AND any of the following ICD-10 codes in any diagnosis field. In addition, the procedure must have been done **explicitly for weight loss purposes** (i.e., presence of one of the diagnosis codes is necessary, but not sufficient for inclusion). This method requires chart review to ensure the procedure was performed explicitly for weight loss purposes.

ICD-10 Bariatric Surgery Procedure Codes

ICD-10 Procedure Code	Code Description
0D16079	Bypass Stomach to Duodenum with Autologous Tissue Substitute, Open Approach
0D1607A	Bypass Stomach to Jejunum with Autologous Tissue Substitute, Open Approach
0D1607B	Bypass Stomach to Ileum with Autologous Tissue Substitute, Open Approach
0D160J9	Bypass Stomach to Duodenum with Synthetic Substitute, Open Approach
0D160JA	Bypass Stomach to Jejunum with Synthetic Substitute, Open Approach
0D160JB	Bypass Stomach to Ileum with Synthetic Substitute, Open Approach
0D160K9	Bypass Stomach to Duodenum with Nonautologous Tissue Substitute, Open Approach
0D160KA	Bypass Stomach to Jejunum with Nonautologous Tissue Substitute, Open Approach
0D160KB	Bypass Stomach to Ileum with Nonautologous Tissue Substitute, Open Approach
0D160Z9	Bypass Stomach to Duodenum, Open Approach
0D160ZA	Bypass Stomach to Jejunum, Open Approach
0D160ZB	Bypass Stomach to Ileum, Open Approach
0D16479	Bypass Stomach to Duodenum with Autologous Tissue Substitute, Percutaneous Endoscopic Approach
0D1647A	Bypass Stomach to Jejunum with Autologous Tissue Substitute, Percutaneous Endoscopic Approach
0D1647B	Bypass Stomach to Ileum with Autologous Tissue Substitute, Percutaneous Endoscopic Approach
0D164J9	Bypass Stomach to Duodenum with Synthetic Substitute, Percutaneous Endoscopic Approach
0D164JA	Bypass Stomach to Jejunum with Synthetic Substitute, Percutaneous Endoscopic Approach
0D164JB	Bypass Stomach to Ileum with Synthetic Substitute, Percutaneous Endoscopic Approach
0D164K9	Bypass Stomach to Duodenum with Nonautologous Tissue Substitute, Percutaneous Endoscopic Approach
0D164KA	Bypass Stomach to Jejunum with Nonautologous Tissue Substitute, Percutaneous Endoscopic Approach

0D164KB	Bypass Stomach to Ileum with Nonautologous Tissue Substitute, Percutaneous Endoscopic Approach
0D164Z9	Bypass Stomach to Duodenum, Percutaneous Endoscopic Approach
0D164ZA	Bypass Stomach to Jejunum, Percutaneous Endoscopic Approach
0D164ZB	Bypass Stomach to Ileum, Percutaneous Endoscopic Approach
0D16879	Bypass Stomach to Duodenum with Autologous Tissue Substitute, Via Natural or Artificial Opening Endoscopic
0D1687A	Bypass Stomach to Jejunum with Autologous Tissue Substitute, Via Natural or Artificial Opening Endoscopic
0D1687B	Bypass Stomach to Ileum with Autologous Tissue Substitute, Via Natural or Artificial Opening Endoscopic
0D168J9	Bypass Stomach to Duodenum with Synthetic Substitute, Via Natural or Artificial Opening Endoscopic
0D168JA	Bypass Stomach to Jejunum with Synthetic Substitute, Via Natural or Artificial Opening Endoscopic
0D168JB	Bypass Stomach to Ileum with Synthetic Substitute, Via Natural or Artificial Opening Endoscopic
0D168K9	Bypass Stomach to Duodenum with Nonautologous Tissue Substitute, Via Natural or Artificial Opening Endoscopic
0D168KA	Bypass Stomach to Jejunum with Nonautologous Tissue Substitute, Via Natural or Artificial Opening Endoscopic
0D168KB	Bypass Stomach to Ileum with Nonautologous Tissue Substitute, Via Natural or Artificial Opening Endoscopic
0D168Z9	Bypass Stomach to Duodenum, Via Natural or Artificial Opening Endoscopic
0D168ZA	Bypass Stomach to Jejunum, Via Natural or Artificial Opening Endoscopic
0D168ZB	Bypass Stomach to Ileum, Via Natural or Artificial Opening Endoscopic
0DB60Z3	Excision of Stomach, Open Approach, Vertical
0DB60ZZ	Excision of Stomach, Open Approach
0DB63Z3	Excision of Stomach, Percutaneous Approach, Vertical
0DB63ZZ	Excision of Stomach, Percutaneous Approach
0DB64Z3	Excision of Stomach, Percutaneous Endoscopic Approach, Vertical
0DB64ZZ	Excision of Stomach, Percutaneous Endoscopic Approach

ICD-10 Morbid Obesity Diagnosis Codes

ICD-10 Diagnosis Code	Code Description
E66.01	Morbid (severe) obesity due to excess calories
E66.09	Other obesity due to excess calories
E66.1	Drug induced obesity
E66.2	Morbid (severe) obesity with alveolar hypoventilation
E66.3	Overweight
E66.8	Other obesity
E66.811	Obesity, class 1
E66.812	Obesity, class 2
E66.813	Obesity, class 3
E66.89	Other obesity not elsewhere classified
E66.9	Obesity, unspecified

ICD-10 Diagnosis Code	Code Description
Z68.35	Body mass index (BMI) 35.0-35.9, adult
Z68.36	Body mass index (BMI) 36.0-36.9, adult
Z68.37	Body mass index (BMI) 37.0-37.9, adult
Z68.38	Body mass index (BMI) 38.0-38.9, adult
Z68.39	Body mass index (BMI) 39.0-39.9, adult
Z68.41	Body mass index (BMI) 40.0-44.9, adult
Z68.42	Body mass index (BMI) 45.0-49.9, adult
Z68.43	Body mass index (BMI) 50.0-59.9, adult
Z68.44	Body mass index (BMI) 60.0-69.9, adult
Z68.45	Body mass index (BMI) 70 or greater, adult

CPT Bariatric Surgery for Weight Loss Procedure Codes

Leapfrog has provided a set of CPT codes for counting **patients** discharged from your hospital who have undergone the procedure during the reporting period on an outpatient basis.

CPT Codes are provided in downloadable Excel files on the Survey Dashboard. To access the files, click the CPT Code Workbook button next to Section 9. You will be required to complete the American Medical Association's Terms of Use before downloading the Excel file and using the individual CPT codes to query your EHR or billing system. You are only required to complete the Terms of Use once per Survey Cycle (April 1 – November 30).

The CPT Code Workbooks (Excel files) are labeled for Section 3A: Total Hip Replacement, Total Knee Replacement, and Bariatric Surgery for Weight Loss and Section 9C: Volume of Procedures. Please note, if you are part of a hospital system, each hospital will need to complete the Terms of Use. This is a requirement of the American Medical Association.

Using the CPT codes found for Bariatric Surgery for Weight Loss in the "Instructions" sheet, count the total number of adult (18 years of age or older) patients discharged for the procedures with the CPT codes listed AND any of the above ICD-10 diagnosis codes in the **primary** diagnosis field. The CPT codes can be in any procedure field.

Total Knee Replacement Measure Specifications

For total knee replacement, there are two sets of codes. One set of ICD-10 codes for counting inpatient discharges and one CPT code for counting outpatient discharges. The two sets of codes are to identify patients who have had the procedure.

To determine the number of patients, ages 18 years and older, discharged for this procedure, hospitals have two options:

- Count the number of patients, ages 18 years and older, discharged with any of the following ICD-10 codes in the **primary** procedure field or the CPT Code in any procedure field. This method does not require chart review. Hospitals should report on total knee replacement procedures performed in the outpatient locations included in Section 9: Outpatient Procedures.
- Count the number of patients, ages 18 years and older, discharged with any of the following ICD-10 codes or CPT Code in any procedure field. **For inpatient cases using ICD-10 codes, exclude any patients where the procedure was done as a revision** (i.e., the presence of one of the procedure codes is necessary, but not sufficient for inclusion). This method requires chart review of inpatient cases to ensure that revisions are not included. Chart review is not required for outpatient cases using the specified CPT Code. Hospitals should report on total knee replacement procedures performed in the outpatient locations included in Section 9: Outpatient Procedures.

ICD-10 Total Knee Replacement Procedure Codes

ICD10 Procedure Code	Code Description
0SRC0J9	Replacement of Right Knee Joint with Synthetic Substitute, Cemented, Open Approach
0SRC0JA	Replacement of Right Knee Joint with Synthetic Substitute, Uncemented, Open Approach
0SRC0JZ	Replacement of Right Knee Joint with Synthetic Substitute, Open Approach
0SRD0J9	Replacement of Left Knee Joint with Synthetic Substitute, Cemented, Open Approach
0SRD0JA	Replacement of Left Knee Joint with Synthetic Substitute, Uncemented, Open Approach
0SRD0JZ	Replacement of Left Knee Joint with Synthetic Substitute, Open Approach
0SRC069	Replacement of Right Knee Joint with Oxidized Zirconium on Polyethylene Synthetic Substitute, Cemented, Open Approach
0SRC06A	Replacement of Right Knee Joint with Oxidized Zirconium on Polyethylene Synthetic Substitute, Uncemented, Open Approach
0SRC06Z	Replacement of Right Knee Joint with Oxidized Zirconium on Polyethylene Synthetic Substitute, Open Approach
0SRD069	Replacement of Left Knee Joint with Oxidized Zirconium on Polyethylene Synthetic Substitute, Cemented, Open Approach
0SRD06A	Replacement of Left Knee Joint with Oxidized Zirconium on Polyethylene Synthetic Substitute, Uncemented, Open Approach
0SRD06Z	Replacement of Left Knee Joint with Oxidized Zirconium on Polyethylene Synthetic Substitute, Open Approach

CPT Total Knee Replacement Procedure Code

Leapfrog has provided a CPT code for counting **patients** discharged from your hospital who have undergone the procedure during the reporting period on an outpatient basis.

CPT Codes are provided in downloadable Excel files on the Survey Dashboard. To access the files, click the CPT Code Workbook button next to Section 9. You will be required to complete the American Medical Association's Terms of Use before downloading the Excel file and using the individual CPT codes to query your EHR or billing system. You are only required to complete the Terms of Use once per Survey Cycle (April 1 – November 30).

The CPT Code Workbooks (Excel files) are labeled for Section 3A: Total Hip Replacement, Total Knee Replacement, and Bariatric Surgery for Weight Loss and Section 9C: Volume of Procedures. Please note, if you are part of a hospital system, each hospital will need to complete the Terms of Use. This is a requirement of the American Medical Association.

Using the CPT code found for Total Knee Replacement in the "Instructions" sheet, count the total number of adult (18 years of age or older) patients discharged for the procedure with the CPT code listed. The CPT code can be in any procedure field.

Total Hip Replacement Measure Specifications

For total hip replacement, there are two sets of codes. One set of ICD-10 codes for counting inpatient discharges and one CPT code for counting outpatient discharges. The two sets of codes are to identify patients who have had the procedure.

To determine the number of patients, ages 18 years and older, discharged for this procedure, hospitals have two options:

- Count the number of patients, ages 18 years and older, discharged with any of the following ICD-10 codes in the **primary** procedure field or the CPT code in any procedure field. This method does not require chart review. Hospitals should report on total hip replacement procedures performed in the outpatient locations included in Section 9: Outpatient Procedures.
- Count the number of patients, ages 18 years and older, discharged with any of the following ICD-10 codes or the CPT code in any procedure field. **For inpatient cases using ICD-10 codes, exclude any patients where the procedure was done as a revision** (i.e., the presence of one of the procedure codes is necessary, but not sufficient for inclusion). This method requires chart review of inpatient cases to ensure that revisions are not included. Chart review is not required for outpatient cases using the specified CPT Code. Hospitals should report on total hip replacement procedures performed in the outpatient locations included in Section 9: Outpatient Procedures.

ICD-10 Total Hip Replacement Procedure Codes

ICD10 Procedure Code	Code Description
0SR9019	Replacement of Right Hip Joint with Metal Synthetic Substitute, Cemented, Open Approach
0SR901A	Replacement of Right Hip Joint with Metal Synthetic Substitute, Uncemented, Open Approach
0SR901Z	Replacement of Right Hip Joint with Metal Synthetic Substitute, Open Approach
0SR9029	Replacement of Right Hip Joint with Metal on Polyethylene Synthetic Substitute, Cemented, Open Approach
0SR902A	Replacement of Right Hip Joint with Metal on Polyethylene Synthetic Substitute, Uncemented, Open Approach
0SR902Z	Replacement of Right Hip Joint with Metal on Polyethylene Synthetic Substitute, Open Approach
0SR9039	Replacement of Right Hip Joint with Ceramic Synthetic Substitute, Cemented, Open Approach
0SR903A	Replacement of Right Hip Joint with Ceramic Synthetic Substitute, Uncemented, Open Approach
0SR903Z	Replacement of Right Hip Joint with Ceramic Synthetic Substitute, Open Approach
0SR9049	Replacement of Right Hip Joint with Ceramic on Polyethylene Synthetic Substitute, Cemented, Open Approach
0SR904A	Replacement of Right Hip Joint with Ceramic on Polyethylene Synthetic Substitute, Uncemented, Open Approach
0SR904Z	Replacement of Right Hip Joint with Ceramic on Polyethylene Synthetic Substitute, Open Approach
0SR90J9	Replacement of Right Hip Joint with Synthetic Substitute, Cemented, Open Approach
0SR90JA	Replacement of Right Hip Joint with Synthetic Substitute, Uncemented, Open Approach
0SR90JZ	Replacement of Right Hip Joint with Synthetic Substitute, Open Approach
0SRA009	Replacement of Right Hip Joint, Acetabular Surface with Polyethylene Synthetic Substitute, Cemented, Open Approach
0SRA00A	Replacement of Right Hip Joint, Acetabular Surface with Polyethylene Synthetic Substitute, Uncemented, Open Approach

0SRA00Z	Replacement of Right Hip Joint, Acetabular Surface with Polyethylene Synthetic Substitute, Open Approach
0SRA019	Replacement of Right Hip Joint, Acetabular Surface with Metal Synthetic Substitute, Cemented, Open Approach
0SRA01A	Replacement of Right Hip Joint, Acetabular Surface with Metal Synthetic Substitute, Uncemented, Open Approach
0SRA01Z	Replacement of Right Hip Joint, Acetabular Surface with Metal Synthetic Substitute, Open Approach
0SRA039	Replacement of Right Hip Joint, Acetabular Surface with Ceramic Synthetic Substitute, Cemented, Open Approach
0SRA03A	Replacement of Right Hip Joint, Acetabular Surface with Ceramic Synthetic Substitute, Uncemented, Open Approach
0SRA03Z	Replacement of Right Hip Joint, Acetabular Surface with Ceramic Synthetic Substitute, Open Approach
0SRA0J9	Replacement of Right Hip Joint, Acetabular Surface with Synthetic Substitute, Cemented, Open Approach
0SRA0JA	Replacement of Right Hip Joint, Acetabular Surface with Synthetic Substitute, Uncemented, Open Approach
0SRA0JZ	Replacement of Right Hip Joint, Acetabular Surface with Synthetic Substitute, Open Approach
0SRB019	Replacement of Left Hip Joint with Metal Synthetic Substitute, Cemented, Open Approach
0SRB01A	Replacement of Left Hip Joint with Metal Synthetic Substitute, Uncemented, Open Approach
0SRB01Z	Replacement of Left Hip Joint with Metal Synthetic Substitute, Open Approach
0SRB029	Replacement of Left Hip Joint with Metal on Polyethylene Synthetic Substitute, Cemented, Open Approach
0SRB02A	Replacement of Left Hip Joint with Metal on Polyethylene Synthetic Substitute, Uncemented, Open Approach
0SRB02Z	Replacement of Left Hip Joint with Metal on Polyethylene Synthetic Substitute, Open Approach
0SRB039	Replacement of Left Hip Joint with Ceramic Synthetic Substitute, Cemented, Open Approach
0SRB03A	Replacement of Left Hip Joint with Ceramic Synthetic Substitute, Uncemented, Open Approach
0SRB03Z	Replacement of Left Hip Joint with Ceramic Synthetic Substitute, Open Approach
0SRB049	Replacement of Left Hip Joint with Ceramic on Polyethylene Synthetic Substitute, Cemented, Open Approach
0SRB04A	Replacement of Left Hip Joint with Ceramic on Polyethylene Synthetic Substitute, Uncemented, Open Approach
0SRB04Z	Replacement of Left Hip Joint with Ceramic on Polyethylene Synthetic Substitute, Open Approach
0SRB0J9	Replacement of Left Hip Joint with Synthetic Substitute, Cemented, Open Approach
0SRB0JA	Replacement of Left Hip Joint with Synthetic Substitute, Uncemented, Open Approach
0SRB0JZ	Replacement of Left Hip Joint with Synthetic Substitute, Open Approach
0SRE009	Replacement of Left Hip Joint, Acetabular Surface with Polyethylene Synthetic Substitute, Cemented, Open Approach
0SRE00A	Replacement of Left Hip Joint, Acetabular Surface with Polyethylene Synthetic Substitute, Uncemented, Open Approach
0SRE00Z	Replacement of Left Hip Joint, Acetabular Surface with Polyethylene Synthetic Substitute, Open Approach
0SRE019	Replacement of Left Hip Joint, Acetabular Surface with Metal Synthetic Substitute, Cemented, Open Approach

0SRE01A	Replacement of Left Hip Joint, Acetabular Surface with Metal Synthetic Substitute, Uncemented, Open Approach
0SRE01Z	Replacement of Left Hip Joint, Acetabular Surface with Metal Synthetic Substitute, Open Approach
0SRE039	Replacement of Left Hip Joint, Acetabular Surface with Ceramic Synthetic Substitute, Cemented, Open Approach
0SRE03A	Replacement of Left Hip Joint, Acetabular Surface with Ceramic Synthetic Substitute, Uncemented, Open Approach
0SRE03Z	Replacement of Left Hip Joint, Acetabular Surface with Ceramic Synthetic Substitute, Open Approach
0SRE0J9	Replacement of Left Hip Joint, Acetabular Surface with Synthetic Substitute, Cemented, Open Approach
0SRE0JA	Replacement of Left Hip Joint, Acetabular Surface with Synthetic Substitute, Uncemented, Open Approach
0SRE0JZ	Replacement of Left Hip Joint, Acetabular Surface with Synthetic Substitute, Open Approach
0SR9069	Replacement of Right Hip Joint with Oxidized Zirconium on Polyethylene Synthetic Substitute, Cemented, Open Approach
0SR906A	Replacement of Right Hip Joint with Oxidized Zirconium on Polyethylene Synthetic Substitute, Uncemented, Open Approach
0SR906Z	Replacement of Right Hip Joint with Oxidized Zirconium on Polyethylene Synthetic Substitute, Open Approach
0SRB069	Replacement of Left Hip Joint with Oxidized Zirconium on Polyethylene Synthetic Substitute, Cemented, Open Approach
0SRB06A	Replacement of Left Hip Joint with Oxidized Zirconium on Polyethylene Synthetic Substitute, Uncemented, Open Approach
0SRB06Z	Replacement of Left Hip Joint with Oxidized Zirconium on Polyethylene Synthetic Substitute, Open Approach

CPT Total Hip Replacement Procedure Code

Leapfrog has provided a CPT code for counting **patients** discharged from your hospital who have undergone the procedure during the reporting period on an outpatient basis.

CPT Codes are provided in downloadable Excel files on the Survey Dashboard. To access the files, click the CPT Code Workbook button next to Section 9. You will be required to complete the American Medical Association's Terms of Use before downloading the Excel file and using the individual CPT codes to query your EHR or billing system. You are only required to complete the Terms of Use once per Survey Cycle (April 1 – November 30).

The CPT Code Workbooks (Excel files) are labeled for Section 3A: Total Hip Replacement, Total Knee Replacement, and Bariatric Surgery for Weight Loss and Section 9C: Volume of Procedures. Please note, if you are part of a hospital system, each hospital will need to complete the Terms of Use. This is a requirement of the American Medical Association.

Using the CPT code found for Total Hip Replacement in the "Instructions" sheet, count the total number of adult (18 years of age or older) patients discharged for the procedure with the CPT code listed. The CPT code can be in any procedure field.

Norwood Procedure Measure Specifications

For Norwood procedure, there are two sets of ICD-10 procedure codes for counting patient discharges. For a patient to be counted, they must have at least one ICD-10 procedure code from each list.

The first set of codes is to identify patients who have had an arch repair. The second set of codes is to identify patients who have had a shunt.

Count the number of patients, ages 17 years and younger, discharged with at least one of the following ICD-10 procedure codes from each list in any procedure field (i.e., each patient discharge will need to have at least one ICD-10 procedure code from the arch repair set AND at least one ICD-10 procedure code from the shunt set). Both procedures would need to be done as part of the same operative session.

ICD-10 Arch Repair Procedure Codes

ICD-10 Procedure Code	Code Description
02UX07Z	Supplement Thoracic Aorta, Ascending/Arch with Autologous Tissue Substitute, Open Approach
02UX0JZ	Supplement Thoracic Aorta, Ascending/Arch with Synthetic Substitute, Open Approach
02UX0KZ	Supplement Thoracic Aorta, Ascending/Arch with Nonautologous Tissue Substitute, Open Approach

ICD-10 Shunt Procedure Codes

ICD-10 Procedure Code	Code Description
021K08P	Bypass Right Ventricle to Pulmonary Trunk with Zooplastic Tissue Substitute, Open Approach
021K08Q	Bypass Right Ventricle to Right Pulmonary Artery with Zooplastic Tissue Substitute, Open Approach
021K08R	Bypass Right Ventricle to Left Pulmonary Artery with Zooplastic Tissue Substitute, Open Approach
021K09P	Bypass Right Ventricle to Pulmonary Trunk with Autologous Venous Tissue, Open Approach
021K09Q	Bypass Right Ventricle to Right Pulmonary Artery with Autologous Venous Tissue, Open Approach
021K09R	Bypass Right Ventricle to Right Pulmonary Artery with Autologous Venous Tissue, Open Approach
021K0AP	Bypass Right Ventricle to Pulmonary Trunk with Autologous Arterial Tissue, Open Approach
021K0AQ	Bypass Right Ventricle to Right Pulmonary Artery with Autologous Arterial Tissue, Open Approach
021K0AR	Bypass Right Ventricle to Right Pulmonary Artery with Autologous Arterial Tissue, Open Approach
021K0JP	Bypass Right Ventricle to Pulmonary Trunk with Synthetic Substitute, Open Approach
021K0JQ	Bypass Right Ventricle to Right Pulmonary Artery with Synthetic Substitute, Open Approach
021K0JR	Bypass Right Ventricle to Left Pulmonary Artery with Synthetic Substitute, Open Approach
021K0KP	Bypass Right Ventricle to Pulmonary Trunk with Nonautologous Tissue Substitute, Open Approach
021K0KQ	Bypass Right Ventricle to Right Pulmonary Artery with Nonautologous Tissue Substitute, Open Approach

ICD-10 Procedure Code	Code Description
021K0KR	Bypass Right Ventricle to Right Pulmonary Artery with Nonautologous Tissue Substitute, Open Approach
021Q08A	Bypass Right Pulmonary Artery from Innominate Artery with Zooplastic Tissue, Open Approach
021Q08B	Bypass Right Pulmonary Artery from Subclavian with Zooplastic Tissue, Open Approach
021Q08D	Bypass Right Pulmonary Artery from Carotid with Zooplastic Tissue, Open Approach
021Q09A	Bypass Right Pulmonary Artery from Innominate Artery with Autologous Venous Tissue, Open Approach
021Q09B	Bypass Right Pulmonary Artery from Subclavian with Autologous Venous Tissue, Open Approach
021Q09D	Bypass Right Pulmonary Artery from Carotid with Autologous Venous Tissue, Open Approach
021Q0AA	Bypass Right Pulmonary Artery from Innominate Artery with Autologous Arterial Tissue, Open Approach
021Q0AB	Bypass Right Pulmonary Artery from Subclavian with Autologous Arterial Tissue, Open Approach
021Q0AD	Bypass Right Pulmonary Artery from Carotid with Autologous Arterial Tissue, Open Approach
021Q0JA	Bypass Right Pulmonary Artery from Innominate with Synthetic Substitute, Open Approach
021Q0JB	Bypass Right Pulmonary Artery from Subclavian with Synthetic Substitute, Open Approach
021Q0JD	Bypass Right Pulmonary Artery from Carotid with Synthetic Substitute, Open Approach
021Q0KA	Bypass Right Pulmonary Artery from Innominate Artery with Nonautologous Tissue Substitute, Open Approach
021Q0KB	Bypass Right Pulmonary Artery from Subclavian with Nonautologous Tissue Substitute, Open Approach
021Q0KD	Bypass Right Pulmonary Artery from Carotid with Nonautologous Tissue Substitute, Open Approach
021V0ZP	Bypass Superior Vena Cava to Pulmonary Trunk, Open Approach
021V0ZQ	Bypass Superior Vena Cava to Right Pulmonary Artery, Open Approach
021V0ZR	Bypass Superior Vena Cava to Left Pulmonary Artery, Open Approach

Safe Surgery Checklist for Adult and Pediatric Complex Surgery Measure Specifications

Important Note: Hospitals that share a CMS Certification Number are required to report by facility. Please carefully review [Leapfrog's Multi-Campus Reporting Policy](#).

Source: The Leapfrog Group, WHO Surgical Safety Checklist and Implementation Manual , AHRQ Endoscopy Checklist
Reporting Period: 12 months Latest 12-month period prior to submission of this section of the Survey
Safe Surgery Checklist Workbook (Excel) To complete the data collection and respond to questions #6-9, hospitals should download the Safe Surgery Checklist Workbook (Excel). This workbook includes five tabs: Instructions, Section 3B (Complex Surgery), Section 3B – Data Entry, Section 9D (Outpatient Procedures), Section 9D – Data Entry. The Section 3B tabs can be used to complete the safe surgery checklist audits for this subsection and to calculate the response for question #9. The workbook is available on the Survey Materials Webpage.
Sampling: Hospitals that perform procedures in both Section 3A and Section 9C, and submit both Section 3 and 9, can randomly sample 15 patients (who had one of the procedures included in Section 3A) and measure and report adherence to the safe surgery checklist based on that sample. Hospitals that ONLY perform the procedures in Section 3A, or that ONLY submit Section 3, must randomly sample 30 patients (who had one of the procedures included in Section 3A) and measure and report adherence to the safe surgery checklist based on that sample. When sampling from a larger population of cases, hospitals that perform multiple procedures (e.g., bariatric surgery for weight loss, total hip replacement, total knee replacement, etc.) included in Section 3A and hospitals that perform procedures for both adult and pediatric patients (e.g., the Norwood Procedures) should obtain a representative sample (i.e., include patients who underwent different procedures and include both adult and pediatric patients, if applicable). <i>Free-standing pediatric hospitals that perform the Norwood Procedure and hospitals that reported a combined total hospital volume of less than the sufficient sample for all the procedures in Section 3A can sample any patients that had a procedure performed under general anesthesia.</i>
Question #6: Did your hospital perform an audit (either in-person or via the medical record or other EHR data) on a sufficient sample of patients who underwent a procedure included in Section 3A and measure adherence to the safe surgery checklist? To respond “yes” to question #6, hospitals must measure and document whether all the elements in questions #3, #4, and #5 were verbalized in the presence of the appropriate personnel for each sampled case. Hospitals that completed the audit should respond “yes” to this question regardless of whether the adherence to the checklist was 100%. Hospitals will report on adherence to the checklist in question #9.
Question #7: How many cases were included in the audit from question #6? Hospitals that perform procedures in both Section 3A and Section 9C, and submit both Section 3 and 9, can randomly sample 15 patients (who had one of the procedures included in Section 3A) and measure and report adherence to the safe surgery checklist based on that sample. Hospitals that ONLY perform the procedures in Section 3A, or that ONLY submit Section 3, must randomly sample 30 patients (who had one of the procedures included in Section 3A) and measure and report adherence to the safe surgery checklist based on that sample.

Question #8: What method was used to perform the audit on a sufficient sample in question #6?

Hospitals can only perform a retrospective audit by reviewing medical records or EHR data if adherence to the safe surgery checklist is clearly documented in the medical record or EHR and the documentation clearly demonstrates that each element was verbalized in the presence of the appropriate personnel. If hospitals cannot clearly determine whether (a) the checklist element was verbalized and (b) that the appropriate personnel were present via a retrospective audit, an in-person observational audit must be completed.

Hospitals performing in-person observational audits must do so in the latest 12 months prior to Survey submission.

Hospitals performing retrospective audits must audit cases from the latest 12 months prior to Survey submission but can also review any case from Section 3A that was performed in the latest calendar year prior to Survey submission.

Question #9: Based on your hospital's audit (either in-person or via the medical record or other EHR data) on a sufficient sample of patients who underwent a procedure included in Section 3A, what was your hospital's documented rate of adherence to the safe surgery checklist (i.e., what percentage of the sampled cases had all elements in questions #3, #4, and #5 completed)?

Based on the audit completed for question #6, determine the total number of patient audits where all elements of the safe surgery checklist (included in questions #3, #4, and #5) were read aloud in the presence of the appropriate personnel 1) before the induction of anesthesia, 2) before the skin incision and/or the procedure began, and 3) before the patient left the operating and/or procedure room.

Included cases:

- The patient audit shows that all elements of the safe surgery checklist, at all three time points, were read aloud in the presence of the appropriate personnel.

Excluded cases:

- The patient audit does not demonstrate that all elements of the safe surgery checklist were read aloud in the presence of the appropriate personnel (i.e., one or more elements of the checklist were not read aloud or the appropriate personnel were not present during the checklist).
- The patient audit does not demonstrate that the safe surgery checklist was read aloud in the presence of the appropriate personnel at all three time points (i.e., before anesthesia, before the skin incision, and before the patient leaves).

Important Note: If a Safe Surgery Checklist element includes the qualifier "if applicable," hospitals should determine if that element of the checklist was applicable to the patient and procedure being performed. If the element was determined to be "not applicable" to the patient and procedure, it does not count against the total adherence. For example, if your hospital performed a bariatric surgery for weight loss, the availability of a device on-site would not be applicable. Therefore, when completing the Safe Surgery Checklist Workbook for this patient, indicate N/A for that element (device on-site) and your hospital would be able to count that case as adherent.

See [FAQs](#) for additional information about responding to the questions in this section.

Section 3: Adult and Pediatric Complex Surgery Frequently Asked Questions (FAQs)

General Questions

1. Does this section apply to critical access hospitals?

Yes. In general, critical access hospitals do not perform many of the procedures that are included in this section, but if the critical access hospital does perform the procedure, the standards still apply.

2. Should we select a procedure from the list in Section 3A question #2 if we only perform that procedure on an outpatient basis?

Hospitals that only perform total hip replacements, total knee replacements, and/or bariatric surgery for weight loss on an outpatient basis should select and report on those procedures in Section 3A.

Otherwise, hospitals should not select and report on the remaining eight procedures if the procedures are always scheduled with the intention of the patient being released on the same day.

If some of the procedures are scheduled with the intention of the patient being admitted and staying in the hospital overnight, the hospital should report on performing the procedure in question #2 and then **ONLY** report on the total number of patients discharged following an inpatient stay.

3. My hospital has a tumor center that only performs total hip replacements and total knee replacements as they come up during a tumor removal surgery, should we select these procedures from the list in Section 3A question #2?

If your hospital has a tumor center where orthopedic tumor surgeries are performed and the **ONLY** total hip replacement and/or total knee replacement procedures ever done at that hospital are for the treatment of the tumor, you should not select and report on total hip replacements or total knee replacements in Section 3A.

Hospital Volume FAQs

4. How should hospitals calculate volume using a 24-month annual average?

To report on a 24-month annual average, calculate the total volume over the past 24 months, and then divide by 2 (i.e., the volume of year one plus the volume of year 2 divided by two equals the 24-month annual average).

5. Can we count patients who have had one of the procedures listed in Section 3A in combination with another procedure not listed in Section 3A?

Yes, hospitals should count all patients that meet the criteria specified in the [Hospital and Surgeon Volume Measure Specifications](#). For example, if a patient has a CABG and a mitral valve repair done at the same time, the hospital should count the patient when calculating total volume for mitral valve repair and replacement.

6. When counting patients, should we only include those patients who had the procedure performed on a scheduled basis?

No. Once a hospital selects a procedure from the list in question #2, they should use the measure specifications for each procedure to count all patients that meet the criteria. This includes patients who had the procedure performed urgently.

7. If a hospital elects to begin a new service line of procedures, how should the hospital report its volume and surgeon volumes while establishing the new line?

Leapfrog gives hospitals an 18-month grace period before having to report on hospital and surgeon volume for a new procedure. From the day that the hospital performs the procedure for the first time, the hospital and its surgeons will have 18 months to reach the annual volume standard. During this period, the hospital does not have to report its procedure volumes for the hospital or its surgeons. However, once the hospital reaches the end of the 18-month grace period, it must report its hospital and surgeon procedure volume.

8. How should we deal with a temporary drop in volume due to losing a surgeon's service?

To accommodate fluctuations in hospital volumes, hospitals have the option of reporting on their average case volumes over a 24-month period.

9. Can we count minimally invasive and/or robotic Mitral Valve Repair and Replacement procedures towards our hospital's volume?

Yes, the ICD-10 codes Leapfrog has provided for this procedure will capture minimally invasive and/or robotic MVR procedures in the hospital's count as these are the codes used for those cases.

10. Our hospital has a free-standing outpatient surgery center that shares our license and/or CMS Certification Number (CCN). Many of our same day total hip replacements, total knee replacements, and bariatric surgery for weight loss procedures are performed there. Can we include these procedures in our total hospital volume when responding to question #3 in Section 3A?

Yes, hospitals may count patient discharges with the appropriate CPT procedure code during the reporting period from hospital outpatient departments that share your hospital's license and/or CMS Certification Number (CCN), including, but not limited to free-standing surgery centers and hospital outpatient departments.

Surgeon Volume FAQs

11. Does the specific procedure and minimum annual surgeon volume standard listed need to be included in our process for privileging surgeons?

Yes. Hospitals must ensure that the specific procedure (as defined using the ICD-10 and CPT procedure codes) and minimum annual surgeon volume standard are included in your process for privileging surgeons. Diagnosis codes can be ignored.

12. Does our privileging process for surgeons have to include the annual surgeon volume standard for initial privileging only or ongoing/renewal of privileging as well?

Both. Leapfrog's minimum annual surgeon volume standards should be fully integrated into your hospital's process for privileging surgeons, including both initial and ongoing privileging. There are two exceptions:

- a. Surgeons who have just finished training: see [FAQ #14](#) below.
- b. Surgeons who were not active for the entire reporting period: see [FAQ #15](#) below.

13. When counting annual surgeon volume for the purposes of privileging, should we consider procedures performed by the surgeon at other hospitals?

Yes. When determining whether a surgeon has met or has exceeded Leapfrog's minimum annual surgeon volume standard, we expect that hospitals will consider total experience in the privileging process – this would include procedures performed within the reporting period at different facilities. It is our understanding that through [the OPPE process](#), hospitals have access to total surgeon volume, including the number of procedures performed at other hospitals.

14. For determining surgeon volume for the purposes of privileging, how should we count procedures that involve surgeons who have just finished training and are building up their experience?

Surgeons who have just finished their training should receive a 24-month grace period to build up their experience. After that point, the surgeon's volume should be tracked and included in privileging decisions. The procedures performed by this surgeon during the reporting period should still be counted towards the hospital's volume total, as the broader staff still had the experience with the procedure.

15. If a surgeon was not “active” during the entire reporting period (e.g., just hired, sabbatical, illness, etc.), should they be included when responding to question #5?

If a surgeon was absent for an extended time during the reporting period, the procedures performed by this surgeon during the reporting period should still be counted towards the hospital's procedure total (question #3). However, the surgeon would not need to be considered when responding to question #5 regarding whether your hospital's process for privileging includes the surgeon having to meet Leapfrog's minimum annual surgeon volume standards until they have been active again for an entire reporting period (likely the next year).

16. When counting surgeon volume for the purposes of privileging, if a procedure is completed by two surgeons (i.e., an assistant or co-surgeon) would they both be able to count the case?

If a surgeon assists another surgeon or is a co-surgeon during a procedure, the procedure should NOT count for both surgeons' procedure totals. The case should be applied to a single surgeon.

17. When determining which surgeons should be required to meet Leapfrog's minimum annual surgeon volume standards for the process of privileging, should surgeons who only ever perform a procedure in emergency circumstances and never perform the procedure on a scheduled basis be included?

For the purposes of reporting on question #5 in Section 3A, hospitals can exclude surgeons who will only ever perform a procedure in emergency circumstances if they never perform the procedure on a scheduled basis.

However, for the purposes of reporting on question #3 in Section 3A, hospitals should count all patients discharged with the relevant procedure or diagnosis for those procedures indicated in question #2 in Section 3A. See FAQ #6.

Safe Surgery Checklist for Adult and Pediatric Complex Surgery FAQs

18. What 12-month reporting period should be used when reporting on this section?

When responding to the questions in Section 3B, hospitals should enter the month in which they complete their observational in-person or retrospective EHR review audits. If your hospital does not perform an audit, enter the month in which you are completing the Survey.

19. Does the safe surgery checklist referenced in Section 3B apply to all procedures, including endoscopies?

Yes, it applies to all procedures in Section 3A. If your hospital does not utilize a safe surgery checklist for all procedures in Section 3A, including endoscopies, respond “no” to question #2.

20. Can different elements of the “Before the induction of anesthesia” checklist (question #3) be performed in different places?

Yes, hospitals may perform some elements of the pre-anesthesia checklist outside of the operating room. Hospitals may read aloud the following elements in a pre-procedure (preop) area: Patient ID, Confirmation of procedure, Patient consent, Site marked, if applicable, and Allergies assessed.

Hospitals should not remove conversation prompts as it is harmful to the purpose of the checklist and should continue debriefing and requiring participation of the surgical team members in key

moments.

21. Do we need to perform a “clinical team introduction” if the team already knows each other and/or will be in the operating room together all day?

Yes. Even if a clinical team knows each other they must perform an introduction stating their name and role at the first procedure of the day. They do not need to reintroduce themselves for the remaining procedures but should confirm everyone was introduced beforehand. However, if any team members change between operations, introductions must be performed again.

22. Do the Safe Surgery Checklist components included in questions #3, #4, and #5 need to be in one document that would align with the [WHO example](#) or can they be in different documents (i.e., pre-anesthesia notes, surgeon H&P, and pre-surgical checklists, etc.)?

It is possible to have separate checklists for each phase of the surgical procedure (i.e., before the induction of anesthesia, before the skin incision and/or before the procedure begins, and before the patient leaves the operating or procedure room). However, each individual component included in questions #3, #4, and #5 should be listed on the checklist(s) and hospitals should document whether the components were read aloud at the appropriate time with the appropriate members of the surgical team present.

23. How is “whole surgical team” defined?

“Whole surgical team” is comprised of the surgeons, anesthesia professionals, nurses, technicians, and other operating room personnel involved in surgery. This is based off the [World Alliance for Patient Safety Implementation Manual Surgical Safety Checklist \(First Edition\)](#).

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SECTION 4: MATERNITY CARE

This section includes questions and reference information for Section 4: Maternity Care. Please carefully review the questions, endnotes, and reference information (e.g., measure specifications, notes, and frequently asked questions) before you begin. Failure to review the reference information could result in inaccurate responses.

Section 4: Maternity Care

Maternity Care Fact Sheet and Bibliography:

<https://ratings.leapfroggroup.org/measure/hospital/2025/maternity-care>

Hospitals that did not deliver newborns during the reporting period or did not have an open labor and delivery unit during the entire reporting period should select “no” in question #2 and move on to the Affirmation of Accuracy. Your hospital’s results will be displayed as “Does Not Apply” on Leapfrog’s public reporting website.

Section 4 includes questions about maternity care volume and services, cesarean birth, episiotomy, newborn bilirubin screening, and DVT prophylaxis for women undergoing cesarean delivery. The section also includes questions about high-risk deliveries, including volume and outcomes. The subsection on cesarean birth (4C) includes questions about cesarean births stratified by race/ethnicity that will not be scored or publicly reported, however, responses will be used for confidential reporting on the [Hospital Details Page](#) in 2025.

Each hospital achieving the standard for Cesarean Birth:

Meets or is better than the 23.6% target for performance on the nationally endorsed outcome measure.

Each hospital achieving the standard for Episiotomy:

Meets or is better than the 5.0% target for performance on the nationally endorsed outcome measure.

Each hospital achieving the standard for Newborn Bilirubin Screening Prior to Discharge:

Meets or exceeds the 90% target for the process measure of care.

Each hospital achieving the standard for Appropriate DVT Prophylaxis in Women Undergoing Cesarean Delivery:

Meets or exceeds the 90% target for the process measure of care.

Each hospital achieving the standard for High-Risk Deliveries:

Achieves favorable hospital volume characteristics for high-risk deliveries by admitting 50 or more very low birth weight newborns/year to its neonatal ICU,

OR

Achieves favorable outcomes for high-risk deliveries as measured by the Vermont Oxford Network.

Download the 2025 Leapfrog Hospital Survey Scoring Algorithm on the [Scoring and Results webpage](#).

4A: Maternity Care Volume and Services

Hospitals that share a CMS Certification Number are required to report by facility. Please carefully review [Leapfrog's Multi-Campus Reporting Policy](#).

Important Notes:

Note 1: This section is only applicable to hospitals that deliver newborn babies. Hospitals that do not deliver newborn babies should select “no” in question #2 in 4A and move on to the Affirmation of Accuracy. Your hospital's results will be displayed as “Does Not Apply” on Leapfrog's public reporting website.

Note 2: Hospitals must use the same 12-month reporting period for all subsections in Section 4: Maternity Care, except for Section 4A questions #4-9 and Section 4B questions #6-8.

Note 3: Maternity Care Services (questions #4-9) will not be scored but will be used in public reporting.

Specifications: See [Maternity Care Volume and Services Measure Specifications](#) in the Reference Information beginning on page 163.

Reporting Period: 12 months

- Surveys submitted prior to September 1:
 - 01/01/2024 – 12/31/2024
- Surveys (re)submitted on or after September 1:
 - 07/01/2024 – 06/30/2025

Note: As a reminder, the [Corrections Period](#) (December 1-January 31) is reserved for corrections to previously submitted Surveys only. Any updates made to reflect a change in performance must be made prior to the November 30 Late Submission and Performance Update Deadline. Updates made to reflect a change in performance after November 30 will not be scored or publicly reported.

Maternity Care Volume

1) 12-month reporting period used:	○ 01/01/2024 – 12/31/2024 ○ 07/01/2024 – 06/30/2025
2) Did the hospital deliver newborn babies during the reporting period? <i>If “no” or “yes, but unit is now closed or wasn’t open for the entire reporting period,” skip the remaining questions in Section 4, including all subsections, and go to the Affirmation of Accuracy. The hospital will be scored as “Does Not Apply.”</i>	○ Yes ○ No ○ Yes, but unit is now closed or wasn’t open for the entire reporting period
3) Total number of live births (i.e., liveborn infants) at this hospital location for the reporting period. <i>If fewer than 10 cases, skip the remaining questions in Section 4, including all subsections, and go to the Affirmation of Accuracy. The hospital will be scored as “Unable to Calculate Score” or “Does Not Apply.”</i>	_____

Maternity Care Services

Reporting Period: Answer questions #4-9 based on the practices currently in place at the time you submit this section of the Survey.

Note: As a reminder, the [Corrections Period](#) (December 1-January 31) is reserved for corrections to previously submitted Surveys only. Any updates made to reflect a change in performance must be made prior to the November 30 Late Submission and Performance Update Deadline. Updates made to reflect a change in performance after November 30 will not be scored or publicly reported.

4) Does your hospital have certified nurse-midwives and/or certified midwives deliver newborns?	☐ Yes ☐ No
5) Does your hospital use doulas for labor and delivery? <i>Select all that apply.</i>	☐ Yes, the hospital employs or contracts with doulas ☐ Yes, the hospital allows patients to bring their own doulas ☐ No
6) Does your hospital offer breastfeeding/lactation consultants? <i>Select all that apply.</i>	☐ Yes, in the hospital ☐ Yes, in the outpatient setting ☐ Yes, at home after discharge ☐ No
7) Does your hospital offer patients the opportunity to attempt vaginal birth after cesarean section (VBAC)?	☐ Yes ☐ No
8) Does your hospital offer postpartum tubal ligation during the labor and delivery admission?	☐ Yes ☐ No
9) Has your hospital adopted a policy that prevents nonmedically indicated early elective deliveries (before 39 completed weeks gestation) that includes all the following: • Written standards for when an early elective delivery is, and is not, appropriate based on ACOG and national guidelines (i.e., The Joint Commission), • Written protocols for the medical director, or other designated physician, to review and approve an early elective delivery when medically indicated based on ACOG and national guidelines, and • Written protocols for staff to follow when scheduling an early elective delivery if approved by the medical director or other designated physician?	☐ Yes ☐ No

4B: Cesarean Birth

Hospitals that share a CMS Certification Number are required to report by facility. Please carefully review [Leapfrog's Multi-Campus Reporting Policy](#).

Important Notes:

Note 1: Hospitals must use the same 12-month reporting period for all subsections in Section 4: Maternity Care, except for Section 4B questions #6-8.

Note 2: Cesarean Birth Stratified by Race/Ethnicity (questions #6-8) will not be scored or publicly reported but will be used for confidential reporting on the Hospital Details Page.

Specifications: See [Cesarean Birth Measure Specifications](#) in the Reference Information beginning on page 164.

Reporting Period: 12 months

Answer questions #1-5 based on all cases (or a sufficient sample of them for questions #2-3)

- Surveys submitted prior to September 1:
 - 01/01/2024 – 12/31/2024
- Surveys (re)submitted on or after September 1:
 - 07/01/2024 – 06/30/2025

Note: As a reminder, the [Corrections Period](#) (December 1-January 31) is reserved for corrections to previously submitted Surveys only. Any updates made to reflect a change in performance must be made prior to the November 30 Late Submission and Performance Update Deadline. Updates made to reflect a change in performance after November 30 will not be scored or publicly reported.

Sufficient Sample: See [Cesarean Birth Measure Specifications](#) for instructions for identifying a sufficient sample for questions #2 and #3.

1) 12-month reporting period used:	○ 01/01/2024 – 12/31/2024 ○ 07/01/2024 – 06/30/2025
2) Total number of nulliparous mothers (or sufficient sample of them) that delivered a live term singleton newborn in the vertex presentation with ≥ 37 weeks of gestation completed, with Excluded Populations removed: <i>If fewer than 10 cases met the criteria for the denominator, skip questions #3-8 and continue to the next subsection. The hospital will be scored as "Unable to Calculate Score."</i>	_____
3) Total number of mothers indicated in question #2 that had their newborn delivered via cesarean section:	_____
4) Do the responses in questions #2 and #3 above represent a sample of cases?	○ Yes ○ No
5) If "yes" to question #4, did your hospital sample using The Joint Commission's sampling algorithm or Leapfrog's sampling instructions, as provided in the Maternity Care Reference Information?	○ The Joint Commission ○ The Leapfrog Group

Cesarean Birth Stratified by Race/Ethnicity**Reporting Period: 24 months**

Answer questions #6-8 based on all cases

- Surveys submitted prior to September 1:
 - 01/01/2023 – 12/31/2024
- Surveys (re)submitted on or after September 1:
 - 07/01/2023 – 06/30/2025

Note: As a reminder, the [Corrections Period](#) (December 1-January 31) is reserved for corrections to previously submitted Surveys only. Any updates made to reflect a change in performance must be made prior to the November 30 Late Submission and Performance Update Deadline. Updates made to reflect a change in performance after November 30 will not be scored or publicly reported.

6) 24-month reporting period used:	☐ 01/01/2023 – 12/31/2024 ☐ 07/01/2023 – 06/30/2025	
7) Did your hospital stratify NTSV cesarean births by race/ethnicity for the reporting period using the measure specifications provided and do you choose to report those data to this Survey? <i>If “no” to question #7, skip question #8 and continue to the next subsection.</i>	☐ Yes ☐ No	
8) Enter your hospital's responses below by race/ethnicity: <i>If the number of cases for a race/ethnicity is less than 10 (in column a), skip column b and then move to the next category. If zero, enter “0” in column a.</i>		
Race/ethnicity	a) Total number of nulliparous mothers that delivered a live term singleton newborn in the vertex presentation with ≥ 37 weeks of gestation completed, with Excluded Populations removed (denominator)	b) Total number of mothers indicated in question #8a that had their newborn delivered via cesarean section (numerator)
Non-Hispanic White	_____	_____
Non-Hispanic Black	_____	_____
Non-Hispanic American Indian or Alaska Native	_____	_____
Non-Hispanic Asian or Pacific Islander	_____	_____
Hispanic	_____	_____
Non-Hispanic Other (including two or more races)	_____	_____
Unknown	_____	_____

4C: Episiotomy

Hospitals that share a CMS Certification Number are required to report by facility. Please carefully review [Leapfrog's Multi-Campus Reporting Policy](#).

Important Note: Hospitals must use the same 12-month reporting period for all subsections in Section 4: Maternity Care, except for Section 4B questions #6-8.

Specifications: See [Episiotomy Measure Specifications](#) in the Reference Information beginning on page 172.

Reporting Period: 12 months

Answer questions #1-3 based on all cases.

- Surveys submitted prior to September 1:
 - 01/01/2024 – 12/31/2024
- Surveys (re)submitted on or after September 1:
 - 07/01/2024 – 06/30/2025

Note: As a reminder, the [Corrections Period](#) (December 1-January 31) is reserved for corrections to previously submitted Surveys only. Any updates made to reflect a change in performance must be made prior to the November 30 Late Submission and Performance Update Deadline. Updates made to reflect a change in performance after November 30 will not be scored or publicly reported.

1) 12-month reporting period used:	○ 01/01/2024 – 12/31/2024 ○ 07/01/2024 – 06/30/2025
2) Total number of vaginal deliveries, with Excluded Populations removed: <i>If fewer than 10 cases met the criteria for the denominator, skip question #3 and continue to the next subsection. The hospital will be scored as "Unable to Calculate Score."</i>	_____
3) Total number of mothers indicated in question #2 that had an episiotomy procedure performed:	_____

4D: Process Measures of Quality

Hospitals that share a CMS Certification Number are required to report by facility. Please carefully review [Leapfrog's Multi-Campus Reporting Policy](#).

Important Note: Hospitals must use the same 12-month reporting period for all subsections in Section 4: Maternity Care, except for Section 4B questions #6-8.

Specifications: See [Process Measures of Quality Measure Specifications](#) in the Reference Information beginning on page 173.

Reporting Period: 12 months

Answer questions #1-9 based on all cases (or a sufficient sample of them).

- Surveys submitted prior to September 1:
 - 01/01/2024 – 12/31/2024
- Surveys (re)submitted on or after September 1:
 - 07/01/2024 – 06/30/2025

Note: As a reminder, the [Corrections Period](#) (December 1-January 31) is reserved for corrections to previously submitted Surveys only. Any updates made to reflect a change in performance must be made prior to the November 30 Late Submission and Performance Update Deadline. Updates made to reflect a change in performance after November 30 will not be scored or publicly reported.

Sufficient Sample: See [Process Measures of Quality Measure Specifications](#) for instructions for identifying a sufficient sample for questions #3-4 and #7-8.

1) 12-month reporting period used:	☐ 01/01/2024 – 12/31/2024 ☐ 07/01/2024 – 06/30/2025
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Newborn Bilirubin Screening Prior to Discharge

2) Did your hospital perform a medical record audit on all cases (or a sufficient sample of them) and measure adherence to the newborn bilirubin screening prior to discharge clinical guideline? <i>If “no” to question #2, skip questions #3-5 and continue to question #6. The hospital will be scored as “Did Not Measure.”</i> <i>If “yes, but fewer than 10 cases met the inclusion criteria for the denominator,” skip questions #3-5 and continue to question #6. The hospital will be scored as “Unable to Calculate Score.”</i>	☐ Yes ☐ No ☐ Yes, but fewer than 10 cases met the inclusion criteria for the denominator
3) Number of cases measured against the guideline, either all cases or a sufficient sample of them (denominator):	_____
4) Number of cases in question #3 that adhere to the clinical process guideline (numerator):	_____
5) Do the responses in questions #3 and #4 represent a sample of cases?	☐ Yes ☐ No

Appropriate DVT Prophylaxis in Women Undergoing Cesarean Delivery

6) Did your hospital perform a medical record audit on all cases (or a sufficient sample of them) and measure adherence to the appropriate DVT prophylaxis in women undergoing cesarean delivery clinical guideline? <i>If “no” to question #6, skip questions #7-9 and continue to the next subsection. The hospital will be scored as “Did Not Measure.”</i> <i>If “yes, but fewer than 10 cases met the inclusion criteria for the denominator,” skip questions #7-9 and continue to the next subsection. The hospital will be scored as “Unable to Calculate Score.”</i>	☐ Yes ☐ No ☐ Yes, but fewer than 10 cases met the inclusion criteria for the denominator
7) Number of cases measured against the guideline, either all cases or a sufficient sample of them (denominator):	_____
8) Number of cases in question #7 that adhere to the clinical process guideline (numerator):	_____
9) Do the responses in questions #7 and #8 represent a sample of cases?	☐ Yes ☐ No

4E: High-Risk Deliveries

Hospitals that share a CMS Certification Number are required to report by facility. Please carefully review [Leapfrog's Multi-Campus Reporting Policy](#).

Important Note: Only include units that were open for the entire reporting period and that remain currently open.

1) Does your hospital electively admit high-risk deliveries ³⁰? <i>If “no” to question #1, skip the remaining questions in Section 4E, and go to the Affirmation of Accuracy. The hospital will be scored as “Does Not Apply.”</i>	☐ Yes ☐ No
2) Does your hospital operate a neonatal ICU (NICU), or is it co-located ³¹ with a hospital that operates a NICU, that admits or accepts transfers of very low birth weight babies ³²? <i>If “no” to question #2, skip the remaining questions in Section 4E, and go to the Affirmation of Accuracy. The hospital will be scored as “Limited Achievement.”</i> <i>If the NICU is co-located in another hospital and your hospital immediately transfers all complicated newborns there, answer question #3 and either questions #4-5 or #6-10 based on information pertaining to the co-located hospital's NICU.</i>	☐ Yes ☐ No
3) Hospitals that participate in the Vermont Oxford Network (VON) and have a recent 12-month report available may elect to report their hospital's Volume (questions #4-5) OR the VON's Death or Morbidity Measure ³³ (questions #6-10). Hospitals that do not participate in the Vermont Oxford Network should report their hospital's Volume (questions #4-5). Please indicate which measure the hospital will report on: <i>If you elect to report on Volume, answer questions #4-5 and skip questions #6-10.</i> <i>If you elect to report on the VON National Performance Measure, skip questions #4-5. Please ensure that you have entered an accurate VON Transfer Code in the Hospital Profile and submitted the Data Share Authorization letter to VON. Otherwise, you will be scored as “Declined to Respond.”</i>	☐ Volume ☐ VON National Performance Measure

Neonatal Intensive Care Unit(s) – Volume

Important Note: Hospitals must use the same 12-month reporting period for all subsections in Section 4: Maternity Care, except for Section 4B questions #6-8.

Specifications: See [Neonatal Intensive Care Unit\(s\) – Volume Measure Specifications](#) in the Reference Information beginning on page 173.

Reporting Period: 12 months

- Surveys submitted prior to September 1:
 - 01/01/2024 – 12/31/2024
- Surveys (re)submitted on or after September 1:
 - 07/01/2024 – 06/30/2025

Note: As a reminder, the [Corrections Period](#) (December 1-January 31) is reserved for corrections to previously submitted Surveys only. Any updates made to reflect a change in performance must be made prior to the November 30 Late Submission and Performance Update Deadline. Updates made to reflect a change in performance after November 30 will not be scored or publicly reported.

4) 12-month reporting period used:	○ 01/01/2024 – 12/31/2024 ○ 07/01/2024 – 06/30/2025
5) For the reporting period, how many very low birth weight babies were admitted to your hospital's neonatal intensive care unit(s)?	_____

Neonatal Intensive Care Unit(s) – National Performance Measurement

Important Note: Hospitals participating in the Vermont Oxford Network (VON) may opt to report on the VON National Performance Measure. In order for Leapfrog to obtain the data from VON, the VON data must be finalized, and hospitals must complete the following steps:

1. Provide an accurate [VON Transfer Code](#) in the Hospital Profile,
2. Complete a [Data Sharing Authorization](#) letter and submit it to [VON](#) by **June 16**. Hospitals that submitted their Data Sharing Authorization letter to VON in previous Leapfrog Hospital Survey Cycles do not have to re-submit a new letter in 2025.
3. Select “VON National Performance Measure” in question #3, and
4. Submit the 2025 Leapfrog Hospital Survey by the June 30 Submission Deadline.

Hospitals that select “VON National Performance Measure” in question #3, but do not adhere to the other steps will be scored and publicly reported as “Declined to Respond” for the High-Risk Deliveries measure.

Specifications: See [Neonatal Intensive Care Unit\(s\) – National Performance Measurement Measure Specifications](#) in the Reference Information beginning on page 173.

Reporting Period: 12 months

Responses are based on the latest **12-month** report received from the Vermont Oxford Network (VON) for the **Death or Morbidity Measure**.

- 2023 VON data
- 2024 VON data (*usually available after August 31*)

Leapfrog will update the VON data three times per Survey Cycle for all hospitals that have completed the steps noted above. See deadlines and reporting periods in the [Neonatal Intensive Care Unit\(s\) - National Performance Measurement Measure Specifications](#).

6) Most recent 12-month reporting period for which VON performance results are available:	No response required here. Determined automatically based on VON data.
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Section 4: Maternity Care

7) Hospital's volume based on VON report:	<i>No response required here. Determined automatically based on VON data.</i>
8) Hospital's standardized mortality ratio (SMR) 95% lower bound based on VON report:	<i>No response required here. Determined automatically based on VON data.</i>
9) Hospital's observed to expected ratio of morbidity or mortality (SMR shrunken) based on VON report:	<i>No response required here. Determined automatically based on VON data.</i>
10) Hospital's SMR 95% upper bound based on VON report:	<i>No response required here. Determined automatically based on VON data.</i>

Affirmation of Accuracy

As the hospital CEO or as an employee of the hospital to whom the hospital CEO has delegated responsibility, I have reviewed this information pertaining to the Maternity Care Section at our hospital, and I hereby certify that this information is true, accurate, and reflects the current, normal operating circumstances at our hospital. I am authorized to make this certification on behalf of our hospital.

The hospital and I understand that The Leapfrog Group, its members, the public and entities and persons who contract or have other business dealings with The Leapfrog Group are relying on the truth and accuracy of this information. The hospital and I also understand that The Leapfrog Group will make this information and/or analyses of this information public through the Survey Results public reporting website, The Leapfrog Group's Hospital Safety Grade, and/or other Leapfrog Group products and services. This information and/or analyses and all intellectual property rights therein shall be and remain the sole and exclusive property of The Leapfrog Group in which The Leapfrog Group retains exclusive ownership. This information does not infringe upon any third-party intellectual property rights or any other third-party rights whatsoever and is free and clear of all encumbrances and liens of any kind. The hospital and I acknowledge that The Leapfrog Group may use this information in a commercial manner for profit. The hospital shall be liable for and shall hold harmless and indemnify The Leapfrog Group from any and all damages, demands, costs, or causes of action resulting from any inaccuracies in the information or any misrepresentations in this Affirmation of Accuracy. The Leapfrog Group and its members and entities and persons who contract or have other business dealings with The Leapfrog Group reserve the right to omit or disclaim information that is not current, accurate or truthful.

Affirmed by _____, the hospital's _____,
(first name and last name) (title)
on _____.
(date)

Section 4: Maternity Care Reference Information

What's New in the 2025 Survey

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

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

Section 4A: Maternity Care Volume and Services

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

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

Section 4B: Cesarean Birth

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

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

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

Section 4C: Episiotomy

There are no changes to this subsection.

Section 4D: Process Measures of Quality

In response to feedback and consultation with our Maternity Care Expert Panel, Leapfrog is updating the measure specifications for Appropriate DVT Prophylaxis in Women Undergoing Cesarean Delivery to add further clarification regarding the timing of the prophylaxis. The numerator will continue to include women undergoing cesarean delivery that received either pneumatic compression devices prior to surgery or fractionated or unfractionated heparin or heparinoid. Beginning in 2026, Leapfrog plans to remove the inclusion of patients receiving heparin or heparinoid, unless they also received a pneumatic compression device prior to surgery. As a reminder, the target for this measure is 90%.

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

Section 4E: High-Risk Deliveries

Neonatal Intensive Care Unit(s) – National Performance Measurement

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

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

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

Change Summary Since Release

None. If substantive changes are made to this section of the Survey after release on April 1, 2025, they will be documented in this Change Summary section.

Section 4: Maternity Care Measure Specifications

Maternity Care Volume Measure Specifications

Important Note: Hospitals that share a CMS Certification Number are required to report by facility. Please carefully review [Leapfrog's Multi-Campus Reporting Policy](#).

Reporting Period: 12 months

- Surveys submitted prior to September 1:
 - 01/01/2024 – 12/31/2024
- Surveys (re)submitted on or after September 1:
 - 07/01/2024 – 06/30/2025

Question #3: The number of live births (i.e., infants) at this hospital location (inborn cases only), reported to your state during the reporting period.

Alternatively, the below list of Z codes can be used to identify live births, with the caution that these codes are coded for the newborn, not the mother; likely to be found in your hospital's birth CIS/medical record system; but often not in claims data since normal newborn care may be included in the mother's claim without baby's diagnosis coding.

Z38.00 – Z38.01: Single liveborn infant, born in hospital

Z38.30 – Z38.31: Twin liveborn infant, born in hospital

Z38.61 – Z38.69: Other multiple liveborn infant, born in hospital

Note: This data point is simply used to qualify a hospital for further reporting of the normal delivery measures.

Cesarean Birth Measure Specifications

Important Notes:

Note 1: Hospitals that share a CMS Certification Number are required to report by facility. Please carefully review [Leapfrog's Multi-Campus Reporting Policy](#).

Note 2: Leapfrog uses the specifications created by The Joint Commission (TJC) for the Cesarean Births measure. As such, Leapfrog will update its instructions annually, and more frequently if appropriate, to maintain alignment with TJC. Hospitals can access the TJC's measure specifications directly using the links in the table below.

Note 3: Cesarean Births (questions #2-3) can be reported based on all eligible cases OR a sufficient sample of cases as outlined in the denominator specifications for the 12-month reporting period. Cesarean Births Stratified by Race/Ethnicity (questions #7-8) must be reported based on all eligible cases for the 24-month reporting period.

Source: Joint Commission PC-02 (version 2024B): Discharges between 01/01/2024 – 12/31/2024 - version 2025A: Discharges between 01/01/2025 – 06/30/2025
Reporting Period: 12 months - Surveys submitted prior to September 1: 01/01/2024 – 12/31/2024 - Surveys (re)submitted on or after September 1: 07/01/2024 – 06/30/2025 Note: The discharge date must be used to determine whether a case falls within the reporting period specified. If you measured this quality indicator, reported the results to The Joint Commission (TJC), and continue to submit these data to The Joint Commission, use those data when responding to this subsection of the Survey. Leapfrog will accept data collected for either the chart-abstracted measure (PC-02) or the electronic clinical quality measure (ePC-02). Hospitals participating in the California Maternal Quality Care Collaborative (CMQCC) Maternal Data Center may use the data provided in CMQCC reports when responding to this subsection of the Survey. Download instructions for using the CMQCC reports on the Survey and CPOE Materials webpage. Hospitals participating in the Michigan Obstetrics Initiative (OBI) may use the data provided in OBI reports when responding to this subsection of the Survey. Otherwise, use TJC's PC-02 Cesarean Birth measure specifications to retrospectively collect and report data for this measure. The PC-02 measure specifications are outlined below based on discharge date. To access the measure specifications directly on The Joint Commission's website, see the specification manuals linked below: - version 2024B: Discharges between 01/01/2024 – 12/31/2024 - version 2025A: Discharges between 01/01/2025 – 06/30/2025 eCQM specifications can be found here.
Sampling Cases: Hospitals that report the Perinatal Care Measure Set to TJC may use the sampling methodology used by the TJC to report on questions #2-3. Otherwise, hospitals opting to identify a sufficient sample of mothers for this measure, in lieu of full case reporting, should follow the instructions below. Hospitals may refer to the TJC Measure Algorithm flow chart at the bottom of each set of specifications linked above, for an example of how to identify cases. <u>Sampling instructions for 01/01/2024 – 12/31/2024 discharges:</u> Review your hospital's first delivery as of April 15, 2024.

- Evaluate this case against the inclusion criteria; retain the case for the sample if it meets the inclusion criteria.
- Evaluate this case against the exclusion criteria; retain the case for the sample if it does not meet any of the listed exclusions.
- Move to the next delivery and evaluate for inclusion/exclusion applicability.
- Continue through cases in sequential order until **a sample of at least 30 cases** is reached, or all cases discharged during the reporting period are reviewed, whichever comes first.

When sampling for the 01/01/2024 – 12/31/2024 reporting period, use one set of measure specifications:

- version [2024B](#): Discharges between 01/01/2024 – 12/31/2024 (sample cases as of April 15, 2024)

Sampling instructions for 07/01/2024 – 06/30/2025 discharges:

Sampling requires hospitals to use two different sets of measure specifications and therefore sampling has two steps, both of which need to be completed

Step #1:

- Review your hospital's first delivery as of **July 15, 2024**.
- Evaluate this case against the inclusion criteria; retain the case for the sample if it meets the inclusion criteria.
- Evaluate this case against the exclusion criteria; retain the case for the sample if it does not meet any of the listed exclusions.
- Move to the next delivery and evaluate for inclusion/exclusion applicability.
- Continue through cases in sequential order until **a sample of at least 15 cases** is reached, or all cases discharged during the first 6-month reporting period of 07/01/2024 – 12/31/2024 are reviewed, whichever comes first.

Step #2:

- After sampling the first 15 cases, review your hospital's first delivery as of **January 15, 2025**.
- Evaluate this case against the inclusion criteria; retain the case for the sample if it meets the inclusion criteria.
- Evaluate this case against the exclusion criteria; retain the case for the sample if it does not meet any of the listed exclusions.
- Move to the next delivery and evaluate for inclusion/exclusion applicability.
- Continue through cases in sequential order until **a sample of at least 15 cases** is reached, or all cases discharged during the second 6-month reporting period of 01/01/2025 – 06/30/2025 are reviewed, whichever comes first.

When sampling for the 07/01/2024 – 06/30/2025 reporting period, use the measure specifications based on the correct discharge date, which are outlined below:

- version [2024B](#): Discharges between 07/01/2024 – 12/31/2024 (sample cases as of July 15, 2024)
- version [2025A](#): Discharges between 01/01/2025 – 06/30/2025 (sample cases of January 15, 2025)

Discharges between 01/01/2024 – 12/31/2024 (version 2024B)	Question #2 (denominator): Nulliparous patients delivered of a live term singleton newborn in vertex presentation with Excluded populations removed. <i>Note: The denominator should include both nulliparous mothers with a live term singleton newborn in vertex presentation that had their newborn delivered via cesarean section and nulliparous mothers that delivered vaginally.</i> Included Populations: • ICD-10-PCS Principal Procedure Code or ICD-10-PCS Other Procedure Codes for delivery as defined in Appendix A, Table 11.01.1 Delivery. • Nulliparous patients with ICD-10-CM Principal Diagnosis Code or ICD-10-CM Other Diagnosis Codes for outcome of delivery as
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	defined in Appendix A, Table 11.08 Outcome of Delivery and with a delivery of a newborn with 37 weeks or more of gestation completed. • <i>ICD-10-CM Principal Diagnosis Code or ICD-10 CM Other Diagnosis Codes</i> for term gestational age as defined in Appendix A, Table 11.10 Term Gestational Age Excluded Populations: • <i>ICD-10-CM Principal Diagnosis Code or ICD-10-CM Other Diagnosis Codes</i> for multiple gestations, abnormal presentations, and conditions justifying cesarean delivery as defined in Appendix A, Table 11.09 Multiple Gestations, Abnormal Presentations, and Conditions Justifying Cesarean Delivery • Less than 8 years of age • Greater than or equal to 65 years of age • Gestational Age < 37 weeks or Unable to Determine (UTD) Data Elements: Visit https://manual.jointcommission.org/releases/TJC2024B/MIF0167.html. If fewer than 10 cases during the reporting period, skip the next question. Question #3 (numerator): Patients in the denominator with cesarean births. Included Populations: <i>ICD-10-PCS Principal Procedure Code or ICD-10-PCS Other Procedure Codes</i> for cesarean birth as defined in Appendix A, Table 11.06 Cesarean Birth Excluded Populations: None Data Elements: Visit https://manual.jointcommission.org/releases/TJC2024B/MIF0167.html.
Discharges between 01/01/2025 – 06/30/2025 (version 2025A)	Question #2 (denominator): Nulliparous patients delivered of a live term singleton newborn in vertex presentation with Excluded populations removed. <i>Note: The denominator should include both nulliparous mothers with a live term singleton newborn in vertex presentation that had their newborn delivered via cesarean section and nulliparous mothers that delivered vaginally.</i> Included Populations: • <i>ICD-10-PCS Principal Procedure Code or ICD-10-PCS Other Procedure Codes</i> for delivery as defined in Appendix A, Table 11.01.1 Delivery. • Nulliparous patients with <i>ICD-10-CM Principal Diagnosis Code or ICD-10-CM Other Diagnosis Codes</i> for outcome of delivery as defined in Appendix A, Table 11.08 Outcome of Delivery and with a delivery of a newborn with 37 weeks or more of gestation completed. Excluded Populations: • <i>ICD-10-CM Principal Diagnosis Code or ICD-10-CM Other Diagnosis Codes</i> for multiple gestations, abnormal presentations, and conditions justifying cesarean delivery as defined in Appendix A, Table 11.09 Multiple Gestations, Abnormal Presentations, and Conditions Justifying Cesarean Delivery • Less than 8 years of age

	• Greater than or equal to 65 years of age • Gestational Age < 37 weeks or Unable to Determine (UTD) Data Elements: Visit https://manual.jointcommission.org/releases/TJC2025A/MIF0167.html. If fewer than 10 cases during the reporting period, skip the next question. Question #3 (numerator): Patients in the denominator with cesarean births. Included Populations: ICD-10-PCS Principal Procedure Code or ICD-10-PCS Other Procedure Codes for cesarean birth as defined in Appendix A, Table 11.06 Cesarean Birth Excluded Populations: None Data Elements: Visit https://manual.jointcommission.org/releases/TJC2025A/MIF0167.html.
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Cesarean Birth Stratified by Race/Ethnicity

Source: Joint Commission PC-02 • version 2024B: Discharges between 01/01/2023 – 12/31/2024 • version 2025A: Discharges between 01/01/2025 – 06/30/2025	
Reporting Period: 24 months • Surveys submitted prior to September 1: • 01/01/2023 – 12/31/2024 • Surveys (re)submitted on or after September 1: • 07/01/2023 – 06/30/2025 Note: The discharge date must be used to determine whether a case falls within the reporting period specified. When reporting on Cesarean Birth Stratified by Race/Ethnicity, hospitals must report using a 24-month reporting period as specified in question #6. Hospitals participating in the California Maternal Quality Care Collaborative (CMQCC) Maternal Data Center may use the data provided in CMQCC reports when responding to question #8. Download instructions for using the CMQCC reports on the Survey and CPOE Materials webpage. Hospitals reporting to the U.S. News & World Report Maternity Services Survey may use the data provided to U.S. News & World Report and the crosswalk provided below when responding to question #8. Otherwise, hospitals should use TJC's PC-02 Cesarean Birth measure specifications to retrospectively review all cases and then stratify those cases by race/ethnicity. The PC-02 measure specifications are outlined below based on the discharge date. To access the measure specifications directly on The Joint Commission's website, see the specification manuals linked below: • version 2024B: Discharges between 01/01/2023 – 12/31/2024 • version 2025A: Discharges between 01/01/2025 – 06/30/2025	
Discharges between 01/01/2023 – 12/31/2024 (version 2024B)	Question #8a (denominator): Total number of nulliparous patients delivered of a live term singleton newborn in vertex presentation with Excluded populations removed by the following races/ethnicities: • Non-Hispanic White • Non-Hispanic Black • Non-Hispanic American Indian or Alaska Native • Non-Hispanic Asian or Pacific Islander • Hispanic • Non-Hispanic Other (including two or more races)

- Unknown

Each patient should only be counted once and included in the appropriate race/ethnicity category based on known race/ethnicity information. If race or ethnicity is unknown, include the case in the “Unknown” category. Hispanic patients should be included in the “Hispanic” category regardless of race. If a race/ethnicity category is not used by your hospital, include the case in the “Unknown” category, i.e., if patients with more than one race are listed as “multiracial” regardless of their ethnicity, include these cases in the “Unknown” category. Hospitals that do not collect all races for patients that identify with multiple races are not able to report.

Hospitals reporting to U.S. News can use the below crosswalk when reporting to Leapfrog. Hospitals using CMQCC can use the below crosswalk or information provided directly in their Leapfrog CMQCC report:

CMQCC Race/Ethnicity	U.S. News Race/Ethnicity	Leapfrog Race/Ethnicity
Hispanic-US Born	Hispanic or Latino	Hispanic
Hispanic Non-US Born		
White	White	Non-Hispanic White
	Middle Eastern or North African	
Black	Black or African American	Non-Hispanic Black
Asian	Asian	Non-Hispanic Asian or Pacific Islander
Pacific Islander	Native Hawaiian or Pacific Islander	
Native American (American Indian or Alaska Native)	American Indian or Alaska Native	Non-Hispanic American Indian or Alaska Native
Other	N/A	Non-Hispanic Other (including two or more races)
Multiracial	Multiracial and/or Multiethnic	
Unknown	Unknown	Unknown

Note: The denominator should include both nulliparous mothers with a live term singleton newborn in vertex presentation that had their newborn delivered via cesarean section and nulliparous mothers that delivered vaginally.

Included Populations:

- ICD-10-PCS Principal Procedure Code or ICD-10-PCS Other Procedure Codes for delivery as defined in Appendix A, Table [11.01.1 Delivery](#).
- Nulliparous patients with ICD-10-CM Principal Diagnosis Code or ICD-10-CM Other Diagnosis Codes for outcome of delivery as defined in Appendix A, Table [11.08 Outcome of Delivery](#) and with a delivery of a newborn with 37 weeks or more of gestation completed.
- ICD-10-CM Principal Diagnosis Code or ICD-10 CM Other Diagnosis Codes for term gestational age as defined in Appendix A, [Table 11.10 Term Gestational Age](#)

Excluded Populations:

	• <i>ICD-10-CM Principal Diagnosis Code or ICD-10-CM Other Diagnosis Codes</i> for multiple gestations, abnormal presentations, and conditions justifying cesarean delivery as defined in Appendix A, Table 11.09 Multiple Gestations, Abnormal Presentations, and Conditions Justifying Cesarean Delivery • Less than 8 years of age • Greater than or equal to 65 years of age • Gestational Age < 37 weeks or Unable to Determine (UTD) Data Elements: Visit https://manual.jointcommission.org/releases/TJC2024B/MIF0167.html. If fewer than 10 cases during the reporting period for any race/ethnicity, skip the next question. Question #8b (numerator): Patients in the denominator with cesarean births by the following races/ethnicities: • Non-Hispanic White • Non-Hispanic Black • Non-Hispanic American Indian or Alaska Native • Non-Hispanic Asian or Pacific Islander • Hispanic • Non-Hispanic Other (including two or more races) • Unknown Included Populations: <i>ICD-10-PCS Principal Procedure Code or ICD-10-PCS Other Procedure Codes</i> for cesarean birth as defined in Appendix A, Table 11.06 Cesarean Birth Excluded Populations: None Data Elements: Visit https://manual.jointcommission.org/releases/TJC2024B/MIF0167.html.
Discharges between 01/01/2025 – 06/30/2025 (version 2025A)	Question #8a (denominator): Total number of nulliparous patients delivered of a live term singleton newborn in vertex presentation with Excluded populations removed by the following races/ethnicities: • Non-Hispanic White • Non-Hispanic Black • Non-Hispanic American Indian or Alaska Native • Non-Hispanic Asian or Pacific Islander • Hispanic • Non-Hispanic Other (including two or more races) • Unknown Each patient should only be counted once and included in the appropriate race/ethnicity category based on known race/ethnicity information. If race or ethnicity is unknown, include the case in the “Unknown” category. Hispanic patients should be included in the “Hispanic” category regardless of race. If a race/ethnicity category is not used by your hospital, include the case in the “Unknown” category, i.e., if patients with more than one race are listed as “multiracial” regardless of their ethnicity, include these cases in the “Unknown” category. Hospitals that do not collect all races for patients that identify with multiple races are not able to report. Hospitals reporting to U.S. News can use the below crosswalk when reporting to Leapfrog. Hospitals using CMQCC can use the below crosswalk or information provided directly in their Leapfrog CMQCC report:

CMQCC Race/Ethnicity	U.S. News Race/Ethnicity	Leapfrog Race/Ethnicity
Hispanic-US Born	Hispanic or Latino	Hispanic
Hispanic Non-US Born		
White	White	Non-Hispanic White
	Middle Eastern or North African	
Black	Black or African American	Non-Hispanic Black
Asian	Asian	Non-Hispanic Asian or Pacific Islander
Pacific Islander	Native Hawaiian or Pacific Islander	
Native American (American Indian or Alaska Native)	American Indian or Alaska Native	Non-Hispanic American Indian or Alaska Native
Other	N/A	Non-Hispanic Other (including two or more races)
Multiracial	Multiracial and/or Multiethnic	
Unknown	Unknown	Unknown

Note: The denominator should include both nulliparous mothers with a live term singleton newborn in vertex presentation that had their newborn delivered via cesarean section and nulliparous mothers that delivered vaginally.

Included Populations:

- ICD-10-PCS Principal Procedure Code or ICD-10-PCS Other Procedure Codes for delivery as defined in Appendix A, Table [11.01.1 Delivery](#).
- Nulliparous patients with ICD-10-CM Principal Diagnosis Code or ICD-10-CM Other Diagnosis Codes for outcome of delivery as defined in Appendix A, Table [11.08 Outcome of Delivery](#) and with a delivery of a newborn with 37 weeks or more of gestation completed.

Excluded Populations:

- ICD-10-CM Principal Diagnosis Code or ICD-10-CM Other Diagnosis Codes for multiple gestations abnormal presentations and conditions justifying cesarean delivery as defined in Appendix A, Table [11.09 Multiple Gestations, Abnormal Presentations, and Conditions Justifying Cesarean Delivery](#)
- Less than 8 years of age
- Greater than or equal to 65 years of age
- [Gestational Age](#) < 37 weeks or Unable to Determine (UTD)

Data Elements: Visit

<https://manual.jointcommission.org/releases/TJC2025A/MIF0167.html>.

If fewer than 10 cases during the reporting period, skip the next question.

	Question #8b (numerator): Patients in the denominator with cesarean births by the following races/ethnicities: • Non-Hispanic White • Non-Hispanic Black • Non-Hispanic American Indian or Alaska Native • Non-Hispanic Asian or Pacific Islander • Hispanic • Non-Hispanic Other (including two or more races) • Unknown Included Populations: <i>ICD-10-PCS Principal Procedure Code or ICD-10-PCS Other Procedure Codes</i> for cesarean birth as defined in Appendix A, Table 11.06 Cesarean Birth Excluded Populations: None Data Elements: Visit https://manual.jointcommission.org/releases/TJC2025A/MIF0167.html
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Episiotomy Measure Specifications

Important Note: Hospitals that share a CMS Certification Number are required to report by facility. Please carefully review [Leapfrog's Multi-Campus Reporting Policy](#).

Source: National Quality Forum #0470
Reporting Period: 12 months - Surveys submitted prior to September 1: 01/01/2024 – 12/31/2024 - Surveys (re)submitted on or after September 1: 07/01/2024 – 06/30/2025 Note: The discharge date must be used to determine whether a case falls within the reporting period specified.
Hospitals participating in the California Maternal Quality Care Collaborative (CMQCC) Maternal Data Center may use the data provided in CMQCC reports when responding to this subsection of the Survey. Download instructions for using the CMQCC reports on the Survey and CPOE Materials webpage.
Question #2 (denominator): Total number of vaginal deliveries during the reporting period, with Excluded Populations removed. For the purposes of this measure, use the following MS-DRGs to identify a vaginal delivery: 768: Vaginal delivery with O.R. procedure except sterilization and/or D&C 796: Vaginal delivery with sterilization/D&C with MCC 797: Vaginal delivery with sterilization/D&C with CC 798: Vaginal delivery with sterilization/D&C without CC/MCC 805: Vaginal delivery without sterilization/D&C with MCC 806: Vaginal delivery without sterilization/D&C with CC 807: Vaginal delivery without sterilization/D&C without CC/MCC The following APR-DRGs should also be used to identify a vaginal delivery if your hospital uses APR-DRG coding: 541: Vaginal delivery with sterilization and/or D&C 542: Vaginal delivery with complicating procedures excluding sterilization and/or D&C 560: Vaginal delivery The following Tricare DRGs should also be used to identify a vaginal delivery if your hospitals uses Tricare DRG coding: 762 Vaginal delivery with sterilization or D&C with MCC 763 Vaginal delivery with sterilization or D&C with CC 764 Vaginal delivery with sterilization or D&C without CC/MCC 768 Vaginal delivery with O.R. procedure except sterilization and/or D&C 805 Vaginal delivery without sterilization or D&C with MCC 806 Vaginal delivery without sterilization or D&C with CC 807 Vaginal delivery without sterilization or D&C without CC/MCC Excluded Populations: Exclude any cases with the following ICD-10-CM diagnostic code in any field: - O66.0: Obstructed labor due to shoulder dystocia
Question #3 (numerator): Total number of mothers included in question #2 (the denominator) that had an episiotomy procedure performed. For the purposes of this measure, the following ICD-10-PCS procedure codes should be used for identifying an episiotomy: 0W8NXZZ: Division of female perineum, external approach

Process Measures of Quality Measure Specifications

Important Notes:

Note 1: Hospitals that share a CMS Certification Number are required to report by facility. Please carefully review [Leapfrog's Multi-Campus Reporting Policy](#).

Note 2: For Maternity Care Process Measures, hospitals with a sufficient sample size (as defined below), can randomly sample for the denominator of each indicator, and measure and report adherence based on that sample. Most likely, the numerator criteria for these two measures will require medical chart review if these specific data are not already extracted or coded consistently for other purposes.

Newborn Bilirubin Screening Prior to Discharge

Source: Providence Health
Reporting Period: 12 months - Surveys submitted prior to September 1: 01/01/2024 – 12/31/2024 - Surveys (re)submitted on or after September 1: 07/01/2024 – 06/30/2025 Note: The discharge date must be used to determine whether a case falls within the reporting period specified.
Hospitals participating in the California Maternal Quality Care Collaborative (CMQCC) Maternal Data Center may use the data provided in CMQCC reports when responding to this subsection of the Survey. Download instructions for using the CMQCC reports on the Survey and CPOE Materials webpage .
Sampling: If you have <u>fewer than 30 cases</u> that meet the criteria for inclusion in the denominator of the process measure during the time period of the medical record audit, include ALL of these cases in measuring adherence to the process guidelines. You need NOT use more than 12 months of historical data to increase the eligible cases beyond 30; just measure and report on ALL eligible cases that you have in that reporting period. If you have <u>more than 30 cases</u> that meet the criteria for inclusion in the denominator of the process measure during the time period of the medical record audit, you may randomly sample at least 30 of them for the denominator of each guideline, and measure and report adherence based on that sample.
Question #3 (denominator): Eligible cases include all normal newborns born at or beyond 35 completed weeks gestation that were delivered in the hospital during the reporting period (all inborns) with Excluded Populations removed. Excluded Populations: - admitted to a neonatal ICU, either at your hospital or another hospital; or - with parental refusal to test; or - prenatal documentation of severe congenital anomalies in the newborn and documentation that the newborn will receive comfort care measures only; or - newborn died prior to discharge
Question #4 (numerator): Number of eligible cases included in the denominator who have a serum or transcutaneous bilirubin screen prior to discharge to identify risk of hyperbilirubinemia.

Appropriate DVT Prophylaxis in Women Undergoing Cesarean Delivery

Source: National Quality Forum #0473
Reporting Period: 12 months • Surveys submitted prior to September 1: ◦ 01/01/2024 – 12/31/2024 • Surveys (re)submitted on or after September 1: ◦ 07/01/2024 – 06/30/2025 Note: The discharge date must be used to determine whether a case falls within the reporting period specified.
Hospitals participating in the California Maternal Quality Care Collaborative (CMQCC) Maternal Data Center may use the data provided in CMQCC reports when responding to this subsection of the Survey. Download instructions for using the CMQCC reports on the Survey and CPOE Materials webpage.
Sampling: If you have <u>fewer than 30 cases</u> that meet the criteria for inclusion in the denominator of the process measure during the time period of the medical record audit, include ALL of these cases in measuring adherence to the process guidelines. You need NOT use more than 12 months of historical data to increase the eligible cases beyond 30; just measure and report on ALL eligible cases that you have in that reporting period. If you have <u>more than 30 cases</u> that meet the criteria for inclusion in the denominator of the process measure during the time period of the medical record audit, you may randomly sample at least 30 of them for the denominator of each guideline, and measure and report adherence based on that sample.
Question #7 (denominator): Eligible cases include all women undergoing cesarean delivery during the reporting period. Include cases with one of the following MS-DRG codes: • 783: Cesarean section with sterilization with MCC • 784: Cesarean section with sterilization with CC • 785: Cesarean section with sterilization without CC/MCC • 786: Cesarean section without sterilization with MCC • 787: Cesarean section without sterilization with CC • 788: Cesarean section without sterilization without CC/MCC The following APR-DRGs should also be used to identify a cesarean delivery if your hospital uses APR-DRG coding: • 539: Cesarean section with sterilization • 540: Cesarean section without sterilization The following Tricare DRGs should also be used to identify a cesarean delivery if your hospitals uses Tricare DRG coding: • 771 Cesarean section without sterilization with MCC • 772 Cesarean section without sterilization with CC • 773 Cesarean section without sterilization without CC/MCC • 783 Cesarean section with sterilization with MCC • 784 Cesarean section with sterilization with CC • 785 Cesarean section with sterilization without CC/MCC
Excluded Populations: None.
Question #8 (numerator) Number of eligible cases included in the denominator who received either • fractionated or unfractionated heparin or heparinoid, or • pneumatic compression devices prior to surgery. Note: Use of a pneumatic compression device may be documented in the OR log but must be placed pre-operatively to qualify for inclusion in the numerator. For a list of approved pneumatic compression devices, see the devices listed under “Intermittent Pneumatic Compression Device (IPC)” in Table 2.1 VTE Prophylaxis Inclusion Table.

High-Risk Deliveries Measure Specifications**Important Notes:**

Note 1: Hospitals that share a CMS Certification Number are required to report by facility. Please carefully review [Leapfrog's Multi-Campus Reporting Policy](#).

Note 2: Hospitals should report on the selection from Section 4E question #3 (**either** Volume OR the National Performance Measure (VON)).

Neonatal Intensive Care Unit(s) – Volume

Hospitals opting to report on Volume should only use ICD-10-CM codes as indicated in the specifications below. When calculating hospital volume, count the number of patients with any one or more of the specified diagnosis codes for high-risk deliveries, subject to the other inclusion/exclusion criteria below. The diagnosis codes may be in any field. The count can include inborn as well as transfer cases.

Source: The Leapfrog Group	
Reporting Period: 12 months - Surveys submitted prior to September 1: 01/01/2024 – 12/31/2024 - Surveys (re)submitted on or after September 1: 07/01/2024 – 06/30/2025	
Note: The discharge date must be used to determine whether a case falls within the reporting period specified.	
Question #5 (Instructions for Volume Reporting)	
Included Populations: Number of newborns admitted to the neonatal ICU with the following ICD-10-CM codes:	
ICD-10-CM Code	Description
P05.02	Newborn light for gestational age, 500-749 grams
P05.03	Newborn light for gestational age, 750-999 grams
P05.04	Newborn light for gestational age, 1000-1249 grams
P05.05	Newborn light for gestational age, 1250-1499 grams
P05.12	Newborn small for gestational age, 500-749 grams
P05.13	Newborn small for gestational age, 750-999 grams
P05.14	Newborn small for gestational age, 1000-1249 grams
P05.15	Newborn small for gestational age, 1250-1499 grams
P05.2	Newborn affected by fetal malnutrition not light or small for gestational age
P05.9	Newborn affected by slow intrauterine growth, unspecified
P07.02	Extremely low birth weight newborn, 500-749 grams
P07.03	Extremely low birth weight newborn, 750-999 grams
P07.14	Other low birth weight newborn, 1000-1249 grams
P07.15	Other low birth weight newborn, 1250-1499 grams
Excluded Populations: Newborns admitted to the neonatal ICU weighing 1500 grams or more.	

Neonatal Intensive Care Unit(s) – National Performance Measurement

Hospitals participating in the Vermont Oxford Network (VON) may opt to report on the VON National Performance Measure. In order for Leapfrog to obtain the data from VON, the VON data must be finalized, and hospitals must complete the following steps:

1. Provide an accurate [VON Transfer Code](#) in the Hospital Profile,
2. Complete a [Data Sharing Authorization](#) letter and submit it to [VON](#) by **June 16** (Hospitals that submitted their Data Sharing Authorization letter to VON in previous Leapfrog Hospital Survey Cycles do not have to re-submit a new letter in 2025),
3. Select “VON National Performance Measure” in question #3, and
4. Submit the 2025 Leapfrog Hospital Survey by the June 30 Submission Deadline.

Hospitals that select “VON National Performance Measure” in question #3, but do not adhere to the other steps will be scored and publicly reported as “Declined to Respond” for the High-Risk Deliveries measure.

Data will be available for review on the Leapfrog Hospital Survey Hospital Details Page beginning on July 12. The VON data Leapfrog obtains can be found in the Vermont Oxford Network’s Nightingale Internet Reporting System. Leapfrog has provided instructions for using the VON Nightingale online tool on the [Survey and CPOE Materials webpage](#). These instructions can be used to verify the data that Leapfrog is obtaining from VON, which includes:

Variable	From the Vermont Oxford Network (SMR Report from Nightingale online tool)
Volume	From the latest 12-month standardized mortality or morbidity ratio (SMR) report for Death or Morbidity, the hospital’s “N” for the volume of cases for the reporting period.
SMR 95% (lower bound)	From the same report, the hospital’s “SMR 95% (lower)” for Death or Morbidity. This represents the lower value of your hospital’s 95% confidence interval.
SMR (shrunk)	From the same report, the hospital’s “SMR (shrunk)” for Death or Morbidity. This is the weighted average of the hospital value and the population (Vermont Oxford Network) mean value.
SMR 95% (upper bound)	From the same report, the hospital’s “SMR 95% (upper)” for Death or Morbidity. This represents the upper value of your hospital’s 95% confidence interval.

Deadlines and Reporting Periods

Leapfrog will update the VON data three times per Survey Cycle for all hospitals that have completed the steps noted above according to the deadlines and reporting periods listed in the following table:

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

* Hospitals that successfully submitted a Data Sharing Authorization letter in previous years are not required to submit another letter in 2025.

**Anticipated release of 2024 VON data.

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

See [FAQs](#) for additional information about responding to the questions in this section.

Section 4: Maternity Care Frequently Asked Questions (FAQs)

- 1. Under normal circumstances our hospital does not perform newborn deliveries. However, during the reporting period we had a few emergency situations and/or transfers. Should we indicate delivering newborns during the reporting period?**

If your hospital does not electively perform newborn deliveries (i.e., no labor/delivery unit, only admit in an emergency situation), you would respond “no” to question #2 in Section 4A, as hospitals are instructed to report inborns only.

- 2. Should newborns that are delivered outside of the hospital that are brought to labor and delivery be included in the total number of live births in Section 4A?**

When calculating the total number of live births in Section 4A question #3, refer to the measure specifications for Maternity Care Volume. Only inborns should be included in the total volume.

- 3. Should hospitals use delivery date or discharge date when including births/cases for the measures reported in Section 4: Maternity Care?**

The discharge date should be used to determine whether a case falls within the reporting period specified.

- 4. What would qualify as offering breastfeeding/lactation consultants “at home after discharge” for the purposes of question #6 in Section 4A?**

“At home after discharge” includes lactation services provided in the home either in-person or via telehealth with video capabilities. A phone call would not be sufficient.

- 5. Can our hospital answer “yes” to question #8 in Section 4A if we offer pre-planned postpartum tubal ligation during the labor and delivery admission?**

Yes, the tubal ligation can be pre-planned and would qualify if you offer this during the labor and delivery admission.

- 6. In Section 4D, what tools should hospitals use for managing patients that receive a serum or transcutaneous bilirubin screen to assess the risk of hyperbilirubinemia prior to discharge?**

One example a hospital can use is the Bhutani Nomogram. For an example, please see: *American Academy of Pediatrics Clinical Practice Guidelines: Management of Hyperbilirubinemia in the Newborn Infant 35 or More Weeks of Gestation*.

<http://pediatrics.aappublications.org/content/114/1/297.full>

Tip: To view any Figure in the reference, click on it to open, then again to enlarge.

Other tools may also be used if the serum or transcutaneous screen is conducted prior to discharge and risk is managed appropriately.

- 7. In Section 4D, what codes or diagnoses should be used to identify severe congenital anomalies for exclusions for newborn bilirubin screening prior to discharge?**

Leapfrog’s Maternity Care Expert Panel has opted to not overcomplicate the measure by providing ICD-codes for identifying congenital anomalies in the newborn. Instead, we would suggest that you focus on identifying the following exclusions: documentation that the newborn will receive comfort care measures only, which would accompany the prenatal documentation of severe congenital anomalies in the newborn.

If you have concerns about the level of effort required to identify these exclusions, please note that Leapfrog allows hospitals to report on a sample of 30 cases for those facilities that opt to report on a sample instead of full case reporting. You can find those instructions in the [Maternity Care Process Measure Specifications](#).

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SECTION 5: PHYSICIAN AND NURSE STAFFING

This section includes questions and reference information for Section 5: Physician and Nurse Staffing. Please carefully review the questions, endnotes, and reference information (e.g., measure specifications, notes, and frequently asked questions) before you begin. Failure to review the reference information could result in inaccurate responses.

Section 5: Physician and Nurse Staffing

Adult and Pediatric ICU Physician Staffing Fact Sheet and Bibliography:

<https://ratings.leapfroggroup.org/measure/hospital/2025/specially-trained-doctors-care-critical-care-patients>

Nursing Workforce Fact Sheet and Bibliography:

<https://ratings.leapfroggroup.org/measure/hospital/2025/nursing-workforce>

Hospitals that do not admit adult critical care patients or operate an adult general medical, surgical, medical/surgical, or neuro ICU should select “No” in question #2 in Section 5A: Adult ICU Physician Staffing and move on to Section 5B: Pediatric ICU Physician Staffing. Hospitals that do not admit pediatric critical care patients or operate a pediatric general medical, surgical, medical/surgical, or neuro ICU should select “No” in question #2 in Section 5B: Pediatric ICU Physician Staffing and move on to Section 5C: Nursing Workforce.

Hospitals that regularly admit adult and/or pediatric critical care patients to a mixed acuity unit, should select “Yes” in question #2 in Section 5A: Adult ICU Physician Staffing and/or Section 5B: Pediatric ICU Physician Staffing and respond to all applicable questions. The standard applies to all adult and pediatric general medical, surgical, medical/surgical, and neuro critical care patients (medical and surgical), including those patients in mixed acuity units.

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

Section 5 includes questions about the management of critical care patients and the staffing structure of your hospital's adult and pediatric general medical, surgical, medical/surgical, and neuro ICUs, and questions about your hospital's nursing staffing and skill mix (previously included in Section 6).

Each hospital achieving the standard for Adult and/or Pediatric ICU Physician Staffing assures that:

All critical care patients³⁴ in its General Medical, Surgical, Medical/Surgical, and Neuro ICUs¹⁴ are managed or co-managed³⁵ by physicians certified in critical care medicine³⁶ who:

- Are ordinarily present in the ICU³⁷ during daytime hours for at least 8 hours per day, 7 days per week, and during this time provide clinical care exclusively³⁷ in the ICU
OR
- Are present via telemedicine³⁸, in combination with on-site intensivist coverage, for a total of 24 hours per day, 7 days per week; meet all of Leapfrog's ICU requirements for intensivist presence in the ICU via telemedicine; and supported by an on-site intensivist who establishes and revises the daily care plan for each ICU patient, **and**
- At other times*
 - Return more than 95% of ICU calls within 5 minutes, based on a quantified analysis³⁹ of notification device response time; and
 - Can rely on a physician, physician assistant, nurse practitioner⁴², or an FCCS-certified nurse “effector”⁴⁰ who is in the hospital and able to reach ICU patients within 5 minutes in more than 95% of cases, based on a quantified hospital analysis of response time of the effector reaching the patient.

*Not applicable for hospitals with 24/7 intensivist coverage.

Each hospital achieving the standard for Total Nursing Care Hours per Patient Day:

Has a ratio of total nursing care hours per patient day that is greater than or equal to the 50th percentile (where higher is better) for that hospital's cohort (small teaching, large teaching, non-teaching, mixed acuity, pediatric, or critical access hospital).

Each hospital achieving the standard for RN Hours per Patient Day:

Has a ratio of RN hours per patient day that is greater than or equal to the 50th percentile (where higher is better) for that hospital's cohort (small teaching, large teaching, non-teaching, mixed acuity, pediatric, or critical access hospital).

Each hospital achieving the standard for Nursing Skill Mix:

Has a percentage of total productive nursing hours worked by RN nursing staff that is higher than or equal to the 50th percentile (where higher is better) for the hospital's cohort (small teaching, large teaching, non-teaching, mixed acuity, pediatric, or critical access hospitals).

Each hospital achieving the standard for Percentage of RNs who are BSN-Prepared:

Has a percentage of RNs who are BSN-prepared that is greater than or equal to 80%.

Download the 2025 Leapfrog Hospital Survey Scoring Algorithm on the [Scoring and Results webpage](#).

5A: Adult ICU Physician Staffing

Hospitals that share a CMS Certification Number are required to report by facility. Please carefully review [Leapfrog's Multi-Campus Reporting Policy](#).

Important Notes:

Note 1: Each of the endnotes referenced in the questions below must be reviewed before responding to each question.

Note 2: Some intensivist “presence” may be accomplished via tele-intensivists per Leapfrog’s specifications ([More Information](#)³⁸). However, at this time hospitals cannot achieve the standard through the sole use of tele-intensivists.

Note 3: On an interim basis, other categories of physicians may be considered by Leapfrog to be “certified in Critical Care Medicine” ([More Information](#)³⁶).

Note 4: The standard applies to all adult general medical, surgical, medical/surgical, and neuro critical care patients (medical and surgical), including those patients in mixed acuity units.

Reporting Period: 3 months

Answer questions #1-15 based on the staffing structure currently in place at the time that you submit this section of the Survey. The staffing structure should have been in place for at least the past 3 months and reflect the ordinary staffing structure for each applicable ICU.

Note: As a reminder, the [Corrections Period](#) (December 1-January 31) is reserved for corrections to previously submitted Surveys only. Any updates made to reflect a change in performance must be made prior to the November 30 Late Submission and Performance Update Deadline. Updates made to reflect a change in performance after November 30 will not be scored or publicly reported.

1) What is the latest 3-month reporting period for which your hospital is submitting responses to this section? 3 months ending:	_____ Format: Month/Year
2) Does your hospital operate any adult General Medical, Surgical, Medical/Surgical, or Neuro ICUs ¹⁴ ? <i>If your hospital has more than one applicable adult ICU, respond to all questions in this section based on the adult ICU that has the lowest level of staffing by physicians certified in critical care medicine (More Information¹⁴).</i> <i>If your hospital does not operate an applicable adult ICU but regularly admits adult critical care patients to mixed acuity units, select “yes” and respond to the remaining questions in Section 5A.</i> <i>If “no” to question #2, skip the remaining questions in Section 5A and continue to the next subsection. The hospital will be scored as “Does Not Apply.”</i>	☐ Yes ☐ No
3) Is the ICU staffed with physicians who are certified in critical care medicine ³⁶ and present on-site or via telemedicine? <i>If “no, the ICU is not staffed with any physicians certified in critical care medicine” to question #3, skip the remaining</i>	☐ Yes, the ICU is staffed with physicians certified in critical care medicine ☐ Yes, the ICU is staffed with physicians certified in critical care medicine

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Section 5: Physician and Nurse Staffing

questions in Section 5A and continue to the next subsection. This hospital will be scored as “Limited Achievement.”	based on Leapfrog’s expanded definition ○ No, the ICU is not staffed with any physicians certified in critical care medicine
4) Do the physicians who are certified in critical care medicine³⁶ (whether present on-site or via telemedicine) manage or co-manage all critical care patients³⁴ in the ICU? If “no” to question #4, skip questions #5-11 and continue to question #12.	○ Yes, all patients are managed or co-managed by a physician certified in critical care medicine when the physician is present (on-site or via telemedicine) ○ No, not all patients are managed or co-managed by a physician certified in critical care medicine when the physician is present (on-site or via telemedicine)

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

5) Are all critical care patients³⁴ in the ICU managed or co-managed³⁵ by one or more physicians certified in critical care medicine³⁶ who meet all the following criteria: • ordinarily present³⁷ on-site in the ICU during daytime hours; • for at least 8 hours per day, 7 days per week; and • providing clinical care exclusively³⁷ in the ICU during these hours? If “yes” to question #5, skip question #6 and continue to question #7.	○ Yes ○ No
6) Are all critical care patients³⁴ in the ICU managed or co-managed³⁵ by one or more physicians certified in critical care medicine³⁶ who meet all the following criteria: • present via telemedicine, in combination with on-site intensivist coverage, for a total of 24 hours per day, 7 days per week; • meet all of Leapfrog’s ICU requirements for intensivist presence in the ICU via telemedicine (More Information³⁸); and • supported by an on-site intensivist who establishes and revises the daily care plan for each ICU patient?	○ Yes ○ No

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

7) When the physicians (from question #3) are not present in the ICU on-site or via telemedicine, do they return more than 95% of calls/pages/texts from these units within five minutes, based on a quantified analysis³⁹ of notification device response time? (More information on the use of telemedicine to cover calls⁴¹)	○ Yes ○ No ○ Not applicable; intensivists are present on-site 24/7
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Section 5: Physician and Nurse Staffing

8) When the physicians (from question #3) are not present on-site in the ICU or not able to physically reach an ICU patient within 5 minutes, can they rely on a physician, physician assistant, nurse practitioner ⁴² , or FCCS-certified nurse or intern “effector” ⁴⁰ who is in the hospital and able to reach these ICU patients within five minutes in more than 95% of the cases, based on a quantified analysis ³⁹ of response time of the effector reaching the patient?	☐ Yes ☐ No ☐ Not applicable; intensivists are present on-site 24/7
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If “no” to either question #7 or #8 in this section, continue to questions #9-15. If “yes” or “not applicable; intensivists are present on-site 24/7” to questions #7 and #8, skip the remaining questions in Section 5A and continue to the next subsection.

9) Are all critical care patients ³⁴ in the ICU managed or co-managed ³⁵ by one or more physicians certified in critical care medicine ³⁶ who meet all the following criteria: • ordinarily present³⁷ on-site in the ICU during daytime hours; • for at least 8 hours per day, 4 days per week or 4 hours per day, 7 days per week; and • providing clinical care exclusively³⁷ in the ICU during these hours?	☐ Yes ☐ No
10) Are all critical care patients ³⁴ in the ICU managed or co-managed ³⁵ by one or more physicians certified in critical care medicine ³⁶ who meet all the following criteria: • present via telemedicine for 24 hours per day, 7 days per week; • meet all of Leapfrog’s modified ICU requirements for intensivist presence in the ICU via telemedicine (More Information⁴³); and • supported in the establishment and revision of daily care planning for each ICU patient by an on-site intensivist, hospitalist, anesthesiologist, or physician trained in emergency medicine?	☐ Yes ☐ No
11) Are all critical care patients ³⁴ in the ICU managed or co-managed ³⁵ by one or more physicians certified in critical care medicine ³⁶ who are: • on-site at least 4 days per week to establish or revise daily care plans for each critical care patient in the ICU?	☐ Yes ☐ No

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

12) If not all critical care patients ³⁴ are managed or co-managed ³⁵ by physicians certified in critical care medicine ³⁶ , either on-site or via telemedicine ³⁸ , are some critical care patients managed or co-managed by these physicians who are: • ordinarily present³⁷ on-site in the ICU during daytime hours; • for at least 8 hours per day, 4 days per week or 4 hours per day, 7 days per week; and • providing clinical care exclusively³⁷ in the ICU during these hours?	☐ Yes ☐ No
13) Does an on-site clinical pharmacist do all the following: • at least 5 days per week, makes daily on-site rounds on all critical care patients³⁴ in the ICU; and • on the other 2 days per week, returns more than 95% of calls/pages/texts from the unit within 5 minutes, based on a quantified analysis³⁹ of notification device response time; OR • makes daily on-site rounds on all critical care patients³⁴ in the ICU 7 days per week?	☐ Yes ☐ No ☐ Clinical pharmacist rounds 7 days per week

14) Does a physician certified in critical care medicine³⁶ lead daily interprofessional rounds on-site on all critical care patients³⁴ in the ICU 7 days per week?	☐ Yes ☐ No
15) Are physicians certified in critical care medicine³⁶ responsible for all ICU admission and discharge decisions when they are: • present on-site for at least 8 hours per day, 4 days per week or 4 hours per day, 7 days per week?	☐ Yes ☐ No

5B: Pediatric ICU Physician Staffing

Hospitals that share a CMS Certification Number are required to report by facility. Please carefully review [Leapfrog's Multi-Campus Reporting Policy](#).

Important Notes:

Note 1: Each of the endnotes referenced in the questions below must be reviewed before responding to each question.

Note 2: Some intensivist “presence” may be accomplished via tele-intensivists per Leapfrog’s specifications ([More Information](#)³⁸). However, at this time hospitals cannot achieve the standard through the sole use of tele-intensivists.

Note 3: On an interim basis, other categories of physicians may be considered by Leapfrog to be “certified in Critical Care Medicine” ([More Information](#)³⁶).

Note 4: The standard applies to all pediatric general medical, surgical, medical/surgical, and neuro critical care pediatric patients (medical and surgical), including those pediatric patients in mixed acuity units.

Reporting Period: 3 months

Answer questions #1-15 based on the staffing structure currently in place at the time that you submit this section of the Survey. The staffing structure should have been in place for at least the past 3 months and reflect the ordinary staffing structure for each applicable ICU.

Note: As a reminder, the [Corrections Period](#) (December 1-January 31) is reserved for corrections to previously submitted Surveys only. Any updates made to reflect a change in performance must be made prior to the November 30 Late Submission and Performance Update Deadline. Updates made to reflect a change in performance after November 30 will not be scored or publicly reported.

1) What is the latest 3-month reporting period for which your hospital is submitting responses to this section? 3 months ending:	_____ <i>Format: Month/Year</i>
2) Does your hospital operate any pediatric General Medical, Surgical, Medical/Surgical, or Neuro ICUs¹⁴? <i>If your hospital has more than one applicable pediatric ICU, respond to all questions in this section based on the pediatric ICU that has the lowest level of staffing by physicians certified in critical care medicine (More Information¹⁴).</i> <i>If your hospital does not operate an applicable pediatric ICU but regularly admits critical care pediatric patients to mixed acuity units, select “yes” and respond to the remaining questions in Section 5B.</i> <i>If “no” to question #2, skip the remaining questions in Section 5B and continue to the next subsection. The hospital will be scored as “Does Not Apply.”</i>	☐ Yes ☐ No

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3) Is the ICU staffed with physicians who are certified in critical care medicine³⁶ and present on-site or via telemedicine? <i>If “no, the ICU is not staffed with any physicians certified in critical care medicine” to question #3, skip the remaining questions in Section 5B and continue to the next subsection. This hospital will be scored as “Limited Achievement.”</i>	○ Yes, the ICU is staffed with physicians certified in critical care medicine ○ Yes, the ICU is staffed with physicians certified in critical care medicine based on Leapfrog’s expanded definition ○ No, the ICU is not staffed with any physicians certified in critical care medicine
4) Do the physicians who are certified in critical care medicine³⁶ (whether present on-site or via telemedicine) manage or co-manage all critical care patients³⁴ in the ICU? <i>If “no” to question #4, skip questions #5-11 and continue to question #12.</i>	○ Yes, all patients are managed or co-managed by a physician certified in critical care medicine when the physician is present (on-site or via telemedicine) ○ No, not all patients are managed or co-managed by a physician certified in critical care medicine when the physician is present (on-site or via telemedicine)

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

5) Are all critical care patients³⁴ in the ICU managed or co-managed³⁵ by one or more physicians certified in critical care medicine³⁶ who meet all the following criteria: • ordinarily present³⁷ on-site in the ICU during daytime hours; • for at least 8 hours per day, 7 days per week; and • providing clinical care exclusively³⁷ in the ICU during these hours? <i>If “yes” to question #5, skip question #6 and continue to question #7.</i>	○ Yes ○ No
6) Are all critical care patients³⁴ in the ICU managed or co-managed³⁵ by one or more physicians certified in critical care medicine³⁶ who meet all the following criteria: • present via telemedicine, in combination with on-site intensivist coverage, for a total of 24 hours per day, 7 days per week; • meet all of Leapfrog’s ICU requirements for intensivist presence in the ICU via telemedicine (More Information³⁸); and • supported by an on-site intensivist who establishes and revises the daily care plan for each ICU patient?	○ Yes ○ No

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

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7) When the physicians (from question #3) are not present in the ICU on-site or via telemedicine, do they return more than 95% of calls/pages/texts from these units within five minutes, based on a quantified analysis ³⁹ of notification device response time? (More information on the use of telemedicine to cover calls ⁴¹)	☐ Yes ☐ No ☐ Not applicable; intensivists are present on-site 24/7
8) When the physicians (from question #3) are not present on-site in the ICU or not able to physically reach an ICU patient within 5 minutes, can they rely on a physician, physician assistant, nurse practitioner ⁴² , or FCCS-certified nurse or intern “effector” ⁴⁰ who is in the hospital and able to reach these ICU patients within five minutes in more than 95% of the cases, based on a quantified analysis ³⁹ of response time of the effector reaching the patient?	☐ Yes ☐ No ☐ Not applicable; intensivists are present on-site 24/7

If “no” to either question #7 or #8 in this section, continue to questions #9-15. If “yes” or “not applicable; intensivists are present on-site 24/7” to questions #7 and #8, skip the remaining questions in Section 5B and continue to the next subsection.

9) Are all critical care patients ³⁴ in the ICU managed or co-managed ³⁵ by one or more physicians certified in critical care medicine ³⁶ who meet all the following criteria: • ordinarily present³⁷ on-site in the ICU during daytime hours; • for at least 8 hours per day, 4 days per week or 4 hours per day, 7 days per week; and • providing clinical care exclusively³⁷ in the ICU during these hours?	☐ Yes ☐ No
10) Are all critical care patients ³⁴ in the ICU managed or co-managed ³⁵ by one or more physicians certified in critical care medicine ³⁶ who meet all the following criteria: • present via telemedicine for 24 hours per day, 7 days per week; • meet all of Leapfrog’s modified ICU requirements for intensivist presence in the ICU via telemedicine (More Information⁴³); and • supported in the establishment and revision of daily care planning for each ICU patient by an on-site intensivist, hospitalist, anesthesiologist, or physician trained in emergency medicine?	☐ Yes ☐ No
11) Are all critical care patients ³⁴ in the ICU managed or co-managed ³⁵ by one or more physicians certified in critical care medicine ³⁶ who are: • on-site at least 4 days per week to establish or revise daily care plans for each critical care patient in the ICU?	☐ Yes ☐ No

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

12) If not all critical care patients ³⁴ are managed or co-managed ³⁵ by physicians certified in critical care medicine ³⁶ , either on-site or via telemedicine ³⁸ , are some critical care patients managed or co-managed by these physicians who are: • ordinarily present³⁷ on-site in the ICU during daytime hours; • for at least 8 hours per day, 4 days per week or 4 hours per day, 7 days per week; and • providing clinical care exclusively³⁷ in the ICU during these hours?	☐ Yes ☐ No
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Section 5: Physician and Nurse Staffing

13) Does an on-site clinical pharmacist do all the following: • at least 5 days per week, makes daily on-site rounds on all critical care patients³⁴ in the ICU; and • on the other 2 days per week, returns more than 95% of calls/pages/texts from the unit within 5 minutes, based on a quantified analysis³⁹ of notification device response time; OR • makes daily on-site rounds on all critical care patients³⁴ in the ICU 7 days per week?	☐ Yes ☐ No ☐ Clinical pharmacist rounds 7 days per week
14) Does a physician certified in critical care medicine³⁶ lead daily interprofessional rounds on-site on all critical care patients³⁴ in the ICU 7 days per week?	☐ Yes ☐ No
15) Are physicians certified in critical care medicine³⁶ responsible for all ICU admission and discharge decisions when they are: • present on-site for at least 8 hours per day, 4 days per week or 4 hours per day, 7 days per week?	☐ Yes ☐ No

5C: Nursing Workforce

Hospitals that share a CMS Certification Number are required to report by facility. Please carefully review [Leapfrog's Multi-Campus Reporting Policy](#).

Total Nursing Care Hours per Patient Day, RN Hours per Patient Day, and Nursing Skill Mix

Important Notes:

Note 1: Hospitals should respond to questions #1-5 and #6-11 if they operate at least one adult or pediatric **single** acuity Medical, Surgical, or Med-Surg unit, defined as a unit where at least 90% of patients in the unit receive the same level of care. If responding to questions #6-11, skip questions #12-14.

Note 2: Hospitals should respond to questions #1-5 and #12-14 if they:

- **do not** operate any adult or pediatric **single** acuity Medical, Surgical, or Med-Surg Units, **but**
- operate at least one adult or pediatric **mixed** acuity Medical, Surgical, or Med-Surg Unit, defined as a unit where more than 10% of the patients in the unit receive varying levels of care (e.g., general medical care and progressive care or intensive care).

Note 3: Single or mixed acuity Medical, Surgical, or Med-Surg Units that had fewer than 15 patient days per month for all 3 months of any quarter of the reporting period should be excluded in questions #6-11 or #12-14.

Note 4: Single or mixed acuity Medical, Surgical, or Med-Surg Units that transitioned to an excluded unit type during the reporting period should be excluded in questions #6-11 or #12-14. For example, if a single acuity Medical Unit transitioned to an ICU during the reporting period, the unit should be excluded when responding to questions #6-11.

Specifications: See [Nursing Workforce Measure Specifications](#) in the Reference Information beginning on page 200.

Reporting Period: 12 months

- Survey submitted prior to September 1:
 - 01/01/2024 – 12/31/2024
- Surveys submitted on or after September 1:
 - 07/01/2024 – 06/30/2025

Note: As a reminder, the [Corrections Period](#) (December 1-January 31) is reserved for corrections to previously submitted Surveys only. Any updates made to reflect a change in performance must be made prior to the November 30 Late Submission and Performance Update Deadline. Updates made to reflect a change in performance after November 30 will not be scored or publicly reported.

1) 12-month reporting period used:	○ 01/01/2024 – 12/31/2024 ○ 07/01/2024 – 06/30/2025
2) Does your hospital operate at least one adult or pediatric single acuity Medical, Surgical, or Med-Surg Unit? <i>A single acuity unit is defined as a unit where at least 90% of the patients receive the same level of care.</i> <i>If “yes” to question #2, skip question #3 and continue to question #4.</i>	○ Yes ○ No

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Section 5: Physician and Nurse Staffing

3) If your hospital does not operate at least one adult or pediatric single acuity Medical, Surgical, or Med-Surg Unit, does your hospital operate at least one adult or pediatric mixed acuity Medical, Surgical or Med-Surg Unit? <i>A mixed acuity unit is defined as a unit where more than 10% of patients receive varying levels of care.</i> <i>If “no” to question #3, skip questions #4-16 and continue to question #17. The hospital will be scored as “Does Not Apply.”</i>	☐ Yes ☐ No
4) Did your hospital calculate total number of patient days, total number of productive hours worked by employed and contracted nursing staff with direct patient care responsibilities (RN, LPN/LVN, and UAP), and total number of productive hours worked by RN nursing staff with direct patient care responsibilities for the reporting period, and do you choose to report those data to this Survey? <i>If “no” to question #4, skip questions #5-16 and continue to question #17. The hospital will be scored as “Did Not Measure.”</i>	☐ Yes ☐ No
5) Which method did your hospital use to calculate the total number of patient days for each single acuity Medical, Surgical, Med-Surg or mixed acuity Medical, Surgical or Med-Surg Unit?	☐ Midnight census (including observation patients) ☐ Midnight census and patient days from actual hours for short stay patients ☐ Patient days from actual hours ☐ Patient days from multiple census reports

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

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

6) Does your hospital operate any adult or pediatric single acuity <u>Medical Units</u>? <i>A single acuity unit is defined as a unit where at least 90% of the patients receive the same level of care.</i> <i>If “no” or “yes, but had fewer than 15 patient days per month for all 3 months of any quarter of the reporting period” to question #6, skip question #7 and continue to question #8.</i>	☐ Yes ☐ No ☐ Yes, but had fewer than 15 patient days per month for all 3 months of any quarter of the reporting period		
7) Enter your hospital's responses for each quarter for all adult and pediatric single acuity <u>Medical Units</u> for the reporting period selected in question #1:			
	(a) Total number of patient days:	(b) Total number of productive hours worked by employed and contracted nursing staff (RN, LPN/LVN, and UAP) with direct patient care responsibilities:	(c) Total number of productive hours worked by RN nursing staff with direct patient care responsibilities:
Quarter 1			
Quarter 2			

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Section 5: Physician and Nurse Staffing

Quarter 3			
Quarter 4			

8) Does your hospital operate any adult or pediatric single acuity Surgical Units? <i>A single acuity unit is defined as a unit where at least 90% of the patients receive the same level of care.</i> <i>If “no” or “yes, but had fewer than 15 patient days per month for all 3 months of any quarter of the reporting period” to question #8, skip question #9 and continue to question #10.</i>	☐ Yes ☐ No ☐ Yes, but had fewer than 15 patient days per month for all 3 months of any quarter of the reporting period
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9) Enter your hospital's responses for each quarter for all adult and pediatric single acuity Surgical Units for the reporting period selected in question #1:			
	(a) Total number of patient days:	(b) Total number of productive hours worked by employed and contracted nursing staff (RN, LPN/LVN, and UAP) with direct patient care responsibilities:	(c) Total number of productive hours worked by RN nursing staff with direct patient care responsibilities:
Quarter 1			
Quarter 2			
Quarter 3			
Quarter 4			

10) Does your hospital operate any adult or pediatric single acuity Med-Surg Units? <i>A single acuity unit is defined as a unit where at least 90% of the patients receive the same level of care.</i> <i>If “no” or “yes, but had fewer than 15 patient days per month for all 3 months of any quarter of the reporting period” to question #10, skip questions #11-14 and continue to question #15.</i> <i>If “yes, but had fewer than 15 patient days per month for all 3 months of any quarter of the reporting period” to questions #6, #8, and #10, skip questions #11-16 and continue to question #17. The hospital will be scored as “Unable to Calculate Score.”</i>	☐ Yes ☐ No ☐ Yes, but had fewer than 15 patient days per month for all 3 months of any quarter of the reporting period
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11) Enter your hospital's responses for each quarter for all adult and pediatric single acuity Med-Surg Units for the reporting period selected in question #1:			
	(a) Total number of patient days:	(b) Total number of productive hours worked by employed and contracted nursing staff (RN, LPN/LVN, and UAP) with direct patient care responsibilities:	(c) Total number of productive hours worked by RN nursing staff with direct patient care responsibilities:
Quarter 1			
Quarter 2			
Quarter 3			

Quarter 4			
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For Hospitals that Only Operate Adult or Pediatric Mixed Acuity Medical, Surgical, or Med-Surg Units

12) Was your adult and/or pediatric mixed acuity Medical, Surgical, or Med-Surg Unit(s) open for the entire reporting period? <i>A mixed acuity unit is defined as a unit where more than 10% of patients receive varying levels of care.</i> <i>If “no” to question #12, skip questions #13-16 and continue to question #17. The hospital will be scored as “Does Not Apply.”</i> <i>If “yes, but had fewer than 15 patient days per month for all 3 months of any quarter of the reporting period” to question #12, skip questions #13-16 and continue to question #17. The hospital will be scored as “Unable to Calculate Score.”</i>	☐ Yes ☐ No ☐ Yes, but had fewer than 15 patient days per month for all 3 months of any quarter of the reporting period
13) What type(s) of adult or pediatric mixed acuity Medical, Surgical, or Med-Surg Units does your hospital operate? <i>Select all that apply.</i> <i>A <u>High Acuity Unit</u> is a mixed acuity unit in which 50-89% of the patients are critical care and the remaining 11-49% can be any other acuity level.</i> <i>A <u>Moderate Acuity Unit</u> is a mixed acuity unit in which 25-49% of the patients are critical care OR 50-89% of the patients are step down care. The remaining percentage can be any other acuity level.</i> <i>A <u>Blended Acuity Unit</u> is a mixed acuity acute care unit in which less than 90% of the patients receive a single acuity level of care, less than 50% receive step down care, and less than 25% receive critical care.</i>	☐ High Acuity ☐ Moderate Acuity ☐ Blended Acuity

14) Enter your hospital's responses for each quarter for all adult and pediatric mixed acuity Medical, Surgical, and Med-Surg Units for the reporting period selected in question #1:			
	(a) Total number of patient days:	(b) Total number of productive hours worked by employed and contracted nursing staff (RN, LPN/LVN, and UAP) with direct patient care responsibilities:	(c) Total number of productive hours worked by RN nursing staff with direct patient care responsibilities:
Quarter 1			
Quarter 2			
Quarter 3			
Quarter 4			

NQF Safe Practice #9 – Nursing Workforce

Important Note: Hyperlinks in question #16 refer to the [Patient Safety Practices FAQs](#) beginning on page 214, not to endnotes. These hyperlinks are not included in the Online Survey Tool.

Specifications: See [NQF Safe Practice Measure Specifications](#) in the Reference Information beginning on page 238.

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

Percentage of RNs who are BSN-Prepared

Specifications: See [Nursing Workforce Measure Specifications](#) in the Reference Information beginning on page 236.

Reporting Period: 12 months

Answer questions #17-19 based on the most recent day within the last 12-months for which you have complete data.

Note: As a reminder, the [Corrections Period](#) (December 1-January 31) is reserved for corrections to previously submitted Surveys only. Any updates made to reflect a change in performance must be made prior to the November 30 Late Submission and Performance Update Deadline. Updates made to reflect a change in performance after November 30 will not be scored or publicly reported.

17) Did your hospital calculate the Percentage of RNs who are BSN-Prepared measure for the reporting period, and do you choose to report those data to this Survey? <i>If “no” to question #17, skip questions #18-19 and continue to the next subsection. The hospital will be scored as “Did Not Measure.”</i>	☐ Yes ☐ No
18) Total number of employed RN nursing staff at the hospital with direct patient care responsibilities:	_____
19) Total number of employed RN nursing staff at the hospital with direct patient care responsibilities who have a BSN degree or higher (e.g., MSN, DNP, PhD):	_____

Affirmation of Accuracy:

As the hospital CEO or as an employee of the hospital to whom the hospital CEO has delegated responsibility, I have reviewed this information pertaining to the Physician and Nurse Staffing Section at our hospital, and I hereby certify that this information is true, accurate, and reflects the current, normal operating circumstances at our hospital. I am authorized to make this certification on behalf of our hospital.

The hospital and I understand that The Leapfrog Group, its members, the public and entities and persons who contract or have other business dealings with The Leapfrog Group are relying on the truth and accuracy of this information. The hospital and I also understand that The Leapfrog Group will make this information and/or analyses of this information public through the Survey Results public reporting website, The Leapfrog Group's Hospital Safety Grade, and/or other Leapfrog Group products and services. This information and/or analyses and all intellectual property rights therein shall be and remain the sole and exclusive property of The Leapfrog Group in which The Leapfrog Group retains exclusive ownership. This information does not infringe upon any third-party intellectual property rights or any other third-party rights whatsoever and is free and clear of all encumbrances and liens of any kind. The hospital and I acknowledge that The Leapfrog Group may use this information in a commercial manner for profit. The hospital shall be liable for and shall hold harmless and indemnify The Leapfrog Group from any and all damages, demands, costs, or causes of action resulting from any inaccuracies in the information or any misrepresentations in this Affirmation of Accuracy. The Leapfrog Group and its members and entities and persons who contract or have other business dealings with The Leapfrog Group reserve the right to omit or disclaim information that is not current, accurate or truthful.

Affirmed by _____, the hospital's _____,
(first name and last name) (title)
on _____.
(date)

Section 5: Physician and Nurse Staffing Reference Information

What's New in the 2025 Survey

Leapfrog renamed Section 5: ICU Physician Staffing to Section 5: Physician and Nurse Staffing and moved Section 6C: Nursing Workforce to Section 5C: Nursing Workforce.

Section 5A: Adult ICU Physician Staffing and Section 5B: Pediatric ICU Physician Staffing

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

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

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

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

Section 5C: Nursing Workforce

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

Leapfrog is updating question #3 to clarify that hospitals should only respond to the questions about mixed acuity units if the hospital does not operate any of the applicable single acuity units. Further clarification on single acuity medical, surgical, and med-surg units to include or exclude, as well as additional clarification on the definition of acuity (i.e., level of care), will be added. Critical Access Units, defined as units where more than 10% of beds are for skilled nursing (swing beds), will be added as an exclusion for both single acuity and mixed acuity units.

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

Leapfrog is also updating the measure specifications for total productive hours worked by employed and contracted nursing staff with direct patient care responsibilities to clarify that sitter hours can only be

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Section 5: Physician and Nurse Staffing

included if the sitter is authorized to physically touch the patient when providing direct patient care (i.e., does not need to call another staff member if physical intervention of any type is required).

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

For NQF Safe Practice #9 on the 2025 Leapfrog Hospital Survey, Leapfrog will continue to accept 2020 American Nurses Credentialing Center (ANCC) Pathway to Excellence® criteria and will add 2024 ANCC Pathway to Excellence® criteria. There are no changes to the scoring algorithm for Section 5C: Nursing Workforce.

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

Change Summary Since Release

None. If substantive changes are made to this section of the Survey after release on April 1, 2025, they will be documented in this Change Summary section.

Nursing Workforce Measure Specifications

Important Note: Hospitals that share a CMS Certification Number are required to report by facility. Please carefully review [Leapfrog's Multi-Campus Reporting Policy](#).

Total Nursing Care Hours per Patient Day, RN Hours per Patient Day, and Nursing Skill Mix Measure Specifications

Source: American Nurses Association (ANA) (National Quality Forum #0204 and #0205)

Reporting Period: 12 months

- Survey submitted prior to September 1:
 - 01/01/2024 – 12/31/2024
- Surveys submitted on or after September 1:
 - 07/01/2024 – 06/30/2025

Hospitals that report this data to NDNQI® (National Database of Nursing Quality Indicators®):

Data for this measure can be obtained directly from NDNQI. See details below.

Hospitals that submit nursing care hours and patient days to NDNQI will be able to respond to questions #5 - 14 in Section 5C. Active NDNQI clients should email NDNQISupport@PressGaney.com or call 855-304-9788 to connect with one of NDNQI's team members and specify that they are requesting support for the purposes of Leapfrog Hospital Survey reporting on Total Nursing Care Hours per Patient Day, RN Hours per Patient Day, and Nursing Skill Mix. For 2025, additional support for these calculations for active NDNQI clients with eligible data will be provided at no additional cost.

For NDNQI units to include, please reach out directly to ndnqisupport@pressganey.com.

Hospitals that do not report this data to NDNQI:

Data for this measure can be obtained using the measure specifications below.

Question #2: Does your hospital operate at least one adult or pediatric single acuity Medical, Surgical, or Med-Surg Unit?

Leapfrog has aligned with the National Database of Nursing Quality Indicators' (NDNQI) unit definitions below.

Single Acuity Medical Unit (adult and pediatric):

A single acuity general care unit in which at least 90% of the patients are admitted to medical services, such as internal medicine, oncology, or cardiology. Medical specialty units such as Cardiac Medical, GI Medical, Infectious Disease Medical, Neurology Medical, Hematology/Oncology Medical, Renal Medical, and Respiratory Medical, are also included.

Single Acuity Surgical Unit (adult and pediatric):

A single acuity general care unit in which at least 90% of the patients are admitted to surgical services, such as general surgery, neurosurgery, or orthopedics. Surgical specialty units such as Bariatric Surgery, Cardio-thoracic Surgery, Gynecologic Surgery, Neurosurgery, Orthopedic Surgery, Plastic Surgery, Transplant Surgery, and Trauma Surgery, are also included.

Single Acuity Med-Surg Combined Unit (adult and pediatric):

A single acuity general care unit that cares for patients admitted for medical, surgical, or family practice services and does not meet the 90% criteria for Medical or Surgical unit type. Specialty med-surg units such as Cardiac Med-Surg, Neuro/Neurosurgery Med-Surg, and Hematology/Oncology Med-Surg, are also included.

Excluded units:

- Labor and Delivery
- Neonatal

• Critical Access Unit: a unit where more than 10% of beds are for skilled nursing (swing beds) • Rehabilitation • Psychiatric • Perioperative • Critical Care • Step Down/Progressive • Hospice • Mixed Acuity Units: a unit where more than 10% of the patients in the unit receive varying levels of care (e.g., general medical care and progressive care or intensive care) • Units with fewer than 15 patient days per month for all 3 months of any quarter of the reporting period • Units that transitioned to an excluded unit type during the reporting period (e.g., a single acuity Medical Unit transitioned to a critical care unit during the reporting period)
Question #3: If your hospital does not operate at least one adult or pediatric single acuity Medical, Surgical, or Med-Surg Unit, does your hospital operate at least one adult or pediatric mixed acuity Medical, Surgical, or Med-Surg Unit? Leapfrog has aligned with the National Database of Nursing Quality Indicators' (NDNQI) unit definitions below. Mixed Acuity Medical, Surgical and Med-Surg Units (adult and pediatric): A unit where more than 10% of patients receive varying levels of care. Types of mixed acuity units include the following: High Acuity Medical, Surgical and Med-Surg Units: A mixed acuity unit in which 50-89% of the patients are critical care and the remaining 11-49% can be any other acuity level. Moderate Acuity Medical, Surgical and Med-Surg Units: A mixed acuity unit in which 25-49% of the patients are critical care OR 50-89% of the patients are step down care. The remaining percent can be any other acuity level. Blended Acuity Medical, Surgical and Med-Surg Units: A mixed acuity acute care unit in which less than 90% of the patients receive a single acuity level of care, less than 50% receive step down care, and less than 25% receive critical care. Excluded units: • Cardiac • Neurology • Hematology/Oncology • Critical Access (a unit where more than 10% of beds are for skilled nursing (swing beds)) • Units with fewer than 15 patient days per month for all 3 months of any quarter of the reporting period • Units that transitioned to an excluded unit type during the reporting period (e.g., a mixed acuity Medical Unit transitioned to a critical care unit during the reporting period)
Question #5: Which method did your hospital use to calculate the total number of patient days for each single acuity Medical, Surgical, Med-Surg or mixed acuity Medical, Surgical or Med-Surg Unit? • Midnight Census (including observation patients): The sum of the daily midnight census counts (the number of <i>all</i> patients on the unit at midnight each day) during the reporting period. Short stay patients (who are in and out of the unit before the census count is taken) should be included; otherwise, this method cannot be used. • Midnight Census and Patient Days from Actual Hours for Short Stay Patients: A combination of Midnight Census and Patient Days from Actual Hours collected during the reporting period.

- **Patient Days from Actual Hours:** The sum of the actual hours for all patients during the reporting period divided by 24; typically obtained from an accounting system that tracks the actual time spent in the hospital by each patient.
- **Patient Days from Multiple Census Reports:** The sum of the daily average censuses collected during the reporting period; typically collected multiple times per day (e.g., every 4 hours or each shift).

Note: Patient days should be calculated to include all patients in adult and pediatric single acuity Medical, Surgical, Med-Surg or mixed acuity Medical, Surgical or Med-Surg Units. This includes patients that do not have inpatient status (i.e., observation patients).

Hospitals that operate adult or pediatric **single acuity** Medical, Surgical, or Med-Surg Units should use the measure specifications [directly below](#) to respond to questions #6-11.

Hospitals that operate adult or pediatric **mixed acuity** Medical, Surgical, or Med-Surg Units should use [the measure specifications for mixed acuity units](#) to respond to questions #12-14.

Single Acuity Adult or Pediatric Medical, Surgical, or Med-Surg Units (questions #6-11)
Question #6: Does your hospital operate any adult or pediatric single acuity Medical Units? Single Acuity Medical Unit (adult and pediatric): A single acuity general care unit in which at least 90% of the patients are admitted to medical services, such as internal medicine, oncology, or cardiology. Medical specialty units such as Cardiac Medical, GI Medical, Infectious Disease Medical, Neurology Medical, Hematology/Oncology Medical, Renal Medical, and Respiratory Medical, are also included. Excluded units: • Labor and Delivery • Neonatal • Critical Access (a unit where more than 10% of beds are for skilled nursing (swing beds)) • Rehabilitation • Psychiatric • Perioperative • Critical Care • Step Down/Progressive • Hospice • Mixed Acuity Units: a unit where more than 10% of the patients in the unit are receive varying levels of care (e.g., general medical care and progressive care or intensive care) • Units with fewer than 15 patient days per month for all 3 months of any quarter of the reporting period • Units that transitioned to an excluded unit type during the reporting period (e.g., a single acuity Medical Unit transitioned to a critical care unit during the reporting period)
Question #7: Single Acuity Medical Units Enter your hospital's responses for each quarter for all adult and pediatric single acuity Medical Units for the reporting period selected in question #1.
Question #7(a): Total number of patient days across all adult and pediatric single acuity Medical Units during each quarter of the reporting period based on your hospital's method for counting patient days. Patient days should be calculated to include all patients in adult and pediatric single acuity Medical Units. This includes patients that do not have inpatient status (i.e., observation patients).
Question #7(b): Total number of productive hours worked by employed and contracted nursing staff (RN, LPN/LVN, and UAP) with direct patient care responsibilities in all adult and pediatric single acuity Medical Units during each quarter of the reporting period.
Productive Hours

Include the following hours worked by employed and contracted RNs, LPN/LVNs, and UAPs:

- Actual direct patient care hours worked by nursing staff
- Overtime spent performing direct patient care
- Orientation hours for new hires that are considered part of the unit's staffing matrix, whose work hours are charged to the unit's cost center, and who would be replaced if they called out sick
- Sitter hours authorized for both physical touch and direct patient care intervention

Exclude the following hours worked by employed and contracted RN, LPN/LVN, and UAP:

- Budgeted or scheduled hours
- Vacation time, sick time, education leave, or committee time
- Orientation hours for new hires that are not considered part of the unit's staffing matrix, whose work hours are not charged to the unit's cost center, and would not be replaced if they call out sick
- Hours from when the unit was staffed but there were no patients in the unit
 - If these nursing hours cannot be removed, then the unit should not be included.
- Virtual or remote hours
- Sitter hours without authorization for both physical touch and direct patient care intervention

Employed and Contracted Nursing Staff

Include the following RN, LPN/LVN, and UAP nursing staff:

- Staff employed by the hospital
- Temporary staff who are not employed by the hospital (i.e., contracted/agency staff)
- Float staff who are assigned to a unit other than their unit of employment on an as-needed basis if they are assigned direct patient care responsibilities
- Staff who are counted in the unit's staffing matrix, are replaced if they call out sick, and whose work hours are charged to the unit's cost center

Exclude the following RN, LPN/LVN, and UAP nursing staff:

- Nursing staff whose primary responsibility is administrative in nature (at least 50% of their time is administrative)
- Specialty teams, patient educators, or case managers who are not assigned to a specific unit
- Unit secretaries or clerks, monitor technicians, and others with no direct patient care responsibilities
- Advanced Practice Registered Nurses (APRNs), including certified nurse-midwife (CNM), clinical nurse specialist (CNS), certified nurse practitioner (CNP), and certified registered nurse anesthetist (CRNA)

A UAP is any unlicensed person, regardless of title, who performs tasks delegated by a nurse. This includes certified nursing aides/assistants (CNAs), patient care assistants (PCAs), patient care technicians (PCTs), state-tested nursing assistants (STNA), nursing assistants-registered (NA/Rs) or certified medication aides/assistants (MA-Cs).

Direct Patient Care Responsibilities

Direct Patient Care Responsibilities are defined as patient centered nursing activities by hospital unit-based staff in the presence of the patient and activities that occur away from the patient that are patient related:

- Medication administration
- Nursing treatments
- Nursing rounds
- Admission, transfer, discharge activities
- Patient teaching
- Patient communication

• Coordination of patient care • Documentation time • Treatment planning • Patient screening (e.g., fall risk) and assessment
Questions #7(c): Total number of productive hours worked by RN nursing staff with direct patient care responsibilities in all adult and pediatric single acuity Medical Units in each quarter. Include the total number of productive work hours worked by employed and contracted RN nursing staff ONLY from question 7B.
Question #8: Does your hospital operate any adult or pediatric single acuity Surgical Units? Single Acuity Surgical Unit (adult and pediatric): A single acuity general care unit in which at least 90% of the patients are admitted to surgical services, such as general surgery, neurosurgery, or orthopedics. Surgical specialty units such as Bariatric Surgery, Cardio-thoracic Surgery, Gynecologic Surgery, Neurosurgery, Orthopedic Surgery, Plastic Surgery, Transplant Surgery, and Trauma Surgery, are also included. Excluded units: • Labor and Delivery • Neonatal • Critical Access (a unit where more than 10% of beds are for skilled nursing (swing beds)) • Rehabilitation • Psychiatric • Perioperative • Critical Care • Step Down/Progressive • Hospice • Mixed Acuity Units: a unit where more than 10% of the patients in the unit are receive varying levels of care (e.g., general medical care and progressive care or intensive care) • Units with fewer than 15 patient days per month for all 3 months of any quarter of the reporting period • Units that transitioned to an excluded unit type during the reporting period (e.g., a single acuity Medical Unit transitioned to a critical care unit during the reporting period)
Question #9: Single Acuity Surgical Units Enter your hospital's responses for each quarter for all adult and pediatric single acuity Surgical Units for the reporting period selected in question #1.
Question #9(a): Total number of patient days across all adult and pediatric single acuity Surgical Units during each quarter of the reporting period based on your hospital's method for counting patient days. Patient days should be calculated to include all patients in adult and pediatric single acuity Surgical Units. This includes patients that do not have inpatient status (i.e., observation patients).
Question #9(b): Total number of productive hours worked by employed and contracted nursing staff (RN, LPN/LVN, and UAP) with direct patient care responsibilities in all single acuity adult and pediatric Surgical Units in each quarter. Productive Hours Include the following hours worked by employee and contract RNs, LPN/LVNs, and UAPs: • Actual direct patient care hours worked by nursing staff • Overtime spent performing direct patient care • Orientation hours for new hires that are considered part of the unit's staffing matrix, whose work hours are charged to the unit's cost center, and who would be replaced if they called out sick • Sitter hours authorized for both physical touch and direct patient care intervention Exclude the following hours worked by employed and contracted RN, LPN/LVN, and UAP:

- Budgeted or scheduled hours
- Vacation time, sick time, education leave, or committee time
- Orientation hours for new hires that are not considered part of the unit's staffing matrix, whose work hours are not charged to the unit's cost center, and would not be replaced if they call out sick
- Hours from when the unit was staffed but there were no patients in the unit
 - If these nursing hours cannot be removed, then the unit should not be included.
- Virtual or remote hours
- Sitter hours without authorization for both physical touch and direct patient care intervention

Employed and Contracted Nursing Staff

Include the following RN, LPN/LVN, and UAP nursing staff:

- Staff employed by the hospital
- Temporary staff who are not employed by the hospital (i.e., contracted/agency staff)
- Float staff who are assigned to a unit other than their unit of employment on an as-needed basis if they are assigned direct patient care responsibilities
- Staff who are counted in the unit's staffing matrix, are replaced if they call out sick, and whose work hours are charged to the unit's cost center

Exclude the following RN, LPN/LVN, and UAP nursing staff:

- Nursing staff whose primary responsibility is administrative in nature (at least 50% of their time is administrative)
- Specialty teams, patient educators, or case managers who are not assigned to a specific unit
- Unit secretaries or clerks, monitor technicians, and others with no direct patient care responsibilities
- Advanced Practice Registered Nurses (APRNs), including certified nurse-midwife (CNM), clinical nurse specialist (CNS), certified nurse practitioner (CNP), and certified registered nurse anesthetist (CRNA)

A UAP is any unlicensed person, regardless of title, who performs tasks delegated by a nurse. This includes certified nursing aides/assistants (CNAs), patient care assistants (PCAs), patient care technicians (PCTs), state-tested nursing assistants (STNA), nursing assistants-registered (NA/Rs) or certified medication aides/assistants (MA-Cs).

Direct Patient Care Responsibilities

Direct Patient Care Responsibilities are defined as patient centered nursing activities by hospital unit-based staff in the presence of the patient and activities that occur away from the patient that are patient related:

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

Questions #9(c): Total number of productive hours worked by **RN nursing staff** with direct patient care responsibilities in all adult and pediatric single acuity **Surgical Units** in each quarter.

Include the total number of productive work hours worked by employed and contracted **RN nursing staff ONLY** from question 9b.

Question #10: Does your hospital operate any adult or pediatric single acuity Med-Surg Units?

Single Acuity Med-Surg Combined Unit (adult and pediatric):

A single acuity general care unit that cares for patients admitted for medical, surgical, or family practice services and does not meet the 90% criteria for Medical or Surgical unit type. Specialty med-surg units such as Cardiac Med-Surg, Neuro/Neurosurgery Med-Surg, and Hematology/Oncology Med-Surg, are also included.

Excluded units:

- Labor and Delivery
- Neonatal
- Critical Access (a unit where more than 10% of beds are for skilled nursing (swing beds))
- Rehabilitation
- Psychiatric
- Perioperative
- Critical Care
- Step Down/Progressive
- Hospice
- Mixed Acuity Units: a unit where more than 10% of the patients in the unit are receive varying levels of care (e.g., general medical care and progressive care or intensive care)
- Units with fewer than 15 patient days per month for all 3 months of any quarter of the reporting period
- Units that transitioned to an excluded unit type during the reporting period (e.g., a single acuity Medical Unit transitioned to a critical care unit during the reporting period)

Question #11: Single Acuity Med-Surg Units

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

Question #11(a): Total number of patient days across all adult and pediatric single acuity **Med-Surg Units** for each quarter included in the reporting period based on your hospital's method for counting patient days.

Patient days should be calculated to include all patients in adult and pediatric single acuity Med-Surg Units. This includes patients that do not have inpatient status (i.e., observation patients).

Question #11(b): Total number of productive hours worked by employed and contracted **nursing staff (RN, LPN/LVN, and UAP)** with direct patient care responsibilities in all single acuity adult and pediatric **Med-Surg Units** in each quarter.

Productive Hours

Include the following hours worked by employed and contracted RNs, LPN/LVNs, and UAPs:

- Actual direct patient care hours worked by nursing staff
- Overtime spent performing direct patient care
- Orientation hours for new hires that are considered part of the unit's staffing matrix, whose work hours are charged to the unit's cost center, and who would be replaced if they called out sick
- Sitter hours authorized for both physical touch and direct patient care intervention

Exclude the following hours worked by employed and contracted RN, LPN/LVN, and UAP:

- Budgeted or scheduled hours
- Vacation time, sick time, education leave, or committee time
- Orientation hours for new hires that are not considered part of the unit's staffing matrix, whose work hours are not charged to the unit's cost center, and would not be replaced if they call out sick
- Hours from when the unit was staffed but there were no patients in the unit
 - If these nursing hours cannot be removed, then the unit should not be included.
- Virtual or remote hours
- Sitter hours without authorization for both physical touch and direct patient care intervention

Employed and Contracted Nursing Staff

Include the following RN, LPN/LVN, and UAP nursing staff:

- Staff employed by the hospital
- Temporary staff who are not employed by the hospital (i.e., contracted/agency staff)
- Float staff who are assigned to a unit other than their unit of employment on an as-needed basis if they are assigned direct patient care responsibilities
- Staff who are counted in the unit's staffing matrix, are replaced if they call out sick, and whose work hours are charged to the unit's cost center

Exclude the following RN, LPN/LVN, and UAP nursing staff:

- Nursing staff whose primary responsibility is administrative in nature (at least 50% of their time is administrative)
- Specialty teams, patient educators, or case managers who are not assigned to a specific unit
- Unit secretaries or clerks, monitor technicians, and others with no direct patient care responsibilities
- Advanced Practice Registered Nurses (APRNs), including certified nurse-midwife (CNM), clinical nurse specialist (CNS), certified nurse practitioner (CNP), and certified registered nurse anesthetist (CRNA)

A UAP is any unlicensed person, regardless of title, who performs tasks delegated by a nurse. This includes certified nursing aides/assistants (CNAs), patient care assistants (PCAs), patient care technicians (PCTs), state-tested nursing assistants (STNA), nursing assistants-registered (NA/Rs) or certified medication aides/assistants (MA-Cs).

Direct Patient Care Responsibilities

Direct Patient Care Responsibilities are defined as patient centered nursing activities by hospital unit-based staff in the presence of the patient and activities that occur away from the patient that are patient related:

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

Questions #11(c): Total number of productive hours worked by **RN nursing staff** with direct patient care responsibilities in all adult and pediatric single acuity **Med-Surg Units** in each quarter.

Include the total number of productive work hours worked by RN nursing staff ONLY from question 11b.

Mixed Acuity Adult or Pediatric Medical, Surgical, or Med-Surg Units (questions #12-14)

Question #12: Was your adult and/or pediatric mixed acuity Medical, Surgical, or Med-Surg Unit(s) open for the entire reporting period?

Leapfrog has aligned with the National Database of Nursing Quality Indicators' (NDNQI) unit definitions below.

Excluded units:

- Cardiac

• Neurology • Hematology/Oncology • Critical Access (a unit where more than 10% of beds are for skilled nursing (swing beds)) • Units with fewer than 15 patient days per month for all 3 months of any quarter of the reporting period • Units that transitioned to an excluded unit type during the reporting period (e.g., a mixed acuity Medical Unit transitioned to a critical care unit during the reporting period)
Question #13: What type(s) of adult and/or pediatric mixed acuity Medical, Surgical or Med-Surg Units does your hospital operate? Leapfrog has aligned with the National Database of Nursing Quality Indicators' (NDNQI) unit definitions below. High Acuity Medical, Surgical and Med-Surg Units: A mixed acuity unit in which 50-89% of the patients are critical care and the remaining 11-49% can be any other acuity level. Moderate Acuity Medical, Surgical and Med-Surg Units: A mixed acuity unit in which 25-49% of the patients are critical care OR 50-89% of the patients are step down care. The remaining percent can be any other acuity level. Blended Acuity Medical, Surgical and Med-Surg Units: A mixed acuity acute care unit in which less than 90% of the patients receive a single acuity level of care, less than 50% receive step down care, and less than 25% receive critical care.
Question #14: Mixed Acuity Medical, Surgical and Med-Surg Units Enter your hospital's responses for each quarter for all adult and pediatric mixed acuity Medical, Surgical and Med-Surg Units for the reporting period selected in question #1.
Question #14(a): Total number of patient days across all adult and pediatric mixed acuity Medical, Surgical and Med-Surg Units for each quarter included in the reporting period based on your hospital's method for counting patient days. Patient days should be calculated to include all patients in all adult and pediatric mixed acuity Medical, Surgical or Med-Surg Units. This includes patients that do not have inpatient status (i.e., observation patients).
Question #14(b): Total number of productive hours worked by employed and contracted nursing staff (RN, LPN/LVN, and UAP) with direct patient care responsibilities in all adult and pediatric mixed acuity Medical, Surgical, and Med-Surg Units in each quarter. <u>Productive Hours</u> Include the following hours worked by employed and contracted RNs, LPN/LVNs, and UAPs: • Actual direct patient care hours worked by nursing staff • Overtime spent performing direct patient care • Orientation hours for new hires that are considered part of the unit's staffing matrix, whose work hours are charged to the unit's cost center, and who would be replaced if they called out sick • Sitter hours authorized for both physical touch and direct patient care intervention Exclude the following hours worked by employed and contracted RN, LPN/LVN, and UAP: • Budgeted or scheduled hours • Vacation time, sick time, education leave, or committee time • Orientation hours for new hires that are not considered part of the unit's staffing matrix, whose work hours are not charged to the unit's cost center, and would not be replaced if they call out sick • Hours from when the unit was staffed but there were no patients in the unit ◦ If these nursing hours cannot be removed, then the unit should not be included. • Virtual or remote hours • Sitter hours without authorization for both physical touch and direct patient care intervention

Employed and Contracted Nursing Staff

Include the following RN, LPN/LVN, and UAP nursing staff:

- Staff employed by the hospital
- Temporary staff who are not employed by the hospital (i.e., contracted/agency staff)
- Float staff who are assigned to a unit other than their unit of employment on an as-needed basis if they are assigned direct patient care responsibilities
- Staff who are counted in the unit's staffing matrix, are replaced if they call out sick, and whose work hours are charged to the unit's cost center

Exclude the following RN, LPN/LVN, and UAP nursing staff:

- Nursing staff whose primary responsibility is administrative in nature (at least 50% of their time is administrative)
- Specialty teams, patient educators, or case managers who are not assigned to a specific unit
- Unit secretaries or clerks, monitor technicians, and others with no direct patient care responsibilities
- Advanced Practice Registered Nurses (APRNs), including certified nurse-midwife (CNM), clinical nurse specialist (CNS), certified nurse practitioner (CNP), and certified registered nurse anesthetist (CRNA)

A UAP is any unlicensed person, regardless of title, who performs tasks delegated by a nurse. This includes certified nursing aides/assistants (CNAs), patient care assistants (PCAs), patient care technicians (PCTs), state-tested nursing assistants (STNA), nursing assistants-registered (NA/Rs) or certified medication aides/assistants (MA-Cs).

Direct Patient Care Responsibilities

Direct Patient Care Responsibilities are defined as patient centered nursing activities by hospital unit-based staff in the presence of the patient and activities that occur away from the patient that are patient related:

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

Question #14(c): Total number of productive hours worked by **RN nursing staff** with direct patient care responsibilities in all adult and pediatric **mixed acuity Medical, Surgical, and Med-Surg Units** in each quarter.

Include the total number of productive work hours worked by employed and contracted RN nursing staff **ONLY** from question 14b.

See [FAQs](#) for additional information about responding to the questions in this section.

Percentage of RNs who are BSN-Prepared Specifications

Source: The Leapfrog Group
Reporting Period: Answer questions #17-19 based on the most recent day within the last 12-months for which you have complete data.
Question #18 (denominator): Total number of employed RN nursing staff at the hospital with direct patient care responsibilities. <u>Included RN Nursing Staff:</u> - Staff employed by the hospital in most all hospital units, including observation, co-located³¹ outpatient units, and emergency departments who: - Are counted in the unit's staffing matrix, and - Are replaced if they call in sick, and - Whose work hours are charged to the unit's cost center - Float staff who are assigned to a unit other than their unit of employment on an as-needed basis if they are assigned direct patient care responsibilities <u>Excluded RN Nursing staff:</u> - Staff that are not employed by the hospital (i.e., contracted/agency staff) - Staff that are exclusively assigned to skilled nursing units or mixed acuity neonatal units - Staff that are part of specialty teams or are patient educators or case managers who are not assigned to a specific unit - Unit secretaries or clerks or others with no direct patient care responsibilities - Staff that are primarily responsible for administrative tasks (at least 50% of their time is administrative) - Advanced Practice Registered Nurses (APRNs), including certified nurse-midwife (CNM), clinical nurse specialist (CNS), certified nurse practitioner (CNP), and certified registered nurse anesthetist (CRNA) <u>Direct Patient Care Responsibilities</u> are defined as patient centered nursing activities by hospital unit-based staff in the presence of the patient and activities that occur away from the patient that are patient related: - Medication administration - Nursing treatments - Nursing rounds - Admission, transfer, discharge activities - Patient teaching - Patient communication - Coordination of patient care - Documentation time - Treatment planning - Patient screening (e.g., fall risk) and assessment Question #19 (numerator): Total number of employed RN nursing staff at the hospital with direct patient care responsibilities who have a BSN degree or higher (e.g., MSN, DNP, and PhD). Note: Hospitals can use any method to identify RN nursing staff who have a BSN degree or higher, including: - NDNQI Annual RN Survey - Data collected by the nurse managers at the hospital - Information from HR or credentialing office, or - Staff survey via SurveyMonkey or other free data collection tool.

See [FAQs](#) for additional information about responding to the questions in this section.

Section 5: Physician and Nurse Staffing Frequently Asked Questions (FAQs)

Adult and Pediatric ICU Physician Staffing FAQs

ICU General Questions

1. What is the reporting period for the ICU measure?

Hospitals should report on Section 5A and 5B based on their staffing structure at the time they submit this section of the Survey. The staffing structure must have been in place for at least the past 3 months and should reflect the ordinary staffing structure for the ICU.

2. How should hospitals report if they have more than one type of qualifying ICU?

If your hospital has more than one applicable ICU (i.e., multiple adult ICUs or multiple pediatric ICUs), respond to all questions in each section based on the ICU that has the lowest level of staffing by physicians certified in critical care medicine. Review [endnote 34](#) for more information.

3. Does Leapfrog's ICU standard apply to mixed acuity units? A multi-organizational service unit (MOSU) unit?

The standard applies to all adult and pediatric general medical, surgical, medical/surgical, and neuro critical care patients (medical and surgical), including those patients in mixed acuity units and other non-critical care units.

4. Are cardiac critical care patients in a general medical, surgical, and medical/surgical ICU required to be co-managed by an intensivist?

Cardiac critical care patients in a general medical, surgical, or medical/surgical ICU that are in beds dedicated to cardiac critical care patients and being cared for by dedicated cardiac physicians (e.g., cardiologist or cardiac surgeon) and nursing staff are not included in Leapfrog's ICU Physician Staffing standard and do not need to be managed/co-managed by the intensivist. However, cardiac critical care patients in a general medical, surgical, or medical/surgical ICU bed being cared for by general medical or surgical critical care physicians and nursing staff are included in the standard and do need to be managed/co-managed by the intensivist. Additional clarification is available [here](#).

5. Does Leapfrog's ICU Physician Staffing standard include cardiac critical care patients?

For the purposes of reporting on Section 5A and 5B, cardiac critical care patients in general medical, surgical, or medical/surgical ICU beds being cared for by general medical and/or surgical critical care physicians and nursing staff are included in the standard and need to be managed/co-managed by the intensivist. Cardiac critical care patients in a general medical, surgical, or medical/surgical ICU that are in beds dedicated to cardiac critical care patients and being cared for by dedicated cardiac physicians (e.g., cardiologist or cardiac surgeon) and nursing staff are not included in Leapfrog's ICU Physician Staffing standard and do not need to be managed/co-managed by the intensivist.

ICU Certification

6. Is there any empirical basis for specifying a minimum annual number of days of ICU experience for each board-eligible physician providing ICU care?

No. Accordingly, if it is added to the Leapfrog standard in the future, it will be based on newly published research and expert advice.

7. Do all intensivists serving as tele-intensivists need to meet Leapfrog's definition of "certified in critical care medicine"?

Yes. All intensivists who serve as tele-intensivists do need to meet [Leapfrog's definition](#) of "certified in critical care medicine."

8. Is a physician who is awaiting the results of the certification test considered “certified in critical care medicine”?

A physician is considered certified in critical care medicine as long as the board that originally certified the physician in critical care medicine deems that physician certified. Intensivists that are close to having their certification lapse should check with the board that certified them to see how exactly that board defines a lapsed certification.

9. Are physicians board certified in critical care medicine from the American Osteopathic Association (AOA) considered “certified in critical care medicine” for Leapfrog’s ICU Physician Staffing Standard?

Yes. Physicians with a board certification in critical care from American Osteopathic Association (AOA) are considered “certified in critical care medicine.”

10. How should intensivists trained in critical medicine in a foreign country be treated for purposes of meeting the ICU Physician Staffing (IPS) Standard?

Foreign trained physicians who were certified in critical care medicine in the country in which they trained would be considered certified for the purposes of the ICU Physician Staffing (IPS) standard.

ICU Telemedicine

11. Can you clarify what you mean by combined presence of tele-intensivists and on-site intensivists, as needed, for 24 hours per day/7 days per week in question #6 for Sections 5A and 5B?

Hospitals can achieve Leapfrog’s IPS Standard by having daily on-site intensivist coverage combined with a telemedicine service that meets all ten of [the Leapfrog requirements](#). For example, an on-site intensivist takes two hours in the morning to establish and revise the daily care plan for each ICU patient, then a tele-intensivist picks up management or co-management of the ICU patients and is continually monitoring all critical care patients for the remaining 22 hours, for a combined total of 24 hours per day/7 days per week.

Hospitals should minimize [the number of hand-offs](#) between the on-site intensivist and the tele-intensivist during a 24-hour period and maximize the continuous time that one type of intensivist is caring for critical care patients. **Leapfrog does not recommend more than 4 hand-offs per 24 hours.**

12. Our hospital uses a telemedicine service to provide coverage in our ICU for 16 hours/7 days per week coverage when the on-site intensivist is not present at the hospital. Can our hospital still fully meet Leapfrog’s standard?

Hospitals that use telemedicine to cover “call” for the on-site intensivist are able to fully meet Leapfrog’s standard if: (1) the telemedicine service meets all ten of [the Leapfrog requirements](#); and (2) the hospital has an “effector” (physician/PA/NP/FCCS-certified nurse or intern) on-site during that time period to carry out the tele-intensivist’s orders and can reach the ICU patient within 5 minutes, 95% of the time.

ICU Response Time

13. Does Leapfrog specify standards for second tier calls (e.g., the initial call to a physician is not answered within 5 minutes)?

No. We do not intend to reach this level of detail in our specifications, absent a compelling case that the gain would offset its added complexity.

14. Are there definitions for what constitutes high and low urgency calls/pages/texts?

No, and hospitals don’t have to focus only on high urgency calls/pages/texts, but some notification device systems can make this differentiation, and, in these instances, low urgency calls/pages/texts can be excluded from the analysis of response times.

15. If my hospital has few instances where there is no intensivist coverage, how should we conduct the response time audit? Can we perform mock pages to satisfy the intent?

Unannounced mock pages would meet the intent. For the audit to be reliable, 20 unannounced mock pages over 90 days should be evaluated.

16. When an intensivist is not on-site in the ICU, can hospitals use a non-FCCS-certified CRNA as the “effector?”

No. To serve as the “effector,” CRNAs require FCCS-certification.

17. When an intensivist is not on-site in the ICU, can hospitals use FCCS-certified interns as the “effector?”

Yes. An FCCS-certified intern can serve as the “effector.”

ICU Rounding

18. How does Leapfrog define “makes on-site daily rounds” for clinical pharmacists in question #13 within Sections 5A and 5B?

A clinical pharmacist would need to make on-site daily rounds (5 or 7 days per week) on **all** critical care patients (not some or most critical care patients) in **all** applicable ICUs (adult or pediatric general medical, surgical, medical/surgical, and neuro ICUs).

Please note that if your clinical pharmacist is rounding 5 days per week, then, during the other 2 days per week, a clinical pharmacist still needs to respond to calls/texts/pages within 5 minutes, as determined by a response time audit.

19. Are pharmacy residents considered clinical pharmacists in question #13 within Sections 5A and 5B?

To be considered a clinical pharmacist, Leapfrog only requires that the pharmacist have a Doctor of Pharmacy (PharmD) degree. Therefore, a PharmD graduate completing a residency would meet Leapfrog’s criterion to be considered a clinical pharmacist.

20. What roles should be included in interprofessional rounds in question #14 within Sections 5A and 5B?

For rounds to be considered interprofessional, the team should include 3 or more persons.

Typical personnel that would be part of the rounding team include physician, nurse, pharmacist, physical and/or occupational therapist, and nutritionist.

Total Nursing Care Hours per Patient Day, RN Hours per Patient Day, and Nursing Skill Mix FAQs

21. Why has Leapfrog aligned their unit type definitions with NDNQI?

Though NDNQI participation is not required to report on the Total Nursing Care Hours per Patient Day, RN Hours per Patient Day, or Nursing Skill Mix measures, a number of hospitals participate in NDNQI and have data available to report to the Leapfrog Hospital Survey.

22. How is patient acuity defined?

Patient acuity is the level of care that patients are receiving. The three levels of care are:

- critical care (highest level of acuity)
- step down (lower level of acuity that patients in a critical care unit yet a higher level of acuity than is provided on a general care unit)
- general care

Single acuity medical, surgical and med-surg units are units where at least 90% of the patients receive general care. Mixed acuity medical, surgical and med-surg units are units where less than 90% of the patients receive a single acuity level of care (more than 10% of patient receive varying levels of care).

NQF Safe Practice #9 – Nursing Workforce FAQs

23. How do I know if my hospital is eligible to report it has a current Pathways to Excellence designation?

Hospitals that applied for Pathway to Excellence designation beginning in January 2021 and onward were certified using the 2020 or 2024 Pathways to Excellence® criteria and are eligible to report that they have a current designation.

Hospitals can check the Designation Year or Redesignation Year on the [American Nurses Credentialing Center website](#). If the year is 2021 or later, the hospital meets the Pathways to Excellence® criteria.

24. 15e: If the state has set minimum nurse to patient staffing ratios, do hospitals in that state automatically meet the intent of this element?

No. Minimum ratios do not necessarily address the “adequacy” issue, as the make-up of your hospital’s patient population may require more intensive staffing than is prescribed by the state’s minimum.

25. 15e: What are the minimum requirements to qualify as a “staffing plan?”

“A staffing plan” refers to nursing policies and procedures or a specific process used by the organization to pre-determine appropriate staffing patterns based on usual patient mix and nursing qualifications. A hospital must demonstrate full achievement of its targets.

Organizations must integrate several data sets into a staffing system that predefines and quantifies appropriate staffing targets. These data sets include:

- Historical Data (e.g., patient volumes, acuity levels, and staff volumes of direct caregivers)
- Comparative Data (e.g., comparisons between similar units internally and comparative external data from hospitals of like size and geographic location)
- Clinical Outcomes
- Skill Mix of Staff (e.g., licensing levels and educational training, years of experience, and volume of new graduates on a unit)
- Physical environment (e.g., distance staff have to travel to access support equipment, visibility of patients, locations of nursing stations to patient rooms, etc.)
- Type of patient care needs
- Support services available

Daily monitoring should take place to determine variances between predetermined staffing patterns and actual staffing patterns. If necessary, corrective action should be taken. Regular monitoring should take place to determine the accuracy of targets established and determine adjustments as needed.

Percentage of RNs who are BSN-Prepared FAQs

26. Should RNs with direct patient care responsibilities exclusively assigned to outpatient units or hospital clinics be included when reporting on the Percentage of RNs who are BSN-Prepared measure?

Yes. The total number of RN nursing staff employed at the hospital should include nurses with direct care responsibilities in most hospital units, including observation, [co-located](#)³¹ outpatient units, and emergency departments. Only employed RNs exclusively assigned to Skilled Nursing units or Mixed Acuity Neonatal units should be excluded when reporting on the measure.

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SECTION 6: PATIENT SAFETY PRACTICES

This section includes questions and reference information for Section 6: Patient Safety Practices. Please carefully review the questions, endnotes, and reference information (e.g., measure specifications, notes, and frequently asked questions) before you begin. Failure to review the reference information could result in inaccurate responses.

Section 6: Patient Safety Practices

NQF Safe Practices Fact Sheets:

<https://ratings.leapfroggroup.org/measure/hospital/2025/effective-leadership-prevent-errors>

Hand Hygiene Fact Sheet and Bibliography:

<https://ratings.leapfroggroup.org/measure/hospital/2025/handwashing>

Diagnostic Excellence Bibliography:

<https://ratings.leapfroggroup.org/measure/hospital/2025/whats-new-2025>

Hospital Boarding in the Emergency Department (ED) Bibliography:

<https://ratings.leapfroggroup.org/measure/hospital/2025/whats-new-2025>

Section 6 includes questions about your hospital's adherence to two National Quality Forum-endorsed Safe Practices, and questions about your hospital's hand hygiene practices. It also includes a subsection on diagnostic excellence (6D) and a new subsection on Hospital Boarding in the Emergency Department (ED) (6E) – both subsections are optional and will not be scored or publicly reported.

Each hospital achieving the standard for NQF Safe Practice #1 – Culture of Safety Leadership Structures and Systems and NQF Safe Practice #2 – Culture Measurement, Feedback, and Intervention:

Has earned 100% of points (adopted all elements) for the NQF Safe Practice.

Each hospital achieving the standard for Hand Hygiene:

Has met all elements for the Monitoring domain including collecting compliance data on at least 200 hand hygiene opportunities* each month in each patient care unit. Has also met all elements for the Feedback domain, as well as **2 of the 3** remaining domains for hand hygiene:

- Training and Education Domain
- Infrastructure Domain
- Culture Domain

OR

Has met all elements for the Monitoring domain including collecting compliance data on at least 100 hand hygiene opportunities* each month in each patient care unit, as well as **all 4** remaining domains for hand hygiene:

- Feedback Domain
- Training and Education Domain
- Infrastructure Domain
- Culture Domain

**or at least the number of hand hygiene opportunities outlined based on the unit type in [Tables 1-3 or Tables 4-6](#).*

Download the 2025 Leapfrog Hospital Survey Scoring Algorithm on the [Scoring and Results webpage](#).

6A: NQF Safe Practice #1 – Culture of Safety Leadership Structures and Systems

Hospitals that share a CMS Certification Number are required to report by facility. Please carefully review [Leapfrog's Multi-Campus Reporting Policy](#).

Important Notes:

Note 1: Page numbers throughout this subsection refer to the [NQF Safe Practices for Better Healthcare – 2010 Update](#) report, not this document.

Note 2: Hyperlinks throughout this subsection refer to the [Patient Safety Practices FAQs](#) beginning on page 251, not to endnotes. These hyperlinks are not included in the Online Survey Tool.

Specifications: See [NQF Safe Practice Measure Specifications](#) in the Reference Information beginning on page 238.

Awareness

1.1) Within the last 12 months, in regard to raising the awareness of key stakeholders to our organization's efforts to improve patient safety, the following actions related to the identification and mitigation of risks and hazards have been taken:	
a. board (governance) minutes reflect regular communication regarding all three of the following: i. risks and hazards (as defined by NQF Safe Practice #4 – Identification and Mitigation of Risks and Hazards); ii. culture measurement (as defined by NQF Safe Practice #2 – Culture Measurement, Feedback, and Intervention); and iii. progress towards resolution of safety and quality problems. (p.75)	☐ Yes ☐ No
b. patients and/or families of patients are active participants in the hospital-wide safety and quality committee that meets on a regularly scheduled basis (e.g., biannually or quarterly). (p.75)	☐ Yes ☐ No
c. steps have been taken to report ongoing efforts to improve safety and quality in the organization and the results of these efforts to the community. (p.75)	☐ Yes ☐ No
d. all staff and independent practitioners were made aware of ongoing efforts to reduce risks and hazards and to improve patient safety and quality in the organization. (p.75)	☐ Yes ☐ No

Accountability

1.2) Within the last 12 months, in regard to holding the board, senior administrative leadership, midlevel management, nursing leadership, physician leadership, and frontline caregivers directly accountable for results related to the identification and mitigation of risks and hazards, the organization has done the following:	
a. an integrated patient safety program has been in place for the entire reporting period, providing oversight and alignment of safe practice activities. (p.76)	☐ Yes ☐ No
b. a Patient Safety Officer (PSO) has been appointed and communicates regularly with the board (governance) and senior administrative leadership ; the PSO is the primary point of contact of the integrated patient safety program. (p.76)	☐ Yes ☐ No
c. performance has been documented in performance reviews and/or compensation incentives for all levels of hospital management and hospital-employed caregivers noted above. (p.76)	☐ Yes ☐ No
d. the interdisciplinary patient safety team communicated regularly with senior administrative leadership regarding both of the following and documented these communications in meeting minutes (pp. 76-77): i. progress in meeting safety goals, and ii. provided team training to caregivers.	☐ Yes ☐ No

e. the hospital reported adverse events to external mandatory or voluntary programs. (p.77)	☐ Yes ☐ No
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Ability

1.3) Within the last 12 months, in regard to implementation of the patient safety program, the board (governance) and senior administrative leadership have provided resources to cover the implementation, as evidenced by:	
a. dedicated patient safety program budgets to support the program, staffing, and technology investment. (p.77)	☐ Yes ☐ No

Action

1.4) Within the last 12 months, structures and systems have been in place to ensure that senior administrative leadership is taking direct action, as evidenced by:	
a. CEO and senior administrative leadership are personally engaged in reinforcing patient safety improvements, e.g., “walk-arounds,” and reporting to the board (governance). Calendars reflect allocated time. (p.78)	☐ Yes ☐ No
b. CEO has actively engaged leaders from service lines, midlevel management, nursing leadership, and physician leadership in patient safety improvement actions. (p.79)	☐ Yes ☐ No
c. hospital has established a structure for input into the patient safety program by licensed independent practitioners and the organized medical staff and physician leadership. Input documented in meeting minutes or materials. (p.79)	☐ Yes ☐ No

6B: NQF Safe Practice #2 – Culture Measurement, Feedback, and Intervention

Hospitals that share a CMS Certification Number are required to report by facility. Please carefully review [Leapfrog's Multi-Campus Reporting Policy](#).

Important Notes:

Note 1: Page numbers throughout this subsection refer to the [NQF Safe Practices for Better Healthcare – 2010 Update](#) report, not this document.

Note 2: Hyperlinks throughout this subsection refer to the [Patient Safety Practices FAQs](#) beginning on page 249, not to endnotes. These hyperlinks are not included in the Online Survey Tool.

Note 3: Throughout this subsection, the culture of safety survey referenced in each practice element refers to one administered in the last 24 months as indicated in 2.1a. This means that the same culture of safety survey should be used when responding to each practice element.

Specifications: See [NQF Safe Practice Measure Specifications](#) in the Reference Information beginning on page 238.

Awareness

2.1) Within the last 24 months, in regard to culture measurement, our organization has done the following:	
a. conducted a culture of safety survey of our employees using a nationally recognized tool that has demonstrated validity, consistency, and reliability. The units surveyed account for at least 50% of the aggregated care delivered to patients within the hospital and include the high patient safety risk units or departments. (p.88) <i>If “no” to question 2.1a, skip the remaining questions in Section 6B and continue to the next subsection. The hospital will be scored as “Limited Achievement.”</i>	☐ Yes ☐ No
b. portrayed the results of the culture of safety survey in a report, which reflects both hospital-wide and individual unit level results, as applicable. (p.88)	☐ Yes ☐ No
c. benchmarked results of the culture of safety survey against external organizations, such as “like” hospitals or other hospitals within the same health system.	☐ Yes ☐ No
d. compared results of the culture of safety surveys across roles and staff levels .	☐ Yes ☐ No
e. service line, midlevel managers, or senior administrative leaders used the results of the culture of safety survey to debrief at the relevant unit level, using semi-structured approaches for the debriefings and presenting results in aggregate form to ensure the anonymity of survey respondents.	☐ Yes ☐ No

Accountability

2.2) Within the last 24 months, in regard to accountability for improvements in culture measurement, our organization has done the following:	
a. shared the results of the culture of safety survey with the board (governance) and senior administrative leadership in a formal report and discussion. (p.88)	☐ Yes ☐ No
b. included in performance evaluation criteria for senior administrative leadership both the response rates to the culture of safety survey and the use of the culture of safety survey results in the improvement efforts.	☐ Yes ☐ No

Ability

2.3) Within the last 12 months, in regard to culture measurement, the organization has done the following (or has had the following in place):	
a. conducted staff education program (s) on methods to improve the culture of safety, tailored to the organization's culture of safety survey results.	☐ Yes ☐ No
b. included the costs of culture measurement/follow-up activities in the patient safety program budget .	☐ Yes ☐ No

Action

2.4) Within the last 12 months, in regard to accountability for improvements in culture measurement, our organization has done the following:	
a. developed or implemented explicit, hospital-wide organizational policies and procedures for regular culture measurement. (p.88)	☐ Yes ☐ No
b. disseminated the results of the culture of safety survey widely across the institution, and senior administrative leadership held follow-up meetings with the sampled units to discuss the unit's results and concerns. (p.88)	☐ Yes ☐ No
c. identified performance improvement interventions based on the culture of safety survey results, which were shared with senior administrative leadership and subsequently measured and monitored. (p.88)	☐ Yes ☐ No

6C: Hand Hygiene

Hospitals that share a CMS Certification Number are required to report by facility. Please carefully review [Leapfrog's Multi-Campus Reporting Policy](#).

Important Notes:

Note 1: Hyperlinks not followed by a superscript throughout this subsection refer to the [Patient Safety Practices FAQs](#) beginning on page 251. These hyperlinks are not included in the Online Survey Tool.

Note 2: The framework and questions in this subsection are modeled after the World Health Organization's [Hand Hygiene Self-Assessment Framework](#).

Note 3: Hospital responses should reflect [patient care units](#) only, including all adult and pediatric medical, surgical, and medical/surgical units (including telemetry units), step-down/progressive units, obstetrical units, intensive care units (including neonatal units), pre-operative and post-anesthesia care units, observation units, and dedicated emergency department units.

Note 4: Only include units that were open for the entire reporting period (i.e., most recent month or past three months based on responses selected in monitoring questions #8-10) and that remain currently open.

Specifications: See [Hand Hygiene Measure Specifications](#) in the Reference Information beginning on page 237.

Reporting Period: Answer questions #1-21 based on the practices currently in place at the time you submit this section of the Survey.

Note: For monitoring, this means that the monthly sample size (or quarterly sample size if answering question #10) would need to be met at least once in each patient care unit the month (or quarter) preceding the time of the submission of the Survey and there must be a process in place to meet the monthly (or quarterly) sample size thereafter in each patient care unit every month/quarter.

Note: As a reminder, the [Corrections Period](#) (December 1-January 31) is reserved for corrections to previously submitted Surveys only. Any updates made to reflect a change in performance must be made prior to the November 30 Late Submission and Performance Update Deadline. Updates made to reflect a change in performance after November 30 will not be scored or publicly reported.

Training and Education

1) Do individuals who touch patients or who touch items that will be used by patients⁴⁴ in your patient care units receive hand hygiene training from a professional with appropriate training and skills⁴⁵ at both: - the time of onboarding, and - annually thereafter? <i>If "no" to question #1, skip questions #2-3 and continue to question #4.</i>	☐ Yes ☐ No
2) In order to pass the initial hand hygiene training, do individuals who touch patients or who touch items that will be used by patients⁴⁴ in your patient care units need to physically demonstrate proper hand hygiene with soap and water and alcohol-based hand sanitizer?	☐ Yes ☐ No

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3) Are all six of the following topics included in your hospital's initial and annual hand hygiene training: • Evidence linking hand hygiene and infection prevention; • When individuals who touch patients or who touch items that will be used by patients⁴⁴ should perform hand hygiene (e.g., WHO's 5 Moments for Hand Hygiene, CDC's Guideline for Hand Hygiene); • How individuals who touch patients or who touch items that will be used by patients⁴⁴ should clean their hands with alcohol-based hand sanitizer and soap and water as to ensure they cover all surfaces of hands and fingers, including thumbs and fingernails; • When gloves should be used in addition to hand washing (e.g., caring for <i>C. diff.</i> patients) and how hand hygiene should be performed when gloves are used; • The minimum time that should be spent performing hand hygiene with soap and water and alcohol-based hand sanitizer; and • How hand hygiene compliance is monitored?	☐ Yes ☐ No
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Infrastructure

4) Does your hospital conduct quarterly audits on a sample of dispensers in your patient care units to ensure all the following: • Paper towels, soap dispensers, and alcohol-based hand sanitizer dispensers are refilled when they are empty or near empty, and • Batteries in automated paper towel dispensers, soap dispensers, and alcohol-based hand sanitizer dispensers (if automated dispensers are used in the patient care units) are replaced?	☐ Yes ☐ No
5) Do all rooms and bed spaces in your patient care units have: • an alcohol-based hand sanitizer dispenser located at the entrance to the room or bed space, and • alcohol-based hand sanitizer dispenser(s) located inside the room or bed space that are equally accessible to the location of all patients in the room or bed space?	☐ Yes ☐ No

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6) Does your hospital conduct audits of the volume of alcohol-based hand sanitizer that is delivered with each activation of a wall-mounted dispenser (manual and automated) on a sample of dispensers in your patient care units at all the following times: • upon installation, • whenever the brand of product or system changes, and • whenever adjustments are made to the dispensers? OR Has your hospital conducted an audit of the volume of alcohol-based hand sanitizer that is delivered with each activation of a wall-mounted dispenser (manual and automated) on a sample of your hospital's <u>existing</u> dispensers if there have been no changes to any dispensers? <i>If “no” or “does not apply, wall-mounted dispensers are not used,” skip question #7 and continue to question #8.</i>	☐ Yes ☐ No ☐ Does not apply, wall-mounted dispensers are not used
7) Do all the audited dispensers deliver, with one activation, 1.0 mL of alcohol-based hand sanitizer OR a volume of alcohol-based hand sanitizer that covers the hands completely and requires 15 or more seconds for hands to dry (on average)?	☐ Yes ☐ No

Monitoring

8) Does your hospital collect hand hygiene compliance data on at least 200 hand hygiene opportunities, or at least the number of hand hygiene opportunities outlined based on the unit type in Tables 1-3, each month in each patient care unit? <i>If “yes” to question #8, skip questions #9-10 and continue to question #11.</i>	☐ Yes, using an electronic compliance monitoring system throughout all patient care units ☐ Yes, using an electronic compliance monitoring system throughout some patient care units and only direct observation in all other patient care units ☐ Yes, using only direct observation throughout all patient care units ☐ No
9) Does your hospital collect hand hygiene compliance data on at least 100 hand hygiene opportunities, or at least the number of hand hygiene opportunities outlined based on the unit type in Tables 4-6, each month in each patient care unit? <i>If “yes” to question #9, skip question #10 and continue to question #11.</i>	☐ Yes, using an electronic compliance monitoring system throughout all patient care units ☐ Yes, using an electronic compliance monitoring system throughout some patient care units and only direct observation in all other patient care units ☐ Yes, using only direct observation throughout all patient care units ☐ No

10) Does your hospital collect hand hygiene compliance data on at least 100 hand hygiene opportunities each quarter in each patient care unit? <i>If “no” to question #10, skip questions #11-19 and continue to question #20.</i>	☐ Yes, using an electronic compliance monitoring system throughout all patient care units ☐ Yes, using an electronic compliance monitoring system throughout some patient care units and only direct observation in all other patient care units ☐ Yes, using only direct observation throughout all patient care units ☐ No
11) Does your hospital use hand hygiene coaches or compliance observers to provide <u>individuals who touch patients or who touch items that will be used by patients</u>⁴⁴ in your patient care units with feedback on both when they are and are not compliant with performing hand hygiene?	☐ Yes ☐ No

Direct Monitoring – Electronic Compliance Monitoring System

If “yes, using an electronic compliance monitoring system throughout all patient care units” or “yes, using an electronic compliance monitoring system throughout some patient care units and only direct observation in all other patient care units” to question #8, question #9, or question #10, answer questions #12-13 based on the units that use an electronic compliance monitoring system.

12) In those patient care units where an electronic compliance monitoring system is used, does the monitoring system used meet both of the following criteria: • The system can identify both opportunities for hand hygiene and that hand hygiene was performed, and • The hospital itself has validated the accuracy of the data collected by the electronic compliance monitoring system?	☐ Yes ☐ No
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13) In those patient care units where an electronic compliance monitoring system is used, are direct observations also conducted for coaching and intervention purposes that meet all the following criteria: • Observers immediately intervene prior to any harm occurring to provide non-compliant individuals with immediate feedback; • Observations identify both opportunities for hand hygiene and compliance with those opportunities; • Observations determine who practiced hand hygiene, verify when they practiced it, and whether their technique was correct; • Observations within a unit are conducted weekly or monthly across all shifts and on all days of the week proportional to the number of individuals who touch patients or who touch items that will be used by patients⁴⁴ on duty for that shift; and • Observations capture a representative sample of the different roles of individuals who touch patients or who touch items that will be used by patients⁴⁴ (e.g., nurses, physicians, techs, environmental services workers)?	☐ Yes ☐ No
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Direct Monitoring – Direct Observation

If “yes, using an electronic compliance monitoring system throughout some patient care units and only direct observation in all other patient care units” or “yes, using only direct observation” to question #8, question #9, or question #10 answer questions #14-15 based on the units that do NOT use an electronic compliance monitoring system.

14) In those patient care units where an electronic compliance monitoring system is NOT used, do the direct observations meet all the following criteria: • Observations identify both opportunities for hand hygiene and compliance with those opportunities; • Observations determine who practiced hand hygiene, verify when they practiced it, and whether their technique was correct; • Observations within a unit are conducted weekly or monthly across all shifts and on all days of the week proportional to the number of individuals who touch patients or who touch items that will be used by patients⁴⁴ on duty for that shift; and • Observations are conducted to capture a representative sample of the different roles of individuals who touch patients or who touch items that will be used by patients⁴⁴ (e.g., nurses, physicians, techs, environmental services workers)?	☐ Yes ☐ No
15) Does your hospital have a system in place for both the initial and recurrent training and validation of hand hygiene compliance observers?	☐ Yes ☐ No

Feedback

16) Are unit-level hand hygiene compliance data fed back to individuals who touch patients or who touch items that will be used by patients ⁴⁴ at least monthly for improvement work?	☐ Yes ☐ No
17) Are unit-level hand hygiene compliance data used for creating unit-level action plans?	☐ Yes ☐ No
18) Is regular (at least every 6 months) feedback of hand hygiene compliance data, with demonstration of trends over time, given to: • senior administrative leadership, physician leadership, and nursing leadership, • the board (governance), and • the medical executive committee? <i>If “no” to question #18, skip question #19 and continue to question #20.</i>	☐ Yes ☐ No
19) If “yes” to question #18, is senior administrative leadership , physician leadership , and nursing leadership held directly accountable for hand hygiene performance through performance reviews or compensation ?	☐ Yes ☐ No

Culture

20) Are patients and visitors invited to remind individuals who touch patients or who touch items that will be used by patients ⁴⁴ to perform hand hygiene?	☐ Yes ☐ No
21) Have all the following individuals (or their equivalents) demonstrated a commitment to support hand hygiene improvement in the last year (e.g., a written or verbal commitment delivered to those individuals who touch patients or who touch items that will be used by patients ⁴⁴): • Chief Executive Officer, • Chief Medical Officer, and • Chief Nursing Officer?	☐ Yes ☐ No

6D: Diagnostic Excellence (Optional – Fact-Finding Only)

Hospitals that share a CMS Certification Number are required to report by facility. Please carefully review [Leapfrog's Multi-Campus Reporting Policy](#).

Important Notes:

Note 1: This subsection will not be scored or publicly reported.

Note 2: A diagnostic error is an event where one or both of the following occurred, with harm or high potential of harm to the patient:

- Delayed, wrong, or missed diagnosis: At least one missed opportunity to pursue or identify an accurate and timely diagnosis based on the information that existed at the time.
- Diagnosis not communicated to the patient: An accurate diagnosis was available but was not effectively communicated to the patient or family caregiver.

All references to “errors in diagnoses” refer to both types of events.

Note 3: Diagnosis excellence means making and communicating a correct and timely diagnosis using appropriate resources while maximizing patient experience and managing uncertainty.

Reporting Period: Answer questions #1-16 based on the practices currently in place at the time you submit this section of the Survey.

Note: As a reminder, the [Corrections Period](#) (December 1-January 31) is reserved for corrections to previously submitted Surveys only. Any updates made to reflect a change in performance must be made prior to the November 30 Late Submission and Performance Update Deadline. Updates made to reflect a change in performance after November 30 will not be scored or publicly reported.

CEO Commitment to Diagnostic Excellence

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

Patient Engagement

3) Has your hospital chartered a Patient and Family Advisory Council (PFAC) that meets at least quarterly? <i>If “no” to question #3, skip question #4 and continue to question #5.</i>	☐ Yes ☐ No
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4) In the past 36 months, has your hospital's PFAC: - received education regarding errors in diagnosis in the hospital or the diagnostic process ⁴⁶, - had input into any initiatives aimed at reducing errors in diagnosis in the hospital, or - led any initiatives aimed at reducing errors in diagnosis in the hospital?	☐ Yes ☐ No
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Risk Assessment and Mitigation

5) In the past 36 months, has your hospital used the Safer Dx Checklist to identify at least one high-priority practice that is not currently at "Full" implementation? <i>If "no" to question #5, skip question #6 and continue to question #7.</i>	☐ Yes, led by our multidisciplinary team ☐ Yes, led by a different entity at the hospital (please specify): _____ ☐ No
6) What steps has your hospital taken to fully implement the practice? <i>Select all that apply.</i>	☐ Allocated budget ☐ Appointed an individual or team responsible for implementation ☐ Set a date for full implementation ☐ None of the above

Convening a Multidisciplinary Team Focused on Diagnostic Excellence

7) In the past 36 months, has your hospital convened a multidisciplinary team that meets all the following requirements: - Solely focused on reducing harm to patients from errors in diagnosis; - Sponsored by either the CEO or CMO; - Includes, at a minimum, representatives from nursing, pharmacy, laboratory medicine, radiology, pathology, hospital medicine or inpatient care specialists, emergency medicine, and quality or risk management; - Meets at least quarterly; - Reports to senior leaders quarterly; and - Reports to the Board annually? <i>The multidisciplinary team should be a distinct entity at your hospital, not the established patient safety committee.</i> <i>If "no" to question #7, skip question #8 and continue to question #9.</i>	☐ Yes ☐ No
8) In the past 24 months, has the multidisciplinary team helped to educate staff on their work on reducing errors in diagnosis?	☐ Yes ☐ No
9) As a standing agenda item of regular meetings, has the multidisciplinary team reviewed any clinical or administrative data, patient experience or patient reported data, or incident reports to identify or track errors in diagnosis? <i>If "no" to question #9, skip question #10 and continue to question #11.</i>	☐ Yes ☐ No ☐ No, but a different team at the hospital has reviewed data or incident reports to identify or track errors in diagnosis

10) In the past 24 months, if an error in diagnosis was identified through the review of any of the data sources used in question #9, did the multidisciplinary team conduct any analyses or case reviews within four weeks of the error being identified and ensure the findings were communicated to the individuals involved in the patient's care and hospital leadership?	☐ Yes ☐ No ☐ No, but a different team at the hospital has conducted at least one root cause analysis or case review of a diagnostic error
11) In the past 24 months, has the multidisciplinary team encouraged all staff (verbally or in writing), including all clinicians who participate in the diagnostic process, to report errors in diagnosis via the hospital's incident or event reporting system?	☐ Yes ☐ No ☐ No, but a different team at the hospital has encouraged all staff to report errors in diagnosis
12) In the past 24 months, has the multidisciplinary team convened emergency medicine staff to identify commonly misdiagnosed conditions (e.g., stroke, heart attack, VTE) in the emergency department? <i>If "no" to question #12, skip question #13 and continue to question #14.</i>	☐ Yes ☐ No ☐ No, but the emergency medicine staff independently meet to identify commonly misdiagnosed conditions
13) In the past 24 months, has the multidisciplinary team worked with the emergency medicine staff to develop or implement any initiatives aimed at improving accurate and timely diagnosis of these commonly misdiagnosed conditions?	☐ Yes ☐ No ☐ No, but the emergency medicine staff have independently implemented at least one such initiative
14) In the past 24 months, has the multidisciplinary team convened radiologists and pathologists to discuss diagnosis related issues, including potential discrepancies, and analyze cases where there is a discrepancy between radiology and pathology findings? <i>If "no" to question #14, skip question #15 and continue to question #16.</i>	☐ Yes ☐ No ☐ No, but radiologists and pathologists independently meet to discuss diagnosis-related issues
15) In the past 24 months, has the multidisciplinary team worked with the pathologists and radiologists to develop or implement protocols to ensure timely review and resolution of discrepancies, and timely communication of diagnoses to patients and their families?	☐ Yes ☐ No ☐ No, but radiologists and pathologists independently developed or implemented at least one such protocol

Training and Education

16) In the past 36 months, has your hospital trained any staff using AHRQ's TeamSTEPPS for Diagnosis Improvement program to improve communication among members of the care team (including nurses, pharmacists, and other allied health professionals), within the context of the diagnostic process or in reducing errors in diagnosis)?	☐ Yes ☐ No
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Closing the Loop on Cancer Diagnosis**Reporting Period: 12 months**

- Survey submitted prior to September 1:
 - 01/01/2024 – 12/31/2024
- Surveys submitted on or after September 1:
 - 07/01/2024 – 06/30/2025

Note: As a reminder, the [Corrections Period](#) (December 1-January 31) is reserved for corrections to previously submitted Surveys only. Any updates made to reflect a change in performance must be made prior to the November 30 Late Submission and Performance Update Deadline. Updates made to reflect a change in performance after November 30 will not be scored or publicly reported.

Sufficient Sample: See [Closing the Loop on Cancer Diagnosis Measure Specifications](#) for instructions on identifying a sufficient sample for questions #19-22.

17) 12-month reporting period used:	☐ 01/01/2024 – 12/31/2024 ☐ 07/01/2024 – 06/30/2025
18) Do pathologists at your hospital routinely document the date in which they communicate pathology reports indicating a diagnosis of colon, lung, or breast cancer to a patient or a patient's ordering physician? <i>If "no" or "our hospital does not operate an on-site pathology service" to question #18, skip the remaining questions in Section 6D and continue to the next subsection.</i>	☐ Yes ☐ No ☐ Our hospital does not operate an on-site pathology service
19) Did your hospital perform an audit on a sufficient sample of patients to calculate the proportion of colon, lung, or breast cancer diagnoses in which the patient or patient's ordering physician was notified within five business days of the report being signed by the pathologist, and do you choose to report those data to this Survey? <i>If "no" or "yes, but fewer than 30 cases met the inclusion criteria for the denominator," skip the remaining questions in Section 6D and continue to the next subsection.</i>	☐ Yes ☐ No ☐ Yes, but fewer than 30 cases met the inclusion criteria for the denominator
20) How many cases were included in the audit from question #19 with a diagnosis of colon, lung, or breast cancer:	_____
21) Total number of patients from question #20 with documented communication between the pathologist and the patient or patient's ordering physician within five business days of the report being signed by the pathologist: <i>Documented communication includes:</i> • A documented phone call between the pathologist and patient or patient's ordering physician of the diagnosis, and • A timestamp, read receipt, or email response indicating that the patient or patient's ordering physician read an electronic communication of the diagnosis.	_____
22) Total number of patients from question #20 who were notified, either by phone or electronically, that the pathology report with their diagnosis was uploaded to the patient portal and ready for review: <i>Hospitals that do not upload pathology reports to the patient portal or notify patients when reports are uploaded, should enter "0."</i>	_____

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

Hospitals that share a CMS Certification Number are required to report by facility. Please carefully review [Leapfrog's Multi-Campus Reporting Policy](#).

Important Notes:

Note 1: This subsection will not be scored or publicly reported.

Note 2: Only include units that were open for the entire reporting period and that remain currently open.

Note 3: When reporting on questions #4 and/or #5, include Emergency Department (ED) visits with an admission to an inpatient non-psychiatric or psychiatric bed, including ED visits with an admission to hospital observation status.

Specifications: See [Hospital Boarding in the Emergency Department \(ED\) Measure Specifications](#) in the Reference Information beginning on page 162.

Reporting Period: 12 months

- Surveys submitted prior to September 1:
 - 01/01/2024 – 12/31/2024
- Surveys (re)submitted on or after September 1:
 - 07/01/2024 – 06/30/2025

Note: As a reminder, the [Corrections Period](#) (December 1-January 31) is reserved for corrections to previously submitted Surveys only. Any updates made to reflect a change in performance must be made prior to the November 30 Late Submission and Performance Update Deadline. Updates made to reflect a change in performance after November 30 will not be scored or publicly reported.

1) 12-month reporting period used:	☐ 01/01/2024 – 12/31/2024 ☐ 07/01/2024 – 06/30/2025
2) Did your hospital operate a dedicated emergency department (ED) ⁴⁷ during the reporting period? <i>If “no” or “yes, but ED is now closed or wasn’t open for the entire reporting period,” skip questions #3-5 and go to the Affirmation of Accuracy.</i>	☐ Yes ☐ No ☐ Yes, but ED is now closed or wasn’t open for the entire reporting period
3) What type(s) of dedicated emergency department(s) ⁴⁷ did your hospital operate? <i>Select all that apply.</i>	☐ Adult only ☐ Pediatric only ☐ Adult/Pediatric combined

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

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

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

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

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

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

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

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

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

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

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Admitted to an inpatient psychiatric bed				
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Affirmation of Accuracy

As the hospital CEO or as an employee of the hospital to whom the hospital CEO has delegated responsibility, I have reviewed this information pertaining to the Patient Safety Practices Section at our hospital, and I hereby certify that this information is true, accurate, and reflects the current, normal operating circumstances at our hospital. I am authorized to make this certification on behalf of our hospital.

The hospital and I understand that The Leapfrog Group, its members, the public and entities and persons who contract or have other business dealings with The Leapfrog Group are relying on the truth and accuracy of this information. The hospital and I also understand that The Leapfrog Group will make this information and/or analyses of this information public through the Survey Results public reporting website, The Leapfrog Group's Hospital Safety Grade, and/or other Leapfrog Group products and services. This information and/or analyses and all intellectual property rights therein shall be and remain the sole and exclusive property of The Leapfrog Group in which The Leapfrog Group retains exclusive ownership. This information does not infringe upon any third-party intellectual property rights or any other third-party rights whatsoever and is free and clear of all encumbrances and liens of any kind. The hospital and I acknowledge that The Leapfrog Group may use this information in a commercial manner for profit. The hospital shall be liable for and shall hold harmless and indemnify The Leapfrog Group from any and all damages, demands, costs, or causes of action resulting from any inaccuracies in the information or any misrepresentations in this Affirmation of Accuracy. The Leapfrog Group and its members and entities and persons who contract or have other business dealings with The Leapfrog Group reserve the right to omit or disclaim information that is not current, accurate or truthful.

Affirmed by _____, the hospital's _____,
(first name and last name) (title)
on _____.
(date)

Section 6: Patient Safety Practices Reference Information

What's New in the 2025 Survey

Section 6A: NQF Safe Practice #1 – Culture of Safety Leadership Structures and Systems

Leapfrog is updating the FAQ for Safe Practice 1.1b to clarify the requirement of having patients and/or families of patients as active participants in the hospital-wide safety and quality committee for hospitals that utilize a systemwide safety and quality committee instead of a local committee.

Additionally, the definition of Board has been updated to clarify that a system-wide board that governs hospitals in the system would meet the criteria.

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

Section 6B: NQF Safe Practice #2 – Culture Measurement, Feedback, and Intervention

There are no changes to this subsection.

Section 6C: Hand Hygiene

Leapfrog is adding further clarification in the measure specifications regarding the units included when reporting on Section 6C: Hand Hygiene, including reminding hospitals to exclude units that are not currently open and/or were not open consistently throughout the entire reporting period (i.e., most recent month or past three months based on responses selected in monitoring questions #8-10). The units are being updated to add further clarification and alignment with reporting in other sections of the Survey, including specifying the inclusion of both single acuity and mixed acuity units when reporting on medical, surgical, and medical/surgical units. In addition, hospitals will need to include any pre-operative and post-anesthesia care units that are located in or co-located with their hospital (previously hospitals were asked to only include those used for inpatient procedures and those used for outpatient procedures listed in Section 9: Outpatient Procedures), as well as those located in free-standing hospital outpatient departments that perform the outpatient procedures listed in Section 9: Outpatient Procedures and that share the hospital's license or CMS Certification Number.

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

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

Section 6D: Diagnostic Excellence

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

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

- Question #1, regarding the CEO's commitment to diagnostic excellence, will be updated to specify that the commitment must specifically focus on errors in diagnosis, and to indicate that the commitment must have been made by the hospital's current CEO or CMO.
- Questions #3 and #4, regarding patient engagement, will be updated to specify a timeframe for Patient and Family Advisory Council (PFAC) meetings and clarify that PFAC activities should focus on diagnosis in the hospital.

- Question #5 and #6, regarding risk assessment and mitigation, will be updated to specify that hospitals should use the Safer Dx Checklist to identify at least one practice not currently fully implemented and to clarify the specific steps the hospital is taking to close those gaps.
- Questions #7-15, regarding convening a multidisciplinary team focused on diagnostic excellence, will be updated to confirm that the multidisciplinary team should be a distinct entity at the hospital, not the established patient safety committee, as well as specifying specific timeframes for activities. A new FAQ will clarify that multidisciplinary teams should be hospital-specific, not system-level.
- Question #16, regarding training and education, will be updated to specify that the AHRQ's TeamSTEPPS for Diagnosis Improvement program is the training hospitals should be using to improve communication among members of the care team within the context of the diagnostic process.
- Questions #17-22, regarding closing the loop on cancer diagnosis, will include new FAQs to clarify which reports should be included, and how patients should be tabulated.

Section 6E: Hospital Boarding in the Emergency Department (ED)

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

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

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

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

- The percentage of ED patients that are admitted to the hospital that had a boarding time in the ED of more than 4 hours (where lower percentages are desirable)
- The median length of stay in the ED for patients admitted to the hospital (where lower values are desirable)
- The 90th percentile length of stay in the ED for patients admitted to the hospital (where lower values are desirable)

Based on responses received during the public comment period and further input from our Emergency Department Boarding Expert Panel, Leapfrog is making the following updates to the originally proposed questions:

- To better recognize the underlying systems issues that are key drivers of admitted inpatients boarding in the ED, Leapfrog will rename the subsection "Hospital Boarding in the Emergency Department (ED)" instead of "ED Boarding."
- Leapfrog will include patients admitted to observation status, as well as those admitted to the hospital's inpatient setting.
- Leapfrog will ask hospitals to report the median ED length of stay instead of the average ED length of stay for patients with an ED visit that are admitted to the hospital given that the average can be skewed by outliers.

- Leapfrog will also ask hospitals to report the 90th percentile ED length of stay for patients with an ED visit that are admitted to the inpatient setting to better understand a “bad” day in the ED.
- To address differences in boarding times among certain populations, such as behavioral health patients and pediatric patients, hospitals will be asked to stratify their data in two different ways: (1) separating adult patients from pediatric patients; and (2) separating patients admitted to an inpatient psychiatric bed from those admitted to an inpatient non-psychiatric bed. Leapfrog will monitor the use of admission to an inpatient psychiatric bed as the stratification decision moving forward, to understand if there are more accurate and/or more feasible approaches to capturing patients with a behavioral health diagnosis.

The questions will not be scored or publicly reported in 2025.

Change Summary Since Release

April 18, 2025 – Updated the measure specifications used to report on Hospital Boarding in the Emergency Department (ED) to exclude ED patients transferred from the ED to another hospital from questions 4a and 5a.

Section 6: Patient Safety Practices Measure Specifications

NQF Safe Practice Measure Specifications

Instructions for Reporting on NQF Safe Practices:

1. **Prepare:**
 - a. Download and review a copy of the National Quality Forum's *Safe Practices for Better Healthcare – 2010 Update* report for reporting on subsections 6A and 6B available at <http://leapfroggroup.org/survey-materials/survey-and-cpoe-materials>.
 - b. Print and review a hard copy of (1) the Survey questions, (2) the practice-specific FAQs, and (3) the scoring algorithm.
2. **Identify Individuals to Assist:** Decide who should participate on your team to assist in collection of the documentation for assessment.
3. **Plan:** The team should be briefed and assigned duties to help capture the key information necessary for submission of this section.
4. **Collect and Maintain:** Key documentation must be collected to support answering the questions in this section of the Survey. Please refer to the [Survey Binder](#) for examples of acceptable documentation. Documentation should be maintained to ensure that your hospital can respond to Leapfrog's request for documentation should you be selected for our [Monthly Documentation Requirements](#). Reviews are performed every month during the Survey Cycle (April 1 to November 30) and throughout the Corrections Period. In addition, the documentation can be helpful if your hospital is planning to update and resubmit this section of the Survey prior to November 30.
5. **Assess:** When all the supporting documents are assembled, it is recommended that hospitals review their final responses to Section 6 with the CEO and/or responsible leadership. Hospitals should update their answers online as they adopt additional practices throughout the Survey Cycle (April 1 to November 30). As a reminder, the [Corrections Period](#) (December 1-January 31) is reserved for corrections to previously submitted Surveys only. Any updates made to reflect a change in performance must be made prior to the November 30 Late Submission and Performance Update Deadline. Updates made to reflect a change in performance after November 30 will not be scored or publicly reported.
6. **Submit:** Section 6 must be completed and affirmed before it can be submitted with the Survey.

Hand Hygiene Measure Specifications

Important Note: Hospitals that share a CMS Certification Number are required to report by facility. Please carefully review [Leapfrog's Multi-Campus Reporting Policy](#).

Source: The framework and questions in this subsection are modeled after the World Health Organization's Hand Hygiene Self-Assessment Framework.
Reporting Period: Answer questions #1-21 based on the practices currently in place at the time you submit this section of the Survey. Note: For monitoring, this means that the monthly sample size (or quarterly sample size if answering question #10) would need to be met at least once in each patient care unit the month (or quarter) preceding the time of the submission of the Survey and there must be a process in place to meet the monthly (or quarterly) sample size thereafter in each patient care unit every month/quarter. If the monitoring sample size is not met at any point after submission, the Survey must be updated and re-submitted. More information about updating a Survey can be found at https://www.leapfroggroup.org/survey-materials/updating-your-hospital-survey. As a reminder, Leapfrog randomly requests documentation on a monthly basis and key documentation must be collected and maintained to support responses to all questions. Hospitals are urged to regularly review their documentation, including reports supporting their monitoring of hand hygiene, and maintain copies throughout the Survey Cycle. Please refer to the Survey Binder for examples.
Patient Care Units: Include only the following patient care units when reporting on the questions in this subsection: • Medical, Surgical, and Medical/Surgical Units (including telemetry units)¹⁹ (adult and/or pediatric) • Step-down/progressive Units²⁰ (adult and/or pediatric) • Obstetrical Units (Labor and Delivery Units²¹, nursery, etc., excluding procedural areas) • General Medical, Surgical, Medical/Surgical, and Neuro ICUs¹⁴ (adult and/or pediatric) • Neonatal ICUs¹⁷ • Specialty ICUs (adult and/or pediatric) • Pre-operative and Post-anesthesia Care Units²² (adult and/or pediatric) • Observation Units (adult and/or pediatric) • Dedicated Emergency Departments⁴⁷ (adult and/or pediatric) Other units that are not denoted above would be excluded for the purposes of reporting on Section 6D Hand Hygiene. The following units would be excluded: • Behavioral Health Units • Psychiatric Units • Palliative Care and Hospice Units • Rehabilitation Units • Operating Rooms • Procedural and Diagnostic Areas, such as Radiology, Endoscopy, Dialysis, and Radiation Units • Admission Units that don't hold patients overnight • Primary Care Clinics • Units that are not currently open and/or were not open consistently throughout the entire reporting period (i.e., most recent month or past three months based on responses selected in monitoring questions #8-10)
Infrastructure Question #4: Does your hospital have a process in place to ensure that all the following are done, as necessary, and quarterly audits are conducted on a sample of dispensers in your patient care units to ensure that the process is followed?

- Refill paper towels, soap dispensers, and alcohol-based hand sanitizer dispensers when they are empty or near empty
- Replace batteries in automated paper towel dispensers, soap dispensers, and alcohol-based hand sanitizer dispensers (if automated dispensers are used in the patient care units)

In order to respond “yes” to question #4, a process must be in place to ensure that paper towel, soap, and alcohol-based hand sanitizer dispensers are refilled when they are empty or near empty and batteries are replaced in automated paper towel, soap, and alcohol-based hand sanitizer dispensers (if automated dispensers are used in patient care units).

In addition, a quarterly audit must be conducted on a sample of paper towel, soap, and alcohol-based hand sanitizer dispensers to include checking that dispensers are refilled and that batteries in automated dispensers are replaced. The quarterly audit should be a supplement to a system that checks these supplies on a routine basis (e.g., environmental services check with their regular cleaning).

Sampling Instructions: The sample must be based on a random or systematic sampling procedure, where the sampling plan assures wide sampling (i.e., the same places would not always be monitored) and includes at least 5% of the dispensers in 20% of the patient care units.

Question #6: Does your hospital conduct audits of the volume of alcohol-based hand sanitizer that is delivered with each activation of a wall-mounted dispenser (manual and automated) on a sample of dispensers in your patient care units at **all** the following times:

- upon installation;
- whenever the brand of product or system changes; and
- whenever adjustments are made to the dispensers;

OR

Has your hospital conducted an audit of the volume of alcohol-based hand sanitizer that is delivered with each activation of a wall-mounted dispenser (manual and automated) on a sample of your hospital’s existing dispensers if there have been no changes to any dispensers?

In order to respond “yes” to question #6, a volume audit on a sample of wall-mounted alcohol-based hand sanitizer dispensers (manual and automated) in your patient care units must be conducted **at least** once (upon installation, whenever the brand of product or system changes, and whenever adjustments are made to the dispensers) using one of the below methods. Prior volume audits are acceptable if they were conducted using the instructions in Leapfrog’s 2019-2024 Surveys, documentation has been maintained, and no changes have been made to the dispensers since the audit.

Sampling Instructions: The sample must be based on a random or systematic sampling procedure, where the sampling plan assures wide sampling (i.e., the same places would not always be monitored) and includes at least 5% of the dispensers.

Method #1 - Auditing Liquid Volume: To audit the **liquid volume** of alcohol-based hand sanitizer that is delivered with each activation of a wall-mounted dispenser (manual and automated), use the following process:

1. Select a sample of dispensers based on a random or systematic sampling procedure.
2. Take a small, graduated plastic medicine cup and have the dispenser deliver 10 doses of alcohol-based hand sanitizer.
3. Divide the total volume dispensed by 10 to get an average of the amount dispensed.

NOTE: Hospitals using foam alcohol-based hand sanitizer will need to follow the steps above, but will instead need to weigh the sample, divide the results by 10 to obtain the average output of the sample, and then convert the weight in grams to milliliters by dividing the weight by the density (which can be provided by your vendor for your specific product).

Method #2 - Auditing Average Hand Rubbing Time: To audit the **average hand rubbing time** of alcohol-based hand sanitizer that is delivered with each activation of a wall-mounted dispenser (manual and automated), use the following process:

1. Select a sample of dispensers based on a random or systematic sampling procedure.
2. Identify multiple individuals (at least 10) with varying hand sizes (by quick observation).
3. For each sampled dispenser, have each of the individuals identified in step #1 dispense a volume of alcohol-based hand sanitizer.
4. For each individual, have a separate individual time the amount of hand rubbing time required for hands to dry completely.
5. Repeat this process for each individual and calculate an **average** time based on the ten observations conducted.
6. Repeat this process for each sampled dispenser.

Question #7: Do all the audited dispensers deliver, with one activation, 1.0 mL of alcohol-based hand sanitizer OR a volume of alcohol-based hand sanitizer that covers the hands completely and requires 15 or more seconds for hands to dry (on average)?

In order to respond “yes” to question #7, the **average** liquid volume for **each** sampled dispenser needs to be at least 1.0 mL (if using method #1) or the **average** hand rubbing time for **each** sampled dispenser needs to be at least 15 seconds (if using method #2).

Monitoring

Hand hygiene opportunities: Hand hygiene opportunities are the number of times that an individual who touches patients or who touches items used by patients should have cleaned their hands given the hand hygiene framework your hospital has adopted (e.g., WHO’s “5 moments,” Ontario’s 4 moments, CDC’s guidelines, etc.). In terms of determining opportunities to monitor, this would depend on the guidelines the hospital chooses to follow.

For example, many facilities choose to audit before and after patient contact or room entry and exit because this is operationally the simplest method. Auditing opportunities before and after dirty tasks is operationally difficult. There is some evidence that measuring adherence on room entry and exit may be an acceptable stand-in for other opportunities within the patient encounter.

Electronic compliance monitoring system: Electronic compliance monitoring systems would include door minder or activity monitoring systems, systems that include the wearing of electronic badges, and camera-based systems that are used to monitor hand hygiene compliance.

Question #8: Does your hospital collect hand hygiene compliance data on at least **200 hand hygiene opportunities**, or at least the number of hand hygiene opportunities outlined based on the unit type in Tables 1-3, **each month in each patient care unit**?

In order to respond “yes” to question #8, your hospital must monitor at least **200 hand hygiene opportunities**, or at least the number of hand hygiene opportunities outlined based on the unit type in Tables 1-3, **each month in each patient care unit** using either:

- An electronic compliance monitoring system throughout all patient care units
- An electronic compliance monitoring system throughout some patient care units and only direct observation in all other patient care units
- Only direct observation throughout all patient care units

Refer to the following tables to determine how many hand hygiene opportunities must be monitored in each patient care unit monthly for question #8. **Historical data** (e.g., past 3 months, 6 months, 12 months, etc.) on the monthly occupancy rates or procedure/patient volumes should be used.

Units/areas can be combined for the purposes of determining if you have met the monthly or quarterly monitoring sample size if they share a common group of staff (i.e., staff are scheduled to work in the broader area and float between units or staff may be scheduled to work either unit on any given day). Hand hygiene opportunities would still need to be monitored throughout both units/areas.

Table 1: Units where the monthly occupancy rate can be calculated

If your unit’s average daily census is...	Your patient care unit needs to collect hand hygiene compliance data for at least
---	--

	this number of <u>hand hygiene opportunities per month</u> for question #8...
13 patients or higher	200
10-12 patients	150
7-9 patients	100
5-6 patients	75
3-4 patients	45
1-2 patients	15

Table 2: Units where the monthly occupancy rate cannot be calculated (e.g., PACU, labor and delivery, outpatient units)

If your unit's average number of procedures/patient volume in a month is...	Your <u>patient care unit</u> needs to collect hand hygiene compliance data for <u>at least this number of hand hygiene opportunities per month</u> for question #8...
400 procedures/patients or greater	200
320-399 procedures/patients	150
240-319 procedures/patients	100
160-239 procedures/patients	75
120-159 procedures/patients	50
60-119 procedures/patients	30
30-59 procedures/patients	15
<30 procedures/patients	5

Table 3: Emergency department units

If your emergency department's average number of visits in a month is...	Your <u>patient care unit</u> needs to collect hand hygiene compliance data for <u>at least this number of hand hygiene opportunities per month</u> for question #8...
2000 visits or greater	200
1500-1999 visits	150
1000-1499 visits	100
750-999 visits	75
500-749 visits	50
250-499 visits	25
150-249 visits	15
<150 visits	5

Question #9: Does your hospital collect hand hygiene compliance data on at least **100 hand hygiene opportunities**, or at least the number of hand hygiene opportunities outlined based on the unit type in Tables 4-6, **each month in each patient care unit**?

In order to respond "yes" to question #9, your hospital must monitor at least **100 hand hygiene opportunities**, or at least the number of hand hygiene opportunities outlined based on the unit type in Tables 4-6, **each month in each patient care unit** using either:

- An electronic compliance monitoring system throughout all patient care units
- An electronic compliance monitoring system throughout some patient care units and only direct observation in all other patient care units
- Only direct observation throughout all patient care units

Refer to the following tables to determine how many hand hygiene opportunities must be monitored in each patient care unit monthly for question #9. **Historical data** (e.g., past 3 months, 6 months, 12 months, etc.) on the monthly occupancy rates or procedure/patient volumes should be used.

Units/areas can be combined for the purposes of determining if you have met the monthly or quarterly monitoring sample size if they share a common group of staff (i.e., staff are scheduled to work in the

broader area and float between units or staff may be scheduled to work either unit on any given day). Hand hygiene opportunities would still need to be monitored throughout both units/areas.

Table 4: Units where the monthly occupancy rate can be calculated

If your unit's average daily census is...	Your patient care unit needs to collect hand hygiene compliance data for <u>at least this number of hand hygiene opportunities per month</u> for question #9...
13 patients or higher	100
10-12 patients	75
7-9 patients	50
5-6 patients	37
3-4 patients	22
1-2 patients	7

Table 5: Units where the monthly occupancy rate cannot be calculated (e.g., PACU, labor and delivery, outpatient units)

If your unit's average number of procedures/patient volume in a month is...	Your patient care unit needs to collect hand hygiene compliance data for <u>at least this number of hand hygiene opportunities per month</u> for question #9...
400 procedures/patients or greater	100
320-399 procedures/patients	75
240-319 procedures/patients	50
160-239 procedures/patients	37
120-159 procedures/patients	25
60-119 procedures/patients	15
30-59 procedures/patients	7
<30 procedures/patients	2

Table 6: Emergency department units

If your emergency department's average number of visits in a month is...	Your patient care unit needs to collect hand hygiene compliance data for <u>at least this number of hand hygiene opportunities per month</u> for question #9...
2000 visits or greater	100
1500-1999 visits	75
1000-1499 visits	50
750-999 visits	37
500-749 visits	25
250-499 visits	15
150-249 visits	7
<150 visits	2

Question #10: Does your hospital collect hand hygiene compliance data on at least **100 hand hygiene opportunities each quarter in each patient care unit**?

In order to respond "yes" to question #10, your hospital must monitor at least **100 hand hygiene opportunities each quarter in each patient care unit** using either:

- An electronic compliance monitoring system throughout all patient care units
- An electronic compliance monitoring system throughout some patient care units and only direct observation in all other patient care units
- Only direct observation throughout all patient care units

There are no alternate sample sizes for the quarterly requirement. Hospitals trying to meet the quarterly requirement in question #10 will need to monitor 100 hand hygiene opportunities a quarter.

Units/areas can be combined for the purposes of determining if you have met the monthly or quarterly monitoring sample size if they share a common group of staff (i.e., staff are scheduled to work in the broader area and float between units or staff may be scheduled to work either unit on any given day). Hand hygiene opportunities would still need to be monitored throughout both units/areas.

Question #12: In those patient care units where an electronic compliance monitoring system is used, does the monitoring system used meet both of the following criteria?

- The system can identify both opportunities for hand hygiene and that hand hygiene was performed
- The hospital itself has validated the accuracy of the data collected by the electronic compliance monitoring system

In order to respond “yes” to question #12, the electronic monitoring system in use must identify both opportunities and that hand hygiene was performed, which could include both group monitoring systems and badge-based systems.

For example, an electronic monitoring system that records when an individual (not identified) enters and exits a room and also records if a dispenser was used within the same time frame, would qualify as the entry and exit is used as a proxy for a hand hygiene opportunity (before and after touching a patient) and the dispenser use is used as a proxy for a hand hygiene event. This data can be adjusted to take visitors into account and used to estimate hand hygiene compliance. Another example would be a badge-based system where individuals or their roles can be identified.

In addition, validation of the accuracy of the data collected by the electronic compliance monitoring system must be performed by hospital personnel or independent third-party personnel, in addition to any validation conducted by the manufacturer. It needs to include both a “planned path” phase where the researcher(s) make timed observations of room entries and exits and use of dispensers and compare their results to data recorded by the electronic compliance monitoring system. Followed by a “behavioral path” phase where observers record the same variables when individuals who touch patients or who touch items that will be used by patients are performing their usual duties, as this tends to be more chaotic and variable. A general validation protocol that can be used for both group monitoring systems and badge-based systems has been described in a fair amount of detail in the 2016 article by Limper H et al. Similar methods for conducting validation studies of badge-based system have been described by Pineles LL, et al. in 2014, and by Doll ME et al. in 2019. The 2023 article from Parker et al. regarding sample sizes for the validation can also be referenced.

Question #13: In those patient care units where an electronic compliance monitoring system is used, are direct observations also conducted for coaching and intervention purposes that meet all the following criteria?

- Observers immediately intervene prior to any harm occurring to provide non-compliant individuals with immediate feedback
- Observations identify both opportunities for hand hygiene and compliance with those opportunities
- Observations determine who practiced hand hygiene, verify when they practiced it, and whether their technique was correct
- Observations within a unit are conducted weekly or monthly across all shifts and on all days of the week proportional to the number of [individuals who touch patients or who touch items that will be used by patients](#)⁴⁴ on duty for that shift
- Observations capture a representative sample of the different roles of [individuals who touch patients or who touch items that will be used by patients](#)⁴⁴ (e.g., nurses, physicians, techs, environmental services workers)

In order to respond “yes” to question #13, direct observations must be conducted for coaching and intervention purposes and meet the following sample sizes at a minimum:

In units with either low hand hygiene compliance* and/or units with high infection rates:**

- On a monthly basis, hospitals will need to perform 20 direct observations.

- If after collecting those observations, more than 50% of the observations were NOT compliant and/or did NOT demonstrate proper technique, the hospital will need to perform an additional 20 observations the following month (40 total observations per unit with low hand hygiene compliance or high infection rates).
- The hospital must continue to collect 40 observations per month until the number of observations that are NOT compliant and/or did not demonstrate proper technique is reduced to less than 50%.

Compliance and infection rates must be assessed at least quarterly and additional observations need to be collected on a monthly basis for the entire quarter if warranted based on the above rules. If a standardized infection ratio cannot be calculated for the quarter, units with 2 or more observed infections should do the additional collection of direct observations.

**Low hand hygiene compliance is defined as two or more standard deviations below the hospital's overall mean hand hygiene compliance rate.*

***High infection rates are defined as two or more standard deviations above the hospital's standardized infection ratio for any of the following healthcare-associated infection measures: CLABSI, CAUTI, MRSA, and C.diff.*

In all other units:

- On a quarterly basis, hospitals using ECM need to perform 10% of the observations noted in Tables 1-3 in ALL patient care units included in Leapfrog's Hand Hygiene Standard (e.g., if the unit would require 200 direct observations without ECM, then with the use of ECM, they need to collect 20 direct observations).
- Units in which direct observation data is being collected monthly (i.e., units with low hand hygiene compliance and/or high infection rates) do not require the additional quarterly data collection.

All direct observations conducted must meet the following criteria:

- Observers immediately intervene prior to any harm occurring to provide non-compliant individuals with immediate feedback
 - Observations identify both opportunities for hand hygiene and compliance with those opportunities
 - Observations determine who practiced hand hygiene, verify when they practiced it, and whether their technique was correct
 - Observations within a unit are conducted weekly or monthly across all shifts and on all days of the week proportional to the number of individuals who touch patients or who touch items that will be used by patients⁴⁴ on duty for that shift
- Observations capture a representative sample of the different roles of individuals who touch patients or who touch items that will be used by patients⁴⁴ (e.g., nurses, physicians, techs, environmental services workers)

Observers must record at least the following:

- The date as well as the start and end time of the observation session (or the date and shift being observed)
- The unit where the observation session is being conducted
- The role of the individual being observed (e.g., nurse, physician, etc.)
- The indication (or moment) for performing hand hygiene (e.g., before/after touching a patient, before/after a procedure, before/after touching patient surroundings, etc.)
- Whether hand hygiene was performed or not performed based on the indication noted and if the technique was correct

Question #14: In those patient care units where an electronic compliance monitoring system is NOT used, do the direct observations meet all the following criteria?

- Observations identify both opportunities for hand hygiene and compliance with those opportunities
- Observations determine who practiced hand hygiene, verify when they practiced it, and whether their technique was correct
- Observations within a unit are conducted weekly or monthly across all shifts and on all days of the week proportional to the number of [individuals who touch patients or who touch items that will be used by patients](#)⁴⁴ on duty for that shift
- Observations capture a representative sample of the different roles of [individuals who touch patients or who touch items that will be used by patients](#)⁴⁴ (e.g., nurses, physicians, techs, environmental services workers)

In order to respond “yes” to question #14, direct observations must be conducted in patient care units that do not use an electronic compliance monitoring system and must meet the following criteria:

- Observations identify both opportunities for hand hygiene and compliance with those opportunities
- Observations determine who practiced hand hygiene, verify when they practiced it, and whether their technique was correct
- Observations within a unit are conducted weekly or monthly across all shifts and on all days of the week proportional to the number of [individuals who touch patients or who touch items that will be used by patients](#)⁴⁴ on duty for that shift
- Observations capture a representative sample of the different roles of [individuals who touch patients or who touch items that will be used by patients](#)⁴⁴ (e.g., nurses, physicians, techs, environmental services workers)

Observers must record at least the following:

- The date as well as the start and end time of the observation session (or the date and shift being observed)
- The unit where the observation session is being conducted
- The role of the individual being observed (e.g., nurse, physician, etc.)
- The indication (or moment) for performing hand hygiene (e.g., before/after touching a patient, before/after a procedure, before/after touching patient surroundings, etc.)
- Whether hand hygiene was performed or not performed based on the indication noted and if the technique was correct

Question #15: Does your hospital have a system in place for both the initial and recurrent training and validation of hand hygiene compliance observers?

In order to respond “yes” to question #15, your hospital must regularly monitor the quality and accuracy of observations that are collected by each observer through initial and recurrent validation (at least once a year) of hand hygiene compliance observers. This would include having an individual trained in infection control simultaneously collecting data with the hand hygiene compliance observers and comparing results. Alternatively, videos which include an interactive assessment and completion of an observation form, such as the [WHO Hand Hygiene Training Film](#) and [Slides Accompanying the Training Films, Videos from Hand Hygiene Australia](#), or internally developed videos with assessment, would also be sufficient for validating hand hygiene compliance observers. Hospitals must expand the testing scenarios that are included in the videos (i.e., the videos should be expanded to include: various types of individuals who touch patients or who touch items that will be used by patients, a larger number of scenarios where individuals are adherent and non-adherent, the inclusion of all moments observed, etc.).

See [FAQs](#) for additional information about responding to the questions in this section.

Closing the Loop on Cancer Diagnosis Measure Specifications

Important Note: Hospitals that share a CMS Certification Number are required to report by facility. Please carefully review [Leapfrog's Multi-Campus Reporting Policy](#).

Source: The Leapfrog Group
Reporting Period: 12 months - Surveys submitted prior to September 1: 01/01/2024 – 12/31/2024 - Surveys submitted on or after September 1: 07/01/2024 – 06/30/2025
Sufficient Sample: Hospitals must randomly sample at least 30 patients 18 years and older who were diagnosed with at least one of colon, lung, or breast cancer, and measure the number of those patients where there is evidence of documented communication (in the medical record or otherwise) between the pathologist and the patient or patient's ordering physician, and the number of those patients who were notified that the pathology report with their diagnosis was uploaded to the patient portal.
Question #20 (denominator): How many cases were included in the audit from question #19 with a diagnosis of colon, lung, or breast cancer?
Question #21 (numerator): Total number of patients from question #20 with documented communication between the pathologist and the patient or patient's ordering physician within five business days of the report being signed by the pathologist: Documented communication includes: A documented phone call between the pathologist and patient or patient's ordering physician of the diagnosis, and a timestamp, read receipt, or email response indicating that the patient or patient's ordering physician read an electronic communication of the diagnosis.
Question #22 (numerator): Total number of patients from question #20 who were notified, either by phone or electronically, that the pathology report with their diagnosis was uploaded to the patient portal and ready for review: Hospitals that do not upload pathology reports to the patient portal or notify patients when reports are uploaded, should enter "0."

Hospital Boarding in the Emergency Department (ED) Boarding Measure Specifications

Important Note: Hospitals that share a CMS Certification Number are required to report by facility. Please carefully review [Leapfrog's Multi-Campus Reporting Policy](#).

Source: The Leapfrog Group
Reporting Period: 12 months - Survey submitted prior to September 1: 01/01/2024 – 12/31/2024 - Surveys submitted on or after September 1: 07/01/2024 – 06/30/2025
Hospital Boarding in the ED Workbook (Excel): To complete the data collection and respond to questions #4-5, hospitals should download the Hospital Boarding in the Emergency Department Workbook (Excel). This workbook includes five tabs: Instructions, Adult Inpatient Non-Psychiatric, Adult Psychiatric, Pediatric Inpatient Non-Psychiatric, Pediatric Psychiatric. The four tabs can be used to calculate the responses to questions #4b. number of adult patients boarding >4 hours, c. median length of stay (LOS), and d. 90th percentile LOS and questions #5b. number of pediatric patients boarding >4 hours, c. median length of stay (LOS), and d. 90th percentile LOS. The workbook is available on the Survey Materials Webpage.
Included Units: Dedicated Emergency Department⁴⁷ (adult, pediatric, and adult/pediatric)
Question #4, column a: Total number of adult ED visits with an inpatient admission or where the patient was placed in hospital observation status. Enter the total number of emergency department (ED) visits during the reporting period for each of the following admission types: Adult (18 years of age or older) patients admitted to an inpatient non-psychiatric bed Adult (18 years of age or older) patients admitted to an inpatient psychiatric bed Include: - Patients with an ED visit that were admitted to the hospital's inpatient setting or placed in hospital observation status. Exclude: - Patients with an ED visit that were placed in ED observation status. Patients transferred to another hospital. Note: A patient can have multiple ED visits with a hospital admission and/or placed in hospital observation status during the performance period so each patient ED visit with an inpatient admission or placement into hospital observation status is included in the denominator (question #4a). If the number of visits for an adult admission type is less than 10 (in column a), skip columns b, c, and d and then move to the next admission type.
Question #4, column b: Number of ED visits indicated in column (a) with a boarding time greater than 4 hours. Enter the total number of emergency department (ED) visits indicated in column (a) with a boarding time greater than 4 hours for each of the following admission types: Adult (18 years of age or older) patients admitted to an inpatient non-psychiatric bed Adult (18 years of age or older) patients admitted to an inpatient psychiatric bed

Include:

- Patients with an ED visit that **were** admitted to the hospital's inpatient setting or **placed in** hospital observation status with an ED boarding time that was longer than 4 hours.

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

Question #4, column c: Median number of **hours** spent in the ED for ED visits indicated in column (a).

Enter the median number of hours spent in the ED for ED visits indicated in column (a) for each of the following admission types:

Adult (18 years of age or older) patients admitted to an inpatient **non-psychiatric bed**
Adult (18 years of age or older) patients admitted to an inpatient **psychiatric bed**

Include:

- Hours spent in the ED for patients with an ED visit that **were** admitted to the hospital's inpatient setting or **placed in** hospital observation status.

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

Question #4, column d: 90th percentile of **hours** spent in the ED for ED visits indicated in column (a).

Enter the 90th percentile of hours spent in the ED for ED visits indicated in column (a) for each of the following admission types:

Adult (18 years of age or older) patients admitted to an inpatient **non-psychiatric bed**
Adult (18 years of age or older) patients admitted to an inpatient **psychiatric bed**

Include:

- Hours spent in the ED for patients with an ED visit that **were** admitted to the hospital's inpatient setting or **placed in** hospital observation status.

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

Question #5, column a: Total number of pediatric ED **visits** with an inpatient admission or **where the patient was placed in hospital** observation status.

Enter the total number of emergency department (ED) visits during the reporting period for each of the following admission types:

Pediatric (17 years of age or younger) patients admitted to an inpatient **non-psychiatric bed**
Pediatric (17 years of age or younger) patients admitted to an inpatient **psychiatric bed**

Include:

- Patients with an ED visit that **were** admitted to the hospital's inpatient setting or **placed in** hospital observation status.

Exclude:

- Patients with an ED visit that were **placed in** ED observation status.
- **Patients transferred to another hospital.**

Note: A patient can have multiple ED visits with a hospital admission **and/or placed in hospital observation status** during the performance period so each patient ED visit with an inpatient admission **or placement into hospital observation status** is included in the denominator (question #4a).

If the number of visits for a pediatric admission type is less than 10 (in column a), skip columns b, c, and d.

Question #5, column b: Number of ED visits indicated in column (a) with a boarding time greater than 4 hours.

Enter the total number of emergency department (ED) visits indicated in column (a) with a boarding time greater than 4 hours for each of the following admission types:

Pediatric (17 years of age or younger) patients admitted to an inpatient **non-psychiatric bed**

Pediatric (17 years of age or younger) patients admitted to an inpatient **psychiatric bed**

Include:

- Patients with an ED visit that **were** admitted to the hospital's inpatient setting or **placed in** hospital observation status with an ED boarding time that was longer than 4 hours.

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

Question #5, column c: Median number of hours spent in the ED for ED visits indicated in column (a).

Enter the median number of hours spent in the ED for ED visits indicated in column (a) for each of the following admission types:

Pediatric (17 years of age or younger) patients admitted to an inpatient **non-psychiatric bed**

Pediatric (17 years of age or younger) patients admitted to an inpatient **psychiatric bed**

Include:

- Hours spent in the ED for patients with an ED visit that **were** admitted to the hospital's inpatient setting or **placed in** hospital observation status.

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

Question #5, column d: 90th percentile of hours spent in the ED for ED visits indicated in column (a).

Enter the 90th percentile of hours spent in the ED for ED visits indicated in column (a) for each of the following admission types:

Pediatric (17 years of age or younger) patients admitted to an inpatient **non-psychiatric bed**

Pediatric (17 years of age or younger) patients admitted to an inpatient **psychiatric bed**

Include:

- Hours spent in the ED for patients with an ED visit that **were** admitted to the hospital's inpatient setting or **placed in** hospital observation status.

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

Patient Safety Practices Frequently Asked Questions (FAQs)

General Questions

1. For the purposes of reporting on Section 6 of the Leapfrog Hospital Survey:

- a. **Frontline caregivers** include, but are not necessarily limited to employed physicians, mid-levels (NPs, PAs), nurses, environmental services staff, allied health professionals, and occupational and physical therapists.
- b. **Service line management** refers to those who manage all functions within a specific service line (e.g., oncology, cardiac, women's, orthopedics). These individuals may be managing a departmental sub-function within a broader department (e.g., cardiac care within the Department of Medicine).
- c. **Midlevel management** includes the intermediate management of an organization that is subordinate to the executive management and responsible for at least two lower levels of staff below them. An example would include a Director of Nursing, who might oversee Nursing Managers, who oversee the nurses who care directly for patients.
- d. **Physician leadership** refers to physicians who serve in a leadership role in the organization. Titles may include positions such as Chief Medical Officer, Vice President for Medical Affairs, Medical Director, and/or Department Chair.
- e. **Nursing leadership** refers to nurses who serve in a leadership role (e.g., Chief Nursing Officer, Vice President/Assistant Vice President of Nursing, Vice President/Assistant Vice President for Clinical Operations, etc.)
- f. **Senior administrative leadership** refers to administrators who are responsible for hospital-wide departments or services (e.g., Chief Executive Officer, Chief Administrative Officer, Chief Nursing Officer, Chief Medical Officer, etc.).
- g. **Patient Safety Officer** refers to the patient safety leader (who may or may not have the title "Patient Safety Officer") who has responsibility for multiple and integrated areas of patient safety. The organization may appoint an officer who may have other assigned duties or may specifically employ a Patient Safety Officer designated with this responsibility. Multiple executives who are responsible for individual areas (i.e., risk, quality, infection prevention, etc.), but do not assess the integrated safety issues, would not qualify.
- h. **Board (governance)** refers to the individual hospital's board of directors, or the board that governs the hospital and can pass policies that impact the hospital, or a system-wide board that governs hospitals in the system, or a committee of the board (such as a board-appointed, hospital-wide Patient Safety and Quality Committee, which includes board members).
- i. **Medical executive committee** refers to a primary governance committee for medical staff. The medical executive committee makes leadership decisions related to medical staff policies, procedures, and rules, with an emphasis on quality control and quality improvement. They also adopt and implement these policies and procedures and are responsible for medical staff appointment and reappointment.

2. Why is it necessary to continue to review a safe practice once it has been implemented?

All too often in the hectic pace of providing patient care in a hospital, with frequent staff turnover and lots of part-time employees, it is difficult to get a change in practice well-established. Annual review with monitoring and tracking of the safe practices will ensure that they are embedded in the operations of the hospital and not lost in the transition of new staff coming in or part-time employees coming and going.

3. The phrase “performance reviews or compensation” is used throughout Section 6 within many **Accountable** elements. Do performance reviews and compensation plans need to have specific language about the Safe Practice or can a set of patient safety goals related to the specific Safe Practice be attached?

A performance review or compensation plan should include specific language about a Safe Practice. A list of Safe Practices and related goals may be incorporated into the performance review and/or compensation plan or formalized programs whereby a measure of success of those activities or programs is tied to individual performance reviews or compensation incentive plans of executives.

Every employee should have a patient safety component included in their annual review. Another option is to include in the employee’s competency review (Ongoing Professional Practice Evaluation, Focused Professional Practice Evaluation).

4. There are several references to hospital budgets throughout Section 6 within many **Ability** elements. How can hospitals meet the intent of these elements?

The intent of these elements is to verify that actions specific to the Safe Practices have been included in hospital budgets. To meet the intent of these elements, hospitals should ensure that these actions can be identified within a department budget or hospital budget. If the budget includes categories that address the Safe Practice but do not specifically name the Safe Practice, then the intent of the element is met.

Further, if a hospital has not allocated budget dollars for activities tied to a Safe Practice but can document expenses specific to the Safe Practice during the reporting period, the intent of the element is met. Plans to allocate specific budget dollars for a Safe Practice should be incorporated into the next upcoming budget year as an ongoing process.

Hospitals may also document training or education expenditures specific to the Safe Practice or expenditures on educational materials that are specific to the Safe Practice.

Hospitals that have invested in in-house staff educators and who include in their job descriptions the coordination and delivery of training and education to appropriate hospital staff on specific Safe Practices meet the intent of this element. For example, if the position description for an in-house educator, such as the Quality Director, includes the coordination and delivery of in-service training and educational sessions related to improving the culture of safety based on the organization’s culture of safety survey results, then the intent of this practice is met. Specific time allocations are not required as long as there is documentation of staff participation through dated meeting minutes or attendance records. Training can be in-person or virtual/ computer-based.

5. How should staff education be measured?

Educational meetings should clearly address the subject matter pertinent to adverse events and performance improvement targeted by the specific Safe Practice. Hospitals should track meeting dates, frequency of training sessions provided, attendance records or completion records, and the percentage of the total staff who received the information. Training can be in-person or virtual/ computer-based.

6. There are several references to developing or implementing Performance Improvement Programs throughout Section 6 within many **Action** elements. How can hospitals meet the intent of these elements?

At a minimum, performance improvement programs should include **all** the following five criteria:

- **Education** regarding the pertinent adverse event frequency, severity, and/or impact of best practices. These expenses should be budgeted and tracked to meet the budget elements of the Safe Practices.
- **Skill building** in use of performance improvement tools. These expenses should be budgeted and tracked to meet the budget elements of the Safe Practices.

- **Measurement** of process measures or outcomes measures. The “Outcome, Process, Structure, and Patient-Centered Measures” section at the end of each Safe Practice in the [NQF Safe Practices for Better Healthcare 2010 Update](#) suggests performance measures that can be used to support measuring and monitoring quality improvement efforts.
- **Process improvement** and interventions.
- **Reporting** of performance outcomes.

A “campaign” such as an awareness campaign would not meet the intent of these elements.

NQF Safe Practice #1 – Leadership Structures and Systems FAQs

7. **1.1a, 1.2b, and 1.2d: Several elements within NQF Safe Practice #1 mention that “regular communication” is required. How does Leapfrog define “regular communication”?**

Regular communication means more than once a year. Some hospitals may discuss these items quarterly or even monthly. Hospitals can document that these communications took place through dated meeting minutes. We would urge hospitals to improve the detail of their board and other meeting minutes to ensure they are able to clearly document that the issues were discussed.

The discussion of these items can be a general note in the minutes, without specific details. However, hospitals should maintain copies of dated presentations and reports related to these agenda items in order to document adherence to these elements. Meetings can be in-person or virtual.

8. **1.1a: If NQF Safe Practice #4 – Identification and Mitigation of Risks and Hazards has been removed from the Leapfrog Hospital Survey, are hospital boards still expected to communicate regularly regarding risks and hazards?**

Though we are not asking hospitals to report on this Safe Practice, it remains important to communicate the actions you are taking to identify and mitigate risks and hazards to patients to your board.

9. **1.1b: What is meant by “patients and/or families of patients are active participants in the hospital-wide safety and quality committee?”**

To meet the intent of this element, hospitals must have patients and/or families of patients participate on the hospital-wide safety and quality committee. The safety and quality committee should have influence over hospital-wide quality and safety issues, not just a particular department or service line. Hospitals with a system-wide safety and quality committee must have one patient representative per campus on the system-wide safety and quality committee.

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

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

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

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

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

10. 1.1c: What are some examples of how a hospital can report to the community ongoing efforts and results of these efforts to improve safety and quality?

Hospitals can utilize several communication vehicles to reach the broader community, including webpages that are prominent from the organization's homepage, electronic newsletters, mailings or annual reports, or an ad in the local paper. The communication must include **both** efforts the hospital is taking to improve safety and quality and the results of those efforts. As the sole focus of the NQF Safe Practices for Better Health Care report is reducing or preventing adverse events (refer to NQF list of adverse events at <https://digitalassets.jointcommission.org/api/public/content/4534bbaaee4f4bd280c2054765f37f4b?v=a60f8f9a>), patient safety and quality efforts **reported to the community** must have this focus as well. In other words, efforts the hospital is taking to improve safety and quality should be related to reducing or preventing these adverse events and the results of those efforts would be the measurable outcomes.

Meetings where a few community members are present would not meet the intent of this practice as the intent is to reach a larger audience.

Each hospital within the same health care system would need to report the results to the community for each hospital in the system because the results of efforts to improve safety and quality would be different at each hospital.

11. 1.2a, 1.3a, 1.4c: What are the minimum requirements to qualify as a “patient safety program?”

As part of accreditation through The Joint Commission, hospitals are required to meet standard LD.03.09.01, which identifies the elements that must be included in an integrated patient safety program (see pages 57 – 62 in the Organization Culture and System Performance Expectations chapter of [The Joint Commission E-dition](#)). Hospitals that are not accredited by The Joint Commission can use these elements as a guide as well.

12. 1.2d: What is the role of an interdisciplinary patient safety committee?

An interdisciplinary patient safety committee is an internal hospital committee that oversees the activities defined in the NQF Safe Practice #1 Practice Element Specifications and develops action plans to create solutions and changes in performance.

13. 1.2d: What is an example of team training that is appropriate for caregivers?

Hospitals can utilize [TeamSTEPPS](#), a comprehensive, evidence-based training program for health care professionals. At a minimum, the elements of basic teamwork training should be met as described on page 96 of the Safe Practices for Better Healthcare– 2010 Update, which is available for download here: <http://www.leapfroggroup.org/survey-materials/survey-and-cpoe-materials>.

Team training to caregivers would need to be provided and then reported to senior administrative leadership by the interdisciplinary patient safety team to meet the intent of Safe Practice 1.2d.

14. 1.2e: How can hospitals that have not had any adverse events during the reporting period earn credit for this element?

First, we urge your hospital to reassess its conclusion that no adverse events occurred; that would be highly unusual. Following the reassessment, if no adverse events were identified and the hospital can document that it has policies in place to report such events when they do occur (to a mandatory or voluntary program), the hospital would meet the intent of this element. Please see Section 7A: Never Events for a list of adverse events and components of a Never Events Policy.

15. 1.4a: What are some examples of how the CEO and senior administrative leadership can be personally engaged in reinforcing patient safety improvements?

Executive walk-arounds are an example of how the CEO and senior administrative leadership can be personally engaged in reinforcing patient safety improvements. The executive walk-arounds provide staff with visibility and access to senior management. They also provide the CEO and senior administrative leadership with the opportunity to address issues and concerns in various departments in real-time, rather than in monthly meetings. Monthly meetings with staff in a centralized location do not meet the intent of this Safe Practice.

Progress on the implementation of walk-arounds can be measured by tracking the number of walk-arounds performed per unit or clinical area for designated time periods as shown in the calendars of the CEO and senior administrative leadership. Some progressive hospitals have tied incentives to regular executive walk-arounds and to reliable exchange of information on clinical unit performance. Some hospitals have established a feedback loop between the CEO and senior administrative leadership and staff to measure the implementation of performance improvement ideas that were generated during executive walk-arounds.

16. 1.4b: What are some examples of how the CEO can actively engage leaders from service lines, midlevel management, clinical leadership, and physician leadership in patient safety improvement actions?

Hospitals can refer to the American College of Healthcare Executives [professional policy statement](#), which includes examples of how leaders should be engaged in patient safety and quality.

17. 1.4c: What are some examples of how hospitals can engage the medical staff as direct contributors to the patient safety program?

Examples may include:

- Senior leadership requests time on Medical Staff Department standing agendas to provide patient safety updates and elicit direct feedback on specific areas as well as “what keeps the medical staff up at night.”
- Medical staff are invited and encouraged to be active participants in clinical unit meetings where patient safety is addressed.
- The board appoints a community-based active medical staff member to represent the organization on a regional patient safety initiative.

18. 1.4c: In a hospital where all medical staff is employed, how do we answer this question?

The intent of this element is to ensure that physicians and medical staff have the opportunity to provide input on the hospital's patient safety plan because often they do not have a significant position in the hierarchical structure of an organization but carry a great deal of influence over how the organization is run. Thus, they are informal leaders who can be change agents and “accelerators or barriers for improvement.” If the organization's board and senior administrative leadership seek and document input from physicians and medical staff regarding patient safety programs, the intent of this element has been met.

NQF Safe Practice #2 – Culture Measurement, Feedback, and Intervention FAQs

19. Why are two different reporting periods used in NQF Safe Practice #2?

Within the *Awareness and Accountability* elements, a 24-month reporting period is used because these elements are related to conducting the culture of safety survey, which is typically conducted every other year. Within the *Ability and Action* elements, a 12-month reporting period is used because these practices are related to follow-up activities that would be completed after the results from the culture of safety survey are available.

20. 2.1a: What are the requirements to qualify as a “culture of safety survey?”

Several surveys are readily available that specifically address culture, safety climate, and teamwork. These surveys incorporate all the additional specifications as outlined in NQF Safe Practice #2 (see 2010 NQF Safe Practice Report).

Hospitals that do not use a nationally recognized culture of safety tool must ensure that their culture of safety survey meets Leapfrog’s guidelines for what constitutes a valid, consistent, and reliable survey tool. These guidelines were developed in consultation with Leapfrog’s Culture of Safety Expert Panel. The guidelines can be found on the [Survey and CPOE Materials webpage](#) under supporting materials for Section 6.

A general employee satisfaction survey that has a small component of the survey addressing organizational culture does not qualify.

21. 2.1a Can an employee engagement survey and nationally recognized culture of safety tool be conducted at the same time?

Yes, if the culture of safety tool is unaltered and administered in its entirety.

22. 2.1a: What does “50% of the aggregated care delivered to patients within the hospital” mean?

As described on page 88 of the NQF Safe Practices for Better Healthcare Report, “a census of units or service areas that in aggregate deliver care to more than 50 percent of the patients receiving care should be surveyed, service lines or units where there is a high patient safety risk should be measured, and there should be a valid sample to allow for unit-level analysis and facilitate improvement.”

23. 2.1b: For reporting individual unit level results, what is the minimum number of responses a hospital should have?

Most major vendors use a threshold of 5 or more responses and a 40% response rate. For larger units, a lower response rate may be acceptable. If a unit does not meet these thresholds, your hospital could aggregate the results of “like” units together (e.g., medical/surgical units, ICUs, ORs). Hospitals should not combine results across “unlike” units.

24. 2.1c: What is meant by “like” hospitals? Can hospitals benchmark against those within the same network or system? How would a pediatric hospital benchmark against other pediatric hospitals?

Hospitals should benchmark their results against hospitals with similar demographics, such as hospital type, number of beds, number of admissions, urban/rural designation, etc. Hospitals in systems or healthcare networks should benchmark throughout the health system, but not within the same region.

Pediatric hospitals utilizing the AHRQ Hospital Survey on Patient Safety Culture can benchmark their results using the [AHRQ’s User Comparative Database Report](#) (refer to instructions starting on page 29).

25. 2.1d: What is meant by roles and staff levels?

Roles are job types (e.g., surgeons, nurses, hospitalists, physician assistants, or clinical and non-clinical, etc.). Staff levels are defined within the organization's hierarchy (e.g., senior administrators, directors, managers, etc.).

26. 2.2b: Does performance evaluation criteria for senior administrative leadership need to include the actual targeted response rate to the culture of safety survey?

Yes. The organization's targeted response rate to the culture of safety survey should be included in performance evaluation criteria for senior administrative leadership. Criteria for using the survey results in improvement efforts should also be included to meet the intent of this element.

27. 2.3a: Which employees should be included in the staff education program? Employees in all units or just those in low-performing units?

Staff education needs to include education for all levels of staff, from senior administrative and clinical leadership to frontline caregivers. In addition, because all units have opportunities for improvement, the staff education should include all units but can focus on deficiencies of a specific unit or department.

28. 2.1e and 2.4b: What is the difference between 2.1e and 2.4b? Both seem to focus on sharing and discussing the Culture of Safety Survey results.

While both elements focus on sharing and discussing Culture of Safety Survey results, these elements focus on different audiences and activities, and the result is that different kinds of feedback are collected. Safe Practice 2.1e requires local leaders (e.g., unit/department manager) to engage their unit/departments in a discussion about the survey results, while Safe Practice 2.4b requires senior administrative leadership to engage each sampled unit in a discussion about the survey results and their concerns.

Hand Hygiene FAQs

Training and Education

29. Are online training modules acceptable for the purposes of question #1 and question #3?

Online training modules are acceptable for the purposes of answering question #1 and question #3 if they meet all requirements outlined in the question.

For question #1, the online training must be done at the frequency specified and would need to be delivered and/or developed by a professional with appropriate training and skills. For question #3, the online training must meet all six topics outlined in the question.

Physical demonstration (question #2) **cannot** be done using an online training module.

30. Can a hospital answer “yes” to the training and education questions #1-3 if the training and education for medical/nursing/pharmacy students is done by the medical/nursing/pharmacy school?

Yes, you can answer “yes” to questions #1-3 if your hospital, alone, or in combination with other hospitals, has developed a standard orientation/on-boarding curriculum for students that meets all requirements outlined in the training and education questions. Your hospital will need to have continued and ongoing input into the curriculum, but the administration of the training and education for students, including physical demonstration of proper hand hygiene technique, could be conducted by the school.

31. What are examples of what can count as “physically demonstrating” proper hand hygiene during the initial hand hygiene training?

Before new individuals to your hospital have contact with patients and the patient care space, they will need to demonstrate proper hand hygiene with soap and water and alcohol-based hand sanitizer. This demonstration could be done as part of other onboarding activities, during occupational health activities as part of the TB test, during department orientations, in small

groups, etc. A group “teach-back” would be acceptable, but with no more than 10 students per one trainer/monitor. An online or in-person “simulation” would not be sufficient for this purpose. Computer-based assessments of an individual’s hand hygiene technique are acceptable if the assessment tracks an individual’s hand motions, is done without providing instructions to the individual during the assessment, and feedback is given to them at the end.

Hospitals that are starting to implement this component should add physical demonstration to their **initial** training for any **new** [individuals who touch patients or who touch items that will be used by patients at their hospital](#). Leapfrog is not asking hospitals to retroactively train individuals.

Infrastructure

32. Is having an electronic system and dashboards that display low product and low battery reports which are used to ensure that the refilling and replacing of dispensers is completed in a timely manner sufficient for meeting the quarterly audit requirements in question #4?

Yes, if you have ongoing and reliable electronic ways of understanding when product or batteries are low, that would suffice for the audit. The goal is to make sure that supplies are available in soap, alcohol-based hand sanitizer, and paper towel dispensers.

33. What does Leapfrog mean by “equally accessible to the location of all patients in the room or bed space” for the purposes of question #5?

Equally means the same distance from any patient’s bed, which can be measured in steps. Leapfrog is not looking for an exact distance, but rather the goal is to ensure that hand hygiene can be easily performed regardless of the location of the patient being cared for in the room or bed space.

Monitoring

34. Why did Leapfrog select 200 hand hygiene opportunities for monthly monitoring in question #8?

200 hand hygiene opportunities were chosen as the sample size based on a study by Yin et. al which showed that 180-195 opportunities would need to be monitored to accurately observe a 10% change in hand hygiene compliance (Yin et al.). The additional sample sizes outlined in the measure specifications are for smaller patient care units where monitoring 200 opportunities may not be feasible.

References:

Steed C, Kelly JW, Blackhurst D, Boeker S, Diller T, Alper P, Larson E. Hospital hand hygiene opportunities: where and when (HOW2)? The HOW2 Benchmark Study. American Journal of Infection control. 2011 Feb 1;39(1):19-26.

Jun Yin MS, Heather Schacht Reisinger PhD, Mark Vander Weg PhD, Marin L. Schweizer PhD, Andrew Jesson, Daniel J. Morgan MD MS, Graeme Forrest MD, Margaret Graham, Lisa Pineles MA and Eli N. Perencevich MD MS. Establishing evidence-based criteria for directly observed hand hygiene compliance monitoring programs: a prospective, multicenter cohort study. Infection Control and Hospital Epidemiology Vol. 35, No. 9 2014 Sep, pp. 1163-8.

35. My hospital uses an electronic compliance monitoring system, but it does not meet all the criteria outlined in questions #12-13. Can I report on the hand hygiene compliance data we collect via direct observation instead?

Yes. If your hospital also uses direct observation to collect hand hygiene compliance data (not just for coaching/intervention) throughout **all** patient care units (including those with the electronic compliance monitoring system), you can select “yes, using only direct observation” in either question #8, question #9, or question #10 and report on your adherence to the direct observation criteria only. Otherwise, you will need to respond “no” to question #12.

36. Is Leapfrog encouraging hospitals to implement electronic compliance monitoring? These systems can be costly, and the technology still needs to advance.

The questions in the hand hygiene standard ask about a variety of strategies that can be used to monitor and improve hand hygiene. Leapfrog is encouraging hospitals to take a multimodal approach. Regarding monitoring, while hospitals can achieve the Leapfrog standard with direct observation alone, Leapfrog is communicating a strong preference for use of electronic monitoring (implemented according to evidence-based principles). In addition to literature suggesting electronic monitoring works better to pinpoint compliance issues, the difference in the sheer number of hand hygiene opportunities covered by the two monitoring strategies represent powerful evidence in favor of electronic monitoring. Electronic monitoring allows facilities to monitor virtually every patient encounter, while direct observation monitors a selection. Based on the evidence, our standard calls for monitoring 200 hand hygiene opportunities per unit per month, which is a small subset of overall hand hygiene opportunities. Even beyond capturing more encounters aligned with the evidence, electronic monitoring alleviates the ethical quandary of an observer watching patient harm without intervening.

As with Computerized Physician Order Entry (CPOE) systems and Bar Code Medication Administration (BCMA) systems, we anticipate that electronic compliance monitoring technology will improve over time and become an important component of a comprehensive hand hygiene program. Electronic monitoring is a routine component of public safety in other industries where compliance is critical, so health care can and should achieve those standards for its patients.

All items included in Section 6D are based on the evidence review and recommendations from Leapfrog's national [Hand Hygiene Expert Panel](#) and others. We have included in the Hand Hygiene bibliography several peer-reviewed studies that have examined the benefits of using electronic monitoring systems over direct observation. The bibliography is available at <https://ratings.leapfroggroup.org/measure/hospital/2025/handwashing>.

37. How does reporting the number of hand hygiene opportunities monitored in questions #8-10 impact our hospital's scoring?

Hospitals can earn "Achieved the Standard" by either answering "yes" to question #8 and monitoring 200 hand hygiene opportunities (or at least the number of hand hygiene opportunities outlined based on the unit type in Tables 1-3 of the [Hand Hygiene Measure Specifications](#)) each month in each patient care unit and also meeting all other elements of the Monitoring and Feedback domains, as well as meeting all elements in 2 of the 3 remaining domains OR by answering "yes" to question #9 and monitoring at least 100 hand hygiene opportunities (or at least the number of hand hygiene opportunities outlined based on the unit type in Tables 4-6 of the [Hand Hygiene Measure Specifications](#)) each month in each patient care unit and also meeting all other elements of the Monitoring domain and all elements in the remaining four domains. Facilities that answer "yes" to question #10 and only monitor 100 hand hygiene opportunities a quarter are only eligible to earn a maximum performance category of "Considerable Achievement" based on their adherence to the elements in the other domains. Hospitals should review the Hand Hygiene scoring algorithm in the [2025 Leapfrog Hospital Survey Scoring Algorithms](#) document for more details.

38. Are online training modules acceptable for the purposes of training hand hygiene compliance observers in question #15?

Online training can be used for the initial and recurrent training of hand hygiene compliance observers. Please refer to the Hand Hygiene Measure Specifications for more information on the requirements for the validation of hand hygiene compliance observers.

Feedback

39. For the purposes of responding to question #19, what are some examples of how hospital leadership can be held accountable through performance reviews or compensation?

A performance review or compensation plan should include specific language about hand hygiene performance. A list of hand hygiene practices and related goals may be incorporated into

the performance review and/or compensation plan or formalized programs whereby a measure of success of those activities or programs is tied to individual performance reviews or compensation incentive plans of executives. Examples include meeting targets for hand hygiene compliance rates, having bonuses tied to structural changes like the implementation of electronic compliance monitoring systems, etc. Language pertaining solely to infection control practices and performance would NOT be sufficient.

Culture

40. What are some examples of how patients and visitors can be invited to remind individuals who touch patients or who touch items that will be used by patients to perform hand hygiene?

Patients and visitors can be invited to remind individuals who touch patients or who touch items that will be used by patients to perform hand hygiene with posters placed in patient care units, bedside placards, buttons worn by the staff, etc.

41. What are some examples of demonstrating a commitment to hand hygiene improvement as referenced in question #21?

Some examples of how individuals can demonstrate a commitment to support hand hygiene improvement are written or verbal commitments given during town hall meetings, videos, e-mails from the CEO, public comments to staff, etc. This needs to be a verbal or written commitment that is delivered to those individuals who touch patients or who touch items that will be used by patients.

Diagnostic Excellence FAQs

42. What are examples of a CEO or CMO commitment to reducing errors in diagnosis?

Examples of a CEO or CMO commitment include verbal remarks at an all-staff “town hall” or “all-hands” meeting, or a segment in an annual report or other publication disseminated to all staff that specifically mentions reducing diagnostic errors.

43. What are examples of a PFAC having input in or leading initiatives aimed at reducing errors in diagnosis?

Hospitals can refer to the [Patient and Family Advisory Council \(PFAC\) Toolkit for Exploring Diagnostic Quality](#) for detailed guidance. One common example of an initiative is to consult with the PFAC for input on materials for admitted patients pertaining to diagnosis, such as a resource developed based on needs identified in a patient survey, or a sepsis education campaign targeted at patients visiting the emergency room.

44. Can our hospital system convene a multidisciplinary team at the system level, instead of individual hospitals assembling teams at their respective facilities?

Multidisciplinary teams convened to solely focus on reducing diagnostic errors should be specific to individual hospitals in order to closely oversee case analyses, review data specific to individual sites, and be responsive to the individual hospital's leadership.

45. What pathology reports should be included in our response to question #19? Are inpatient and outpatient reports included?

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

46. What ICD-10 codes should we use to identify diagnoses of colon, lung, or breast cancer?

Leapfrog has not identified a specific set of ICD-10 codes to use to select these cases.

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SECTION 7: MANAGING SERIOUS ERRORS

This section includes questions and reference information for Section 7: Managing Serious Errors. Please carefully review the questions, endnotes, and reference information (e.g., measure specifications, notes, and frequently asked questions) before you begin. Failure to review the reference information could result in inaccurate responses.

Section 7: Managing Serious Errors

Never Events Fact Sheet: <https://ratings.leapfroggroup.org/measure/hospital/2025/responding-never-events>

Section 7 includes questions about your hospital's response to Never Events. In addition, Leapfrog collects information via its NHSN Group about five healthcare-associated infections (CLABSI, CAUTI, MRSA, *C. diff.*, and SSI: Colon). Hospitals reporting on Section 7B: Healthcare-Associated Infections are required to join Leapfrog's NHSN Group. Important information and deadlines are available on the [Join NHSN Group webpage](#).

Each hospital achieving the standard for Never Events:

Has a policy that includes the nine principles of Leapfrog's Never Events policy and will implement this policy if a "never event" occurs within their hospital.

Each hospital achieving the standards for Healthcare-Associated Infections:

1. Has a CLABSI standardized infection ratio of less than or equal to 0.413 for ICU and select ward inpatients.
2. Has a CAUTI standardized infection ratio of less than or equal to 0.427 for ICU and select ward inpatients.
3. Has a MRSA standardized infection ratio of less than or equal to 0.496 for facility-wide inpatients.
4. Has a *C. diff.* standardized infection ratio of less than or equal to 0.621 for facility-wide inpatients.
5. Has an SSI: Colon standardized infection ratio of less than or equal to 0.349 for inpatients following eligible colon procedures.

Download the 2025 Leapfrog Hospital Survey Scoring Algorithm on the [Scoring and Results webpage](#).

7A: Never Events

Hospitals that share a CMS Certification Number are required to report by facility. Please carefully review [Leapfrog's Multi-Campus Reporting Policy](#).

Important Note: To earn credit for these questions, hospitals must have a policy in place that addresses the National Quality Forum's list of Serious Reportable Events. All references to "never event" or "serious reportable event" are specific to the National Quality Forum list available at <https://digitalassets.jointcommission.org/api/public/content/4534bbaeee4f4bd280c2054765f37f4b?v=a60f8f9a>.

Reporting Period:

Answer questions #1-9 based on the principles currently included in your hospital's never events policy at the time you submit this section of the Survey.

Note: As a reminder, the [Corrections Period](#) (December 1-January 31) is reserved for corrections to previously submitted Surveys only. Any updates made to reflect a change in performance must be made prior to the November 30 Late Submission and Performance Update Deadline. Updates made to reflect a change in performance after November 30 will not be scored or publicly reported.

Below are the nine elements which make up The Leapfrog Group's Policy Statement regarding [never events](#).⁴⁸ Indicate which of the following principles are included in your hospital's current never events policy.

1) We apologize to the patient ⁴⁹ and/or family affected by the never event ⁴⁸ .	☐ Yes ☐ No
2) We report the event to at least one of the following external agencies ⁵⁰ within 15 business days of becoming aware that the never event ⁴⁸ has occurred: • Joint Commission, as part of its Sentinel Events policy; • DNV GL Healthcare; • State reporting program for medical errors; or • Patient Safety Organization (as defined in The Patient Safety and Quality Improvement Act of 2005).	☐ Yes ☐ No
3) We perform a root cause analysis ⁵¹ , which at a minimum, includes the elements required by the chosen external reporting agency. <i>If "no," skip questions #6-7. The hospital will be scored as "Limited Achievement."</i>	☐ Yes ☐ No
4) We waive all costs directly related to the never event ⁴⁸ . <i>In order to respond "yes" to this question, all costs directly related to the never event must be waived to both the patient and the payor.</i>	☐ Yes ☐ No
5) We make a copy of this policy available to patients, patients' family members, and payers upon request.	☐ Yes ☐ No
6) We interview patients and/or families, who are willing and able, to gather evidence for the root cause analysis ⁵¹ .	☐ Yes ☐ No
7) We inform the patient and/or the patient's family of the action(s) that our hospital will take to prevent future recurrences of similar events based on the findings from the root cause analysis ⁵¹ .	☐ Yes ☐ No
8) We have a protocol in place to provide support for caregivers involved in never events ⁴⁸ and make that protocol known to all caregivers and affiliated clinicians.	☐ Yes ☐ No
9) We perform an annual review to ensure compliance with each element of Leapfrog's Never Events Policy for each never event ⁴⁸ that occurred. <i>If "no" to any questions #1-8, skip this question and continue to the next subsection.</i>	☐ Yes ☐ No

7B: Healthcare-Associated Infections

Hospitals that share a CMS Certification Number must have a unique NHSN ID as required by NHSN. Please carefully review Leapfrog's Multi-Campus Reporting Policy on the [Join NHSN Group webpage](#).

Specifications: See [Healthcare-Associated Infections Measure Specifications](#) in the Reference Information beginning on page 269.

Reporting Period: 12 months

- June and August Data Downloads: 01/01/2024 – 12/31/2024
- October and December Data Downloads: 07/01/2024 – 06/30/2025

Leapfrog will update data four times per Survey Cycle for all members of our NHSN group that have provided an accurate NHSN ID in the Hospital Profile and submitted the 2025 Leapfrog Hospital Survey.

Visit the [Join NHSN Group webpage](#) for important information on deadlines for joining Leapfrog's NHSN Group.

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

1) Has your hospital joined Leapfrog's NHSN Group and entered a valid NHSN ID in the Profile so that the standardized infection ratios (SIRs) for each of the following applicable infection measures can be downloaded directly from the CDC's National Healthcare Safety Network (NHSN) for scoring and public reporting: • CLABSI in ICUs and select wards; • CAUTI in ICUs and select wards; • Facility-wide inpatient MRSA Blood Laboratory-identified Events; • Facility-wide inpatient C. diff. Laboratory-identified Events; and • SSI: Colon?	○ Yes, the hospital has joined Leapfrog's NHSN Group, accepted Leapfrog's Rights Acceptance Report/Data Rights Template, and entered a valid NHSN ID in the Profile ○ No, the hospital has not joined Leapfrog's NHSN Group, accepted Leapfrog's Rights Acceptance Report/Data Rights Template, or entered a valid NHSN ID in the Profile and acknowledges that the hospital will be publicly reported as "Declined to Respond" for all five infection measures
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*Hospitals are not required to "re-join" Leapfrog's NHSN Group if they joined and conferred rights in previous Leapfrog Hospital Survey Cycles. However, all hospitals in Leapfrog's NHSN Group must review their Rights Acceptance Report annually (by the published [join-by deadlines](#)) to ensure that Leapfrog has access to the data from all of the locations that were active during the reporting period, even if those locations are no longer active, to ensure that Leapfrog obtains the appropriate SIR. Instructions for joining or verifying that you are in Leapfrog's NHSN Group are available in the "NHSN Guidance: Join the Group, Review/Accept Data Rights Template, and Download Reports" document on our [Join NHSN Group webpage](#).

Hospitals that join Leapfrog's NHSN group, but do not provide an accurate NHSN ID in the Hospital Profile or do not submit the 2025 Leapfrog Hospital Survey, will be scored and publicly reported as "Declined to Respond" for each of the five infection measures. Hospitals that have a predicted value <1 for an infection measure, or hospitals whose number of observed MRSA or CDI infections present on admission are above a pre-determined cut-point, will be scored as "Unable to Calculate" for that measure. Hospitals for whom a measure does not apply during the reporting period (e.g., zero device days or procedure days, no applicable locations) will be scored as "Does Not Apply" for that measure. Hospitals that are PPS-Exempt Cancer hospitals, as classified by CMS, will be scored as "Does Not Apply" for CLABSI and CAUTI only.

For all other deadlines, please refer to the “Deadlines and Reporting Periods” table provided in the [Healthcare-Associated Infections Measure Specifications](#), as well as [online](#).

Affirmation of Accuracy

As the hospital CEO or as an employee of the hospital to whom the hospital CEO has delegated responsibility, I have reviewed this information pertaining to the Managing Serious Errors Section at our hospital, and I hereby certify that this information is true, accurate, and reflects the current, normal operating circumstances at our hospital. I am authorized to make this certification on behalf of our hospital.

The hospital and I understand that The Leapfrog Group, its members, the public and entities and persons who contract or have other business dealing with The Leapfrog Group are relying on the truth and accuracy of this information. The hospital and I also understand that The Leapfrog Group will make this information and/or analyses of this information public through the Survey Results public reporting website, The Leapfrog Group's Hospital Safety Grade, and/or other Leapfrog Group products and services. This information and/or analyses and all intellectual property rights therein shall be and remain the sole and exclusive property of The Leapfrog Group in which The Leapfrog Group retains exclusive ownership. This information does not infringe upon any third-party intellectual property rights or any other third-party rights whatsoever and is free and clear of all encumbrances and liens of any kind. The hospital and I acknowledge that The Leapfrog Group may use this information in a commercial manner for profit. The hospital shall be liable for and shall hold harmless and indemnify The Leapfrog Group from any and all damages, demands, costs, or causes of action resulting from any inaccuracies in the information or any misrepresentations in this Affirmation of Accuracy. The Leapfrog Group and its members and entities and persons who contract or have other business dealing with The Leapfrog Group reserve the right to omit or disclaim information that is not current, accurate or truthful.

Affirmed by _____, the hospital's _____,
(first name and last name) (title)
on _____.
(date)

Section 7: Managing Serious Errors Reference Information

What's New in the 2025 Survey

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

Change Summary Since Release

None. If substantive changes are made to this section of the Survey after release on April 1, 2025, they will be documented in this Change Summary section.

Section 7B: Healthcare-Associated Infections Measure Specifications

Important Note: Hospitals that share a CMS Certification Number must have a unique NHSN ID as required by NHSN. Please carefully review Leapfrog’s Multi-Campus Reporting Policy on the [Join NHSN Group webpage](#).

Checklist for Joining Leapfrog’s NHSN Group and Ensuring the Data are Accurate:

- ☐ **Join or verify that you are in Leapfrog’s NHSN Group by the [join-by dates](#)**
 - Instructions for joining or verifying that you are in Leapfrog’s NHSN Group are available [here](#) in the “NHSN Guidance: Join the Group, Review/Accept Data Rights Template, and Download Reports” document.
 - Join-by dates are listed in the “Deadlines and Reporting Periods” table below.
- ☐ **Review and accept Leapfrog’s Data Rights Template within NHSN**
 - **All hospitals** are required to review and accept the Data Rights Template at least annually before **June 25, 2025**, NHSN join-by date and whenever updates are made to their location mapping in NHSN.
 - Include any locations that were active during the reporting period even if they are currently inactive to ensure that Leapfrog obtains the appropriate SIR.
 - Confirm that you have given Leapfrog access to data from your 2024 NHSN Patient Safety Component - Annual Hospital Survey. Surveillance data from the 2024 NHSN Annual Hospital Survey is used by NHSN to risk adjust SIRs; SIRs cannot be calculated by NHSN or downloaded by Leapfrog if you restrict access to this data.
 - Failure to review and update (as needed) your Data Rights Template may result in Leapfrog pulling incorrect data for your hospital.
 - Instructions for reviewing and accepting the Data Rights Template are available [here](#) in the “NHSN Guidance: Join the Group, Review/Accept Data Rights Template, and Download Reports” document.
- ☐ **Generate datasets and download reports within NHSN on the same day as Leapfrog**
 - All hospitals are required to (a) generate datasets within NHSN, (b) download CMS IPPS reports, and (c) download a copy of your 2024 Patient Safety Component - Annual Hospital Survey from NHSN on the [same day](#) that Leapfrog will be downloading the data from NHSN for all current group members.
 - Instructions for generating datasets and downloading these reports from NHSN are available [here](#) in the “NHSN Guidance: Join the Group, Review/Accept Data Rights Template, and Download Reports” document.
 - NHSN data download dates are listed in the “Deadlines and Reporting Periods” table below (please note that there are four NHSN data download dates per Survey Cycle).
 - By generating datasets and downloading reports within NHSN on the same day as Leapfrog, hospitals can confirm that their data matches the data Leapfrog has obtained.
 - If hospitals do not generate datasets and download reports on the same day as Leapfrog, the Help Desk will not review any discrepancies.
- ☐ **Review SIRs**
 - For verification purposes, hospitals are required to download reports from NHSN on the [same day](#), as described above.
 - Once Leapfrog has published the healthcare-associated infection Survey Results on the [Hospital Details Page](#), hospitals are urged to compare the Survey Results to their NHSN reports that were pulled on the [same day](#) as Leapfrog.
 - Dates on which the Survey Results will be available on the Hospital Details page are listed in the “Deadlines and Reporting Periods” table below.

☐ **Report discrepancies**

If, while comparing your NHSN reports to your Leapfrog Hospital Survey Results, you find a discrepancy, you must contact Leapfrog's [Help Desk](#) immediately. If you do not contact Leapfrog by the **end of the month** in which scored results are [available](#) on your Hospital Details Page (i.e., July, September, November, and January, respectively), the issue will not be investigated by the Help Desk.

Deadlines and Reporting Periods

Join Leapfrog's NHSN Group by	Leapfrog will download data from NHSN for all current group members	Data downloaded from NHSN will be scored and publicly reported for hospitals that have submitted Section 7 by	HAI Reporting Period	Available on Hospital Details Page and Public Reporting Website
June 25, 2025[†]	June 26, 2025 [†]	June 30, 2025	01/01/2024 – 12/31/2024	July 12, 2025 Hospital Details Page July 25, 2025 Public Reporting Website
August 21, 2025	August 22, 2025	August 31, 2025	01/01/2024 – 12/31/2024	September 10, 2025*
October 22, 2025	October 23, 2025	October 31, 2025	07/01/2024 – 06/30/2025	November 12, 2025*
December 17, 2025**	December 18, 2025**	November 30, 2025	07/01/2024 – 06/30/2025	January 12, 2026*

[†]The join-by-date and download date were originally planned for June 19 and 20, respectively. However, due to a technical issue with the CDC's NHSN application, Leapfrog was unable to complete the first download of NHSN HAI data on the planned date.

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

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

Section 7A: Never Events Frequently Asked Questions (FAQs)

1. When reporting Never Events, what “state reporting program for medical errors” applies in my state?

Congress has passed legislation requiring all states to develop a reporting program for medical errors. At this time, many states have already enacted or adopted some requirement that hospitals report serious medical errors or similar adverse events to a state agency. Others are still implementing legislation or regulations that define that requirement. States that have developed programs may also define reportable events differently.

2. What if there is no “state reporting program for medical errors” in my state? Do we still have to report Never Events to meet Leapfrog principles for this policy? To whom?

Hospitals in states that do not have a state reporting program or requirement in effect can meet the reporting requirement of Leapfrog’s principles for implementation of a Never Events policy by reporting all Never Events voluntarily to The Joint Commission, DNV GL Healthcare, or a Patient Safety Organization.

If there is no state-required reporting program in effect, no available Patient Safety Organization to which your hospital can report, and your hospital is not Joint Commission or DNV GL Healthcare accredited, the Leapfrog requirement for reporting to an external agency is amended. Hospitals must report the Never Event to their governance board and must still perform a root-cause analysis internally of each Never Event to meet Leapfrog’s principle for full implementation of its Never Events policy.

3. The reportable adverse events defined by our state’s reporting program don’t include all 25 Never Events endorsed by the National Quality Forum (NQF) and adopted in the Leapfrog policy. Will reporting only the state-required reportable events to the state agency suffice for meeting Leapfrog’s requirement for reporting Never Events to an external agency? Does our hospital have to report other Never Events, as defined by NQF/Leapfrog, to that state agency even though not required by our state’s reporting program?

Hospitals should report all their state-required reportable events to the state agency. All other Never Events, as defined by NQF’s list of Serious Reportable Events, which cannot be reported to the state agency, should be reported to another external agency (e.g., accreditor, Patient Safety Organization), if possible. If reporting those events to another external agency is not possible, the final option is to report those events to the hospital’s governance board.

4. Won’t Leapfrog’s request to have hospitals apologize to the patient put the hospital at risk for liability?

Not necessarily. Research indicates that malpractice suits are often the result of a failure on the hospital’s part to communicate openly with the patient and apologize for its error. Patients feel the most anger when they perceive that no one is willing to take responsibility for the adverse event that has occurred. A sincere apology from the responsible hospital staff can help to heal the breach of trust between doctor/hospital and patient. (When Things Go Wrong: Responding to Adverse Events. Boston, 2006. Mass Coalition for the Prevention of Medical Errors)

5. How does Leapfrog define “waive cost?”

At its core, Leapfrog’s approach to never events is about improving patient care. While the policy asks hospitals to refrain from billing either the patient or a third-party payer, such as a health plan or employer company, for any costs directly related to a serious reportable adverse event, Leapfrog understands that, due to the wide array of circumstances surrounding never events, specific details of what constitutes “waiving cost” should be handled on a case-by-case basis by the parties involved. For an example, please see [“Lessons learned from implementing a principled approach to resolution following patient harm”](#) by Smith et. al.

6. Does Leapfrog recommend any resources for hospitals looking to adhere to Leapfrog's Never Events principles?

Yes, the Agency for Healthcare Research and Quality (AHRQ) has developed and tested the [Communication and Optimal Resolution \(CANDOR\) Toolkit](#), which outlines a process for hospitals and practitioners to respond to unexpected events in a timely, thorough, and just way. The National Patient Safety Foundation (NPSF) has issued a report titled [RCA²: Improving Root Cause Analyses and Actions to Prevent Harm](#), which examines best practices and provides guidelines to help standardize and improve Root Cause Analysis. In addition, hospitals can download tips and tools for interviewing patients and families for the Root Cause Analysis on the [Survey and CPOE Materials webpage](#).

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SECTION 8: PEDIATRIC CARE

This section includes questions and reference information for Section 8: Pediatric Care. Please carefully review the questions, endnotes, and reference information (e.g., measure specifications, notes, and frequently asked questions) before you begin. Failure to review the reference information could result in inaccurate responses.

Section 8: Pediatric Care

Pediatric Care Fact Sheet: <https://ratings.leapfroggroup.org/measure/hospital/2025/pediatric-care>

Hospitals that do not care for (or perform CT scans on) patients 17 years of age or younger should respond “no” to question #2 in 8A and 8B and move on to the Affirmation of Accuracy. Your hospital’s results will be displayed as “Does Not Apply” on Leapfrog’s public reporting website.

Section 8 includes questions about patient experience (CAHPS Child Hospital Survey) and Computed Tomography (CT) radiation dose for pediatric patients.

Each hospital achieving the standard for Patient Experience (CAHPS Child Hospital Survey):

Performed in the top quartile for at least 4 of the 5 CAHPS Child Hospital Survey domains (a subset of the 18 total domains), listed below:

- Communication with Parent – Communication about your child’s medicines
- Communication with Parent – Keeping you informed about your child’s care
- Communication with Child – How well nurses communicate with your child
- Communication with Child – How well doctors communicate with your child
- Attention to Safety and Comfort – Preventing mistakes and helping you report concerns

Each hospital achieving the standard for Pediatric Computed Tomography (CT) Dose:

Received 75% or more of the possible points based on comparing CT radiation doses across two anatomic areas (head and abdomen/pelvis) and five age strata to national benchmarks.

Download the 2025 Leapfrog Hospital Survey Scoring Algorithm on the [Scoring and Results webpage](#).

8A: Patient Experience (CAHPS Child Hospital Survey)

Hospitals that share a CMS Certification Number are required to report by facility. Please carefully review [Leapfrog's Multi-Campus Reporting Policy](#).

Important Notes:

Note 1: This subsection is only applicable to hospitals that care for patients 17 years of age or younger. Hospitals that do not care for patients 17 years of age or younger should respond “no” to question #2 in 8A and move on to 8B. Your hospital’s results will be displayed as “Does Not Apply” on Leapfrog’s public reporting website.

Note 2: To help ensure that the [Top Box Scores](#)⁵² represent an appropriate sample of patients, hospitals must have at least 100 pediatric acute-care admissions to inpatient units other than a neonatal ICU (NICU). Otherwise, they should respond “Yes, but fewer than 100 pediatric admissions were for non-NICU patients” to question #2 and skip the remaining questions in Section 8A. The hospital will be scored as “Does Not Apply.” For example, if your hospital had 600 pediatric acute-care admissions, and 550 of those admissions were to a neonatal ICU, you should respond “Yes, but fewer than 100 pediatric admissions were for non-NICU patients” to question #2 as your hospital only has 50 admissions to inpatient units other than a neonatal ICU.

Specifications: See [Patient Experience \(CAHPS Child Hospital Survey\) Measure Specifications](#) in the Reference Information beginning on page 282.

Reporting Period: 12 months

Answer questions #1-12 for the latest 12-month period prior to the submission of this section of the Survey.

Note: As a reminder, the [Corrections Period](#) (December 1-January 31) is reserved for corrections to previously submitted Surveys only. Any updates made to reflect a change in performance must be made prior to the November 30 Late Submission and Performance Update Deadline. Updates made to reflect a change in performance after November 30 will not be scored or publicly reported.

1) What is the latest 12-month reporting period for which your hospital is submitting responses to this section? 12-month reporting period ending:	<u> </u> <i>Format: Month/Year</i>
2) Did your hospital have at least 500 pediatric acute-care admissions during the 12-month period referenced in Section 1, question #5? <i>Refer to your responses to questions #5 and #13 in Section 1A: Basic Hospital Information. If “no” or “yes, but fewer than 100 pediatric admissions were for non-NICU patients,” skip questions #3-12 and continue to the next subsection. The hospital will be scored as “Does Not Apply.”</i>	☐ Yes ☐ Yes, but fewer than 100 pediatric admissions were for non-NICU patients ☐ No
3) Has your hospital administered, or started to administer the CAHPS Child Hospital Survey during the reporting period? <i>If “no” to question #3, skip questions #4-12 and continue to the next subsection. The hospital will be scored as “Did Not Measure.”</i>	☐ Yes ☐ No
4) Did your hospital administer the full CAHPS Child Hospital Survey or a truncated version? <i>If administering a truncated version, hospitals must follow the specifications for truncating the survey provided in the Patient Experience (CAHPS Child Hospital Survey) Measure Specifications.</i>	☐ Full version ☐ Truncated version

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Section 8: Pediatric Care

5) How many surveys were returned during the reporting period? <i>If less than 100, skip questions #6-12 and continue to the next subsection. The hospital will be scored as “Unable to Calculate Score.”</i>	_____
6) Which of the following modes were used to administer the survey? <i>Select all that apply.</i>	☐ Mail ☐ Phone ☐ Email ☐ Tablet
7) Which of the following times were surveys administered during the reporting period? <i>Select all that apply.</i>	☐ Day of discharge ☐ After discharge

In questions #8-12, report your hospital's [Top Box Score](#)⁵² (rounded to the nearest whole number) from each of the five publicly reported patient experience measures from your 12-month vendor report that matches the reporting period that you selected in question #1.

8) Communication with Parent – Communication about your child's medicines	_____
9) Communication with Parent – Keeping you informed about your child's care	_____
10) Communication with Child – How well nurses communicate with your child	_____
11) Communication with Child – How well doctors communicate with your child	_____
12) Attention to Safety and Comfort – Preventing mistakes and helping you report concerns	_____

8B: Pediatric Computed Tomography (CT) Radiation Dose

Hospitals that share a CMS Certification Number are required to report by facility. Please carefully review [Leapfrog's Multi-Campus Reporting Policy](#).

Important Notes:

Note 1: All pediatric patient (ages 17 years and younger) scans performed at your hospital should be included when reporting on this measure, including cases that were never admitted to an inpatient ward.

Note 2: This section is only applicable to hospitals that perform CT scans on patients 17 years of age or younger. Hospitals that do not perform CT scans on patients 17 years of age or younger should respond "no" to question #2 in 8B and move on to the Affirmation of Accuracy. Your hospital's results will be displayed as "Does Not Apply" on Leapfrog's public reporting website.

Specifications: See [Pediatric Computed Tomography \(CT\) Radiation Dose Measure Specifications](#) in the Reference Information beginning on page 283.

Reporting Period: 12 months

Answer questions #1-7 based on all cases (or a sufficient sample of them)

- Surveys submitted prior to September 1:
 - 01/01/2024 – 12/31/2024
- Surveys (re)submitted on or after September 1:
 - 07/01/2024 – 06/30/2025

Note: As a reminder, the [Corrections Period](#) (December 1-January 31) is reserved for corrections to previously submitted Surveys only. Any updates made to reflect a change in performance must be made prior to the November 30 Late Submission and Performance Update Deadline. Updates made to reflect a change in performance after November 30 will not be scored or publicly reported.

Sufficient Sample: See [Pediatric Computed Tomography \(CT\) Radiation Dose Measure Specifications](#) for instructions on identifying a sufficient sample for questions #2-7.

1) 12-month reporting period used:	○ 01/01/2024 – 12/31/2024 ○ 07/01/2024 – 06/30/2025
2) Does your hospital perform CT scans on pediatric patients? <i>If "no" to question #2, skip the remaining questions in Section 8B, and go to the Affirmation of Accuracy. The hospital will be scored as "Does Not Apply."</i>	○ Yes ○ No
3) Did your hospital calculate its distribution of CT radiation doses for pediatric patients over the reporting period, and do you choose to report those data to this Survey? <i>If "no" to question #3, skip the remaining questions in Section 8B, and go to the Affirmation of Accuracy. The hospital will be scored as "Did Not Measure."</i>	○ Yes ○ No
4) Which of the following is your hospital using to report the CT radiation dose length product (DLP)? <i>If "manual data collection" is not selected, skip question #5 and continue to question #6.</i>	○ Manual Data Collection ○ Dose Monitoring Software ○ ACR National Radiology Data Registry Report

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Section 8: Pediatric Care

5) If using manual data collection, do the responses in questions #6 and #7 represent a sample? <i>If your hospital reviewed all cases for age strata with fewer than 30 encounters and sampled for those age strata with greater than 30 encounters, select “yes.”</i>	☐ Yes ☐ No
---	--

6) Enter your hospital's 25th, 50th, and 75th percentiles (rounded to the nearest whole number) for CT radiation dose length product (DLP) in **head** scans for pediatric patients for each age stratum standardized to 16cm phantoms.

If the number of encounters for an age stratum is less than 10 (in column a), skip columns b, c, and d and then move to the next age stratum. If zero, enter “0” in column a. The hospital will be scored as “Unable to Calculate Score” if all age strata have less than 10 encounters.

Age Stratum	HEAD			
	(a) Number of encounters	(b) 25 th Percentile	(c) 50 th Percentile	(d) 75 th Percentile
< 1 year				
1 - 4				
5 - 9				
10 - 14				
15 - 17				

7) Enter your hospital's 25th, 50th, and 75th percentiles (rounded to the nearest whole number) for CT radiation dose length product (DLP) in **abdomen/pelvis** scans for pediatric patients for each age stratum standardized to 32cm phantoms.

If the number of encounters for an age stratum is less than 10 (in column a), skip columns b, c, and d and then move to the next age stratum. If zero, enter “0” in column a. The hospital will be scored as “Unable to Calculate Score” if all age strata have less than 10 encounters.

Age Stratum	ABDOMEN/PELVIS			
	(a) Number of encounters	(b) 25 th Percentile	(c) 50 th Percentile	(d) 75 th Percentile
< 1 year				
1 - 4				
5 - 9				
10 - 14				
15 - 17				

Affirmation of Accuracy

As the hospital CEO or as an employee of the hospital to whom the hospital CEO has delegated responsibility, I have reviewed this information pertaining to the Pediatric Care Section at our hospital, and I hereby certify that this information is true, accurate, and reflects the current, normal operating circumstances at our hospital. I am authorized to make this certification on behalf of our hospital.

The hospital and I understand that The Leapfrog Group, its members, the public and entities and persons who contract or have other business dealings with The Leapfrog Group are relying on the truth and accuracy of this information. The hospital and I also understand that The Leapfrog Group will make this information and/or analyses of this information public through the Survey Results public reporting website, The Leapfrog Group's Hospital Safety Grade, and/or other Leapfrog Group products and services. This information and/or analyses and all intellectual property rights therein shall be and remain the sole and exclusive property of The Leapfrog Group in which The Leapfrog Group retains exclusive ownership. This information does not infringe upon any third-party intellectual property rights or any other third-party rights whatsoever and is free and clear of all encumbrances and liens of any kind. The hospital and I acknowledge that The Leapfrog Group may use this information in a commercial manner for profit. The hospital shall be liable for and shall hold harmless and indemnify The Leapfrog Group from any and all damages, demands, costs, or causes of action resulting from any inaccuracies in the information or any misrepresentations in this Affirmation of Accuracy. The Leapfrog Group and its members and entities and persons who contract or have other business dealings with The Leapfrog Group reserve the right to omit or disclaim information that is not current, accurate or truthful.

Affirmed by _____, the hospital's _____,
(first name and last name) (title)
on _____.
(date)

Section 8: Pediatric Care Reference Information

What's New in the 2025 Survey

There are no changes to Section 8A: Patient Experience (CAHPS Child Hospital Survey) or Section 8B: Pediatric CT Radiation Dose.

Change Summary Since Release

None. If substantive changes are made to this section of the Survey after release on April 1, 2025, they will be documented in this Change Summary section.

Section 8: Pediatric Care Measure Specifications**Patient Experience (CAHPS Child Hospital Survey) Measure Specifications**

Important Note: Hospitals that share a CMS Certification Number are required to report by facility. Please carefully review [Leapfrog's Multi-Campus Reporting Policy](#).

Source: Agency for Healthcare Quality and Research (AHRQ) (NQF #2548)			
Reporting Period: The latest 12-month period prior to the submission of this section of the Survey. Hospitals can elect to use either survey return date or discharge date to pull reports for this measure.			
This section of the Leapfrog Hospital Survey asks hospitals who care for pediatric patients about their results from the CAHPS Child Hospital Survey. The first several questions are designed to learn more about the current administration of the survey. The last five questions collect the “Top Box” ⁵² score for each of the following five domains: • Communication with Parent – Communication about your child’s medicines • Communication with Parent – Keeping you informed about your child’s care • Communication with Child – How well nurses communicate with your child • Communication with Child – How well doctors communicate with your child • Attention to Safety and Comfort – Preventing mistakes and helping you report concerns Hospitals using Press Ganey, NRC, or PRC to administer the CAHPS Child Hospital Survey can use the AHRQ CAHPS Crosswalk below to ensure they are reporting on the correct domains. The Crosswalk is designed to help translate the standard vendor report to the AHRQ Domains used in questions #8-12 of the Leapfrog Hospital Survey. Hospitals that opt to truncate the CAHPS Child Hospital Survey after question 40, which is the last question required to report on the five domains listed above, must ensure that all questions prior to and including question 40 remain in order and unaltered. In addition, hospitals opting to truncate the survey must retain questions 50-54 and 56-57 (in order and unaltered) which ask for the child and survey participant’s demographic information. Note: Hospitals that collect information captured in questions 51-52 administratively are not required to retained them. For more information regarding which questions from the CAHPS Child Hospital Survey correspond to the five domains listed above, visit https://www.ahrq.gov/cahps/surveys-guidance/hp/about/child-survey-measures.html.			
CAHPS Child Hospital Survey Domain Crosswalk			
AHRQ Domain Name	Press Ganey Domain Name	NRC Domain Name	PRC Domain Name
Communication with Parent – Communication about your child’s medicines	Communication Child’s Med	Communication About Meds	Communication About Medicines
Communication with Parent – Keeping you informed about your child’s care	Informed Child’s Care	Keeping You Informed About Your Child’s Care	Keeping Parent Informed
Communication with Child – How well nurses communicate with your child	Nurses Communicate Child	Nurse Communication With Child	Nurses – Child
Communication with Child – How well doctors communicate with your child	Doctors Communicate Child	Doctor Communication With Child	Doctors – Child
Attention to Safety and Comfort – Preventing mistakes and helping you report concerns	Prevent Mistakes Rpt Conc	Preventing Mistakes and Helping You Report Concerns	Preventing Mistakes

See [FAQs](#) for additional information about responding to the questions in this section.

Pediatric Computed Tomography (CT) Radiation Dose Measure Specifications**Important Notes:**

Note 1: Hospitals that share a CMS Certification Number are required to report by facility. Please carefully review [Leapfrog's Multi-Campus Reporting Policy](#).

Note 2: For purposes of this measure, an “encounter” consists of a full examination and any CT scans performed within one hour of each other involving the designated anatomic area (i.e., head or abdomen/pelvis). For example, two CT scans conducted 30-minutes apart on the same patient's head are considered one “encounter.” CT scans of the same anatomic area performed with and without contrast are considered one “encounter.” Scans of two different anatomic areas performed within one hour would not be considered the same “encounter.” Scans of the same anatomic area performed greater than 60 minutes apart would also not be considered the same “encounter.”

Note 3: This measure includes two sets of instructions in the table below: one for hospitals using dose monitoring software and one for hospitals that are not using dose monitoring software. Please be sure to use the correct set of instructions.

Note 4: Hospitals performing manual data collection must use the CT Dose Workbook provided on the [Survey and CPOE Materials webpage](#) to standardize their CT radiation dose length product (DLP) for head scans to 16cm phantoms and abdomen/pelvis scans to 32cm phantoms.

Source: University of California, San Francisco (NQF #2820)

Reporting Period: 12 months

- Surveys submitted prior to September 1:
 - 01/01/2024 – 12/31/2024
- Surveys (re)submitted on or after September 1:
 - 07/01/2024 – 06/30/2025

Hospitals participating in the ACR National Radiology Data Registry:

Data for this measure can be obtained directly from a special Leapfrog report. See details below.

Hospitals that report to the American College of Radiology (ACR) and receive reports through the National Radiology Data Registry (NRDR) will be able to respond to questions #6-7 in Section 8B using a specialized report that will be made available with the quarterly Dose Index Registry Executive Summary reports. This separate “Leapfrog” report will be available for download through the NRDR portal and will contain data according to the age ranges and measure specifications of the Leapfrog Hospital Survey. **Enter values from the “Leapfrog” tab using the “Table: Pediatric Exams for Leapfrog Survey” and the appropriate percentiles in the Head and Abdomen Pelvis columns rounded to the nearest whole number directly into the Online Hospital Survey Tool.** While this report should be from the most recent 12 months, it does not need to include the full 12 months.

Hospitals using dose monitoring software:

Data for this measure can be obtained using dose monitoring software. See instructions below.

Question #6, column a: Total Number of Encounters

Using your dose monitoring software, obtain the total number of encounters in **head scans** for each age stratum (<1, 1-4, 5-9, 10-14, 15-17). Enter these values into the Survey.

Inclusions:

CT HEAD BRN WO IVCON
 CT HEAD WO IVCON
 CT PEDS HEAD WO IVCON
 CT HEAD
 CT PEDS HEAD BRN WO IVCON
 CT BRN WO IVCON
 CT HEAD BRN
 CT HEAD BRN W IVCON
 CT HEAD W IVCON

CT HEAD WO & W IVCON
 CT HEAD BRN WO & W IVCON
 CT BRN WO & W IVCON
 CT BRN W IVCON

Exclusions:

- Encounters involving facial bones or sinuses
- Encounters where the indication is for a biopsy, including prop studies and stereotactic studies and procedures
- Encounters that cross multiple anatomic areas should be excluded. For example, encounters involving both the head and neck are excluded from the “head” anatomic region.
- Encounters where the documented age is missing or listed as the date of admission (i.e., an accurate birthday could not be obtained and therefore the admission date was used), as is the case for some trauma patients

Sampling Cases: Hospitals using dose monitoring software must report on all encounters in the 12-month reporting period.

Hospitals using Radimetrics Dose Monitoring Software:

- If your hospital is using unique study instance UIDs for every scan performed, review your data to ensure that any scans performed on the same patient and same anatomic area within a one-hour timeframe are being combined into one encounter. The DLPs for all scans within the one-hour timeframe should be combined and that combined value used to calculate the percentiles reported to Leapfrog.
- If your hospital is NOT using unique study instance UIDs and is combining DLPs for all scans performed on the same patient and same anatomic area within one hour into one study instance UID, no review is required as this adheres to the definition of encounter. However, these hospitals should review any repeat or delayed scans to ensure repeat or delayed scans performed greater than 60 minutes apart are not being combined into the same study instance UID.

Question #6, columns b, c, and d: 25th, 50th, and 75th Percentiles

Based on the encounters identified for each age stratum (column a), use your dose monitoring software to calculate the 25th percentile (column b), the 50th percentile (column c), and the 75th percentile (column d) for CT radiation dose length product (DLP) in **head scans standardized to 16cm phantoms**. Enter these values into the Survey rounded to the nearest whole number.

If the number of encounters for an age stratum (i.e., <1 or 1-4, etc.) is less than 10 (column a), skip columns b, c, and d. If the number of encounters for an age stratum is zero, enter “0” in column a, and skip columns b, c, and d. You cannot leave any rows in column a blank.

Phantom Dose Specifications:

For head scans, use a 16 cm phantom dose value. The orange box in the screenshot below the table is an example of a Dose Report which shows the phantom dose value used. The phantom dose value is used to estimate the radiation dose to the patient.

Scout Doses (Topograms) should not be included when calculating the 25th, 50th, or 75th percentiles.

Question #7 column a: Total Number of Encounters

Using your dose monitoring software, obtain the total number of encounters in **abdomen/pelvis** for each age stratum (<1, 1-4, 5-9, 10-14, 15-17). Enter these values into the Survey.

Inclusions:

CT ABD PELVIS W IVCON
 CT ABD/PEL W IVCON
 CT PEDS ABD PELVIS
 CT ABD PELVIS WO IVCON
 CT ABD/PEL WO IVCON
 CT ABD/PEL

CT PEDS ABD/PEL WO IVCON
CT ABD PELVIS WO & W IVCON
CT ABD/PEL WO & W IVCON
CT ABD PELVIS
CT ABD PELVIS WO IVCON

Exclusions:

- Encounters where the indication is for a biopsy, including prop studies and stereotactic studies and procedures
- Encounters that cross multiple anatomic areas should be excluded. For example, encounters involving both the chest and abdomen/pelvis are excluded from the “abdomen/pelvis” anatomic region.
- Encounters where the documented age is missing or listed as the date of admission (i.e., an accurate birthday could not be obtained and therefore the admission date was used), as is the case for some trauma patients

Sampling Cases: Hospitals using dose monitoring software must report on all encounters in the 12-month reporting period.

Question #7, columns b, c, and d: 25th, 50th, and 75th Percentiles

Based on the encounters identified for each age stratum (column a), use your dose monitoring software to calculate the 25th percentile (column b), the 50th percentile (column c), and the 75th percentile (column d) for CT radiation dose length product (DLP) in **abdomen/pelvis scans standardized to 32cm phantoms**. Enter these values into the Survey rounded to the nearest whole number.

If the number of encounters for an age stratum (i.e., <1 or 1-4, etc.) is less than 10 (column a), skip columns b, c, and d. If the number of encounters for an age stratum is zero, enter “0” in column a, and skip columns b, c, and d. You cannot leave any rows in column a blank.

Phantom Dose Specifications:

For abdomen/pelvis scans, use a 32cm phantom dose value. The orange box in the screenshot below the table is an example of a Dose Report which shows the phantom dose value used. The phantom dose value is used to estimate the radiation dose to the patient.

Scout Doses (Topograms) should not be included when calculating the 25th, 50th, or 75th percentiles.

Hospitals not using dose monitoring software:

Data for this measure can be obtained from Dose Reports that come directly from the CT Machine and are sent along with the images to the Picture Archiving and Communications (PACS) used to review the images. See instructions below.

CT Dose Excel Workbook

To assist hospitals who do not use dose monitoring software in calculating the responses to questions #6 and #7, Leapfrog has developed a CT Dose Workbook to assist hospitals in standardizing their CT dose data based on these specifications. The workbook includes 12 tabs: Instructions, Summary, and 10 Data Entry tabs for each anatomic area/age stratum combination. The tabs for head scans are red and the tabs for abdomen/pelvis scans are blue. Once you enter your hospital’s CT radiation dose length product (DLP) data into the appropriate tab, the workbook will automatically calculate your responses to questions #6 and #7 in the Summary tab, and those values should be entered in the Survey.

The CT Dose Workbook is available on the Survey and CPOE Materials [webpage](#) and should be used when reporting on this measure.

Question #6, column a: Total Number of Encounters

To determine the total number of encounters in **head scans** for each age stratum (<1, 1-4, 5-9, 10-14, 15-17), you will need to obtain dose reports. See sampling instructions below.

Inclusions:

CT HEAD BRN WO IVCON
CT HEAD WO IVCON
CT PEDS HEAD WO IVCON
CT HEAD
CT PEDS HEAD BRN WO IVCON
CT BRN WO IVCON
CT HEAD BRN
CT HEAD BRN W IVCON
CT HEAD W IVCON
CT HEAD WO & W IVCON
CT HEAD BRN WO & W IVCON
CT BRN WO & W IVCON
CT BRN W IVCON

Exclusions:

- Encounters involving facial bones or sinuses
- Encounters where the indication is for a biopsy, including prop studies and stereotactic studies and procedures
- Encounters that cross multiple anatomic areas should be excluded. For example, encounters involving both the head and neck are excluded from the “head” anatomic region.
- Encounters where the documented age is missing or listed as the date of admission (i.e., an accurate birthday could not be obtained and therefore the admission date was used), as is the case for some trauma patients

Sampling Cases:

Hospitals that are using information stored in the CT Machine have the option of reporting on all encounters or a sample of encounters. Hospitals opting to identify a sample of encounters for this measure should follow these instructions:

- Review your hospital’s scans starting on January 15, 2024 (or July 15, 2024 if (re)submitting a Survey on or after September 1, 2025).
- Work sequentially until **a sample of at least 30 encounters per anatomic area and age strata combination** (i.e., head <1; head 1-4, etc.) is reached, or all cases in the reporting period are reviewed, whichever comes first.

Question #6, columns b, c, and d: 25th, 50th, and 75th Percentiles

Using your dose reports, enter the phantom dose and **Total DLP (mGY-cm)** for each encounter into each of the 5 “Head” tabs of the [CT Dose Workbook](#). Be sure to review the instructions tab carefully before you begin entering data. The worksheet will automatically standardize your dose data to a 16cm phantom, if necessary. The worksheet will then automatically calculate the total number of encounters, as well as the 25th, 50th, and 75th percentiles for each anatomic area and age stratum.

See the example CT Dose Report from a CT scanner at the end of this table:

- The orange box in the screenshot is an example of a Dose Report which shows the phantom dose value used. The phantom dose value is used to estimate the radiation dose to the patient.
- The red box highlights the Total DLP. Note that your CT scanner may have a differently formatted Dose Report.

Scout Doses (Topograms) should not be included when entering the Total DLP for each encounter into the CT Dose Workbook.

Question #7 column a: Total Number of Encounters

To determine the total number of encounters in **abdomen/pelvis scans** for each age stratum (<1, 1-4, 5-9, 10-14, 15-17), you will need to obtain dose reports. See sampling instructions below.

Inclusions:

CT ABD PELVIS W IVCON
 CT ABD/PEL W IVCON
 CT PEDS ABD PELVIS
 CT ABD PELVIS WO IVCON
 CT ABD/PEL WO IVCON
 CT ABD/PEL
 CT PEDS ABD/PEL WO IVCON
 CT ABD PELVIS WO & W IVCON
 CT ABD/PEL WO & W IVCON
 CT ABD PELVIS
 CT ABD PELVIS WO IVCON

Exclusions:

- Encounters where the indication is for a biopsy, including prop studies and stereotactic studies and procedures
- Encounters that cross multiple anatomic areas should be excluded. For example, encounters involving both the chest and abdomen/pelvis are excluded from the “abdomen/pelvis” anatomic region.
- Encounters where the documented age is missing or listed as the date of admission (i.e., an accurate birthday could not be obtained and therefore the admission date was used), as is the case for some trauma patients

Question #7 columns b, c, and d: 25th, 50th, and 75th Percentiles

Using your dose reports, enter the phantom dose and **Total DLP (mGy-cm)** for each encounter into each of the 5 “Abdomen Pelvis” tabs of the [CT Dose Workbook](#). Be sure to review the instructions tab carefully before you begin entering data. The worksheet will automatically standardize your dose data to a 32cm phantom, if necessary. The worksheet will then automatically calculate the total number of encounters, as well as the 25th, 50th, and 75th percentiles for each anatomic area and age stratum.

See the example CT Dose Report from a CT scanner at the end of this table:

- The orange box in the screenshot is an example of a Dose Report which shows the phantom dose value used. The phantom dose value is used to estimate the radiation dose to the patient.
- The red box highlights the Total DLP. Note that your CT scanner may have a differently formatted Dose Report.

Patient Name:				Exam no: 30312	
Accession Number:				Sep 01 2010	
Patient ID:				LightSpeed VCT	
Exam Description: CT CTA CHEST WO & W CO					
Dose Report					
Series	Type	Scan Range (mm)	CTDIvol (mGy)	DLP (mGy-cm)	Phantom cm
1	Scout	-	-	-	-
2	Scout	-	-	-	-
200	Axial	\$223.250-\$223.250	4.72	2.36	Body 32
3	Helical	\$348.250-\$13.250	25.72	980.67	Body 32
3	Helical	\$519.000-\$284.000	10.90	306.58	Body 32
Total Exam DLP:				1289.61	
1/1					

Scout Doses (Topograms) should not be included when entering the Total DLP for each encounter into the CT Dose Workbook.

See [FAQs](#) for additional information about responding to the questions in this section.

Section 8: Pediatric Care Frequently Asked Questions (FAQs)

Patient Experience (CAHPS Child Hospital Survey) FAQs

1. **Why does Leapfrog refer to two different reporting periods in Section 8A question #2: one reporting period which refers to the number of pediatric admissions during the 12 months from Section 1 and one reporting period which refers to the results of our CAHPS Child Hospital Survey?**

These two reporting periods are different because hospitals that have not historically had 500 pediatric admissions annually may not have begun to administer the CAHPS Survey to their patients and therefore it would not be appropriate to ask these facilities to report on their current results in Section 8A.

2. **Do I need to include neonatal ICU (NICU) discharges when administering the CAHPS Child Hospital Survey and reporting those results to Leapfrog?**

The Child CAHPS Hospital Survey was designed to be administered to pediatric discharges including NICU discharges. Additional details on fielding the CAHPS Child Hospital Survey can be found [here](#).

In 2025, hospitals that have been administering the CAHPS survey without including NICU discharges in their sample can report those results to Leapfrog, provided they meet the minimum sample size and timing requirements in the Leapfrog Hospital Survey. However, we are urging those hospitals to begin including NICU discharges-- per the manual guidelines-- immediately, as CAHPS is designed to include those patients. Hospitals that are just starting to administer the survey in 2025 should include NICU discharges in their sample per the sampling framework detailed in the manual.

3. **Can we use other lower cost modes for administering the CAHPS Child Hospital Survey? Survey administration is costly, and our hospital has low response rates.**

Some hospitals have asked about the use of alternative, lower cost modes of survey administration, such as administering paper surveys at discharge that can then be batched and mailed to a vendor to calculate results. This approach is potentially an opportunity both to lower the cost of administration and to increase response rates.

[Leapfrog's Pediatric Expert Panel](#) has noted that while administering the CAHPS Child Hospital Survey using paper forms at discharge is not on the list of AHRQ-approved modes, hospitals that are trying to find ways to administer the survey and increase response rate should be able to submit results to the 2025 Leapfrog Hospital Survey. That said, the Pediatric Expert Panel has expressed a desire for these different modes to be tested, and so we cannot guarantee that you will be able to submit these results for future Leapfrog Hospital Surveys.

4. **Is Interactive Voice Response (IVR) or texting a link to an online survey an acceptable mode for administering the CAHPS Child Hospital Survey?**

Hospitals that administer the CAHPS Child Hospital Survey via IVR should select "phone" in question #6. Hospitals that administer the CAHPS Child Hospital Survey by texting a link to an online survey to the patient should select "email."

Pediatric Computed Tomography (CT) Radiation Dose FAQs

5. **Is this measure only applicable to pediatric inpatients, or should all pediatric scans be included?**

All pediatric patient (ages 17 years and younger) scans should be included when reporting on this measure, including cases that were never admitted to an inpatient ward.

6. Should multiple phase scans be included in the reporting?

Yes, the intent of this measure is to capture the entire dose a patient receives, even if this radiation is received over multiple phase scans.

7. Should any CT encounters involving anatomic areas not listed in the Survey questions (i.e., head or abdomen/pelvis) be included in the reporting?

No. When reporting CT encounters in the Survey, only encounters involving the head or abdomen/pelvis should be included. Encounters involving any other anatomic area should not be reported. For example, encounters involving both the head and neck are excluded from the “head” anatomic region.

8. Are the CT doses adjusted for any factors other than age, such as height and weight?

No, CT doses are only stratified by age and anatomic region. The pediatric CT radiation dose measure is an NQF-endorsed measure, developed so that all hospitals in the country who do pediatric CT scans can report. Its known limitation is that it does not consider patient size (e.g., height and weight) but instead uses age as a proxy for size. Part of the reason is that unless hospitals use dose monitoring software, which not all hospitals currently do due to cost, they would not have this information readily available to them. However, to align with the American College of Radiology (ACR), head scans are standardized to 16cm phantoms and abdomen/pelvis scans are standardized to 32cm phantoms.

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SECTION 9: OUTPATIENT PROCEDURES

This section includes questions and reference information for Section 9: Outpatient Procedures. Please carefully review the questions, endnotes, and reference information (e.g., measure specifications, notes, and frequently asked questions) before you begin. Failure to review the reference information could result in inaccurate responses.

Section 9: Outpatient Procedures

Outpatient Procedures Fact Sheet and Bibliography:

<https://ratings.leapfroggroup.org/measure/hospital/2025/care-elective-outpatient-surgery-patients>

Section 9 includes questions about the volume and safety of same-day procedures performed in hospital outpatient departments, as well as the experience of patients who had a same-day surgery performed.

Hospitals will not be able to access Section 9 until the American Medical Association's Terms of Use are completed via the CPT Code Workbook button on the Survey Dashboard, and the appropriate CPT Code Workbook is downloaded.

Each hospital achieving the standards for Certified Clinicians Present While Patients Are Recovering:

1. Has an ACLS certified clinician, plus a second clinician, present at all times and immediately available in the building while adult patients are present in the hospital outpatient department.
2. Has a PALS certified clinician, plus a second clinician, present at all times and immediately available in the building while pediatric patients are present in the hospital outpatient department.

Each hospital achieving the standard for Patient Follow-up:

Provided an accurate CCN in the Hospital Profile, reported volume for adult lower gastrointestinal endoscopy procedures in Section 9C, and is in the top quartile of performance for OP-32, Rate of Unplanned Hospital Visits After an Outpatient Colonoscopy, based on responses to the 2022 Leapfrog ASC Survey and Section 9 of the 2022 Leapfrog Hospital Survey submitted by June 30, 2022.

Each hospital achieving the standard for the Safe Surgery Checklist:

1. Uses a safe surgery checklist on **all** patients undergoing an applicable procedure (reported on in Section 9C, if applicable) that includes **all** safe surgery checklist elements; **and**
2. Verbalizes **all** safe surgery checklist elements in the presence of the appropriate personnel; **and**
3. Completes an audit on a sufficient sample of patients to document adherence to the checklist; **and**
4. Has documented adherence to the checklist for at least 90% of the patients included in the audit.

Each hospital achieving the standard for Medication Safety for Outpatient Procedures:

Has met the 90% target for documenting all three components: home medications, visit medications, and allergies/adverse reaction(s) in the clinical record.

Each hospital achieving the standard for Patient Experience (OAS CAHPS):

Performed in the top quartile based on responses to the 2020 Leapfrog ASC and Hospital Surveys submitted by August 31, 2020, for the four OAS CAHPS domains, listed below:

- a) Facilities and Staff
- b) Communication About Your Procedure
- c) Patients' Rating of the Facility
- d) Patients Recommending the Facility

Download the 2025 Leapfrog Hospital Survey Scoring Algorithm on the [Scoring and Results webpage](#).

9A: Basic Outpatient Department Information

Hospitals that share a CMS Certification Number are required to report by facility. Please carefully review [Leapfrog's Multi-Campus Reporting Policy](#).

Important Notes:

Note 1: In order to access this section in the Online Survey Tool, hospitals must complete the American Medical Association's Terms of Use via the CPT Code Workbook button next to Section 9 on the Survey Dashboard and download the appropriate CPT Code Workbook. Instructions for downloading the CPT Code Workbook are available in the [Volume of Procedures Measure Specifications](#). Each hospital must complete these steps even if they are part of a hospital system.

Note 2: This subsection will not be scored but will be used in public reporting.

Note 3: The term "hospital outpatient department" is used to refer to all hospital outpatient departments or areas of the hospital, including areas that are used for **both** inpatient and outpatient procedures, that perform the outpatient procedures listed in Section 9C and that share your hospital's license or CMS Certification Number (CCN). This would include, but is not limited to surgery centers, free-standing hospital outpatient departments, as well as outpatient departments that are located in your hospital or are [co-located](#)³¹ with your hospital. Hospitals should only include hospital outpatient departments or areas of the hospital that perform the procedures listed in Section 9C in an [operating room](#)⁵³ or [procedure room](#)⁵⁴.

Reporting Period: 12 months

- Surveys submitted prior to September 1:
 - 01/01/2024 – 12/31/2024
- Surveys (re)submitted on or after September 1:
 - 07/01/2024 – 06/30/2025

Note: As a reminder, the [Corrections Period](#) (December 1-January 31) is reserved for corrections to previously submitted Surveys only. Any updates made to reflect a change in performance must be made prior to the November 30 Late Submission and Performance Update Deadline. Updates made to reflect a change in performance after November 30 will not be scored or publicly reported.

1. 12-month reporting period used:	☐ 01/01/2024 – 12/31/2024 ☐ 07/01/2024 – 06/30/2025
2. Does your hospital perform any of the procedures listed in Section 9C on an outpatient basis: • in the hospital or at a hospital outpatient department co-located³¹ with the hospital - and/or • at a surgery center or free-standing hospital outpatient department that shares your hospital's license or CMS Certification Number?	☐ Yes ☐ No

If "no" to question #2, skip the remaining questions in Section 9, including all subsections, and go to the Affirmation of Accuracy.

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Section 9: Outpatient Procedures

3. Total number of operating rooms ⁵³ used to perform the outpatient procedures listed in Section 9C:	_____
4. Total number of endoscopic procedure rooms ⁵⁴ used to perform the outpatient procedures listed in Section 9C:	_____

9B: Medical, Surgical, and Clinical Staff

Hospitals that share a CMS Certification Number are required to report by facility. Please carefully review [Leapfrog's Multi-Campus Reporting Policy](#).

Important Notes:

Note 1: The term “hospital outpatient department” is used to refer to all hospital outpatient departments or areas of the hospital, including areas that are used for **both** inpatient and outpatient procedures, that perform the outpatient procedures listed in Section 9C and that share your hospital's license or CMS Certification Number (CCN). This would include, but is not limited to surgery centers, free-standing hospital outpatient departments, as well as outpatient departments that are located in your hospital or are [co-located](#)³¹ with your hospital. Hospitals should only include hospital outpatient departments or areas of the hospital that perform the procedures listed in Section 9C in an [operating room](#)⁵³ or [procedure room](#)⁵⁴.

Note 2: Hyperlinks throughout these questions refer to the [Medical, Surgical, and Clinical Staff FAQs](#) beginning on page 318, as well as to endnotes. FAQ hyperlinks are not included in the Online Survey Tool.

Reporting Period: 3 months

Answer questions #1-2 based on the staffing structure currently in place at the time that you submit this section of the Survey. The staffing structure should have been in place for at least the past 3 months and reflect the ordinary staffing structure for each applicable hospital outpatient department.

Note: As a reminder, the [Corrections Period](#) (December 1-January 31) is reserved for corrections to previously submitted Surveys only. Any updates made to reflect a change in performance must be made prior to the November 30 Late Submission and Performance Update Deadline. Updates made to reflect a change in performance after November 30 will not be scored or publicly reported.

1. Is there an Advanced Cardiovascular Life Support (ACLS) trained [clinician](#)⁵⁵, as well as a second [clinician](#)⁵⁵ (regardless of ACLS training), present at all times and immediately available in the building while an adult patient (13 years and older) is present in the hospital outpatient department?

Hospitals with more than one hospital outpatient department, including a surgery center or free-standing hospital outpatient department, should respond based on the least intensively staffed location.

Hospitals should report on all hospital outpatient departments or areas of the hospital that perform the outpatient procedures listed in Section 9C and that share the hospital's license or CCN.

Hospitals that did not perform any applicable procedures on patients 13 years and older during the reporting period should select “not applicable; pediatric patients only.” The hospital will be scored as “Does Not Apply.”

- ☐ Yes
- ☐ No
- ☐ Not applicable; pediatric patients only

2. Is there a Pediatric Advanced Life Support (PALS) trained clinician⁵⁵, as well as a second clinician⁵⁵ (regardless of PALS training), present at all times and immediately available in the building while a pediatric patient (infant through 12 years) is present in the hospital outpatient department? <i>Hospitals with more than one hospital outpatient department, including a surgery center or free-standing hospital outpatient department, should respond based on the least intensively staffed location.</i> <i>Hospitals should report on all hospital outpatient departments or areas of the hospital that perform the outpatient procedures listed in Section 9C and that share the hospital's license or CCN.</i> <i>Hospitals that do not care for pediatric patients should select "not applicable; adult patients only" and hospitals that only performed applicable pediatric procedures on pediatric patients 13 years and older during the reporting period should select "not applicable; pediatric patients are all aged 13-17," regardless of the presence of clinicians trained in PALS. The hospital will be scored as "Does Not Apply."</i>	○ Yes ○ No ○ Not applicable; adult patients only ○ Not applicable; pediatric patients are all aged 13-17
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9C: Volume of Procedures

Hospitals that share a CMS Certification Number are required to report by facility. Please carefully review [Leapfrog's Multi-Campus Reporting Policy](#).

Important Notes:

Note 1: CPT Codes are provided in downloadable Excel files on the Survey Dashboard. To access the files, click the CPT Code Workbook button next to Section 9. You will be required to complete the American Medical Association's Terms of Use before downloading the Excel file and using the individual CPT codes to query your EHR or billing system. You are only required to complete the Terms of Use once per Survey Cycle (April 1 – November 30).

The CPT Code Workbooks (Excel files) are labeled for Section 3A: Total Hip Replacement, Total Knee Replacement, and Bariatric Surgery for Weight Loss and Section 9C: Volume of Procedures. Please note, if you are part of a hospital system, each hospital will need to complete the Terms of Use. This is a requirement of the American Medical Association.

Note 2: This subsection will not be scored but will be used in public reporting to inform purchasers and consumers about the hospital's experience with the procedure. Additionally, this information will be used to facilitate the search functionality on Leapfrog's [public reporting website](#) (i.e., allowing users to search for hospitals that perform the procedure they need on an outpatient basis).

Note 3: The term "hospital outpatient department" is used to refer to all hospital outpatient departments or areas of the hospital, including areas that are used for **both** inpatient and outpatient procedures, that perform the outpatient procedures listed in Section 9C and that share your hospital's license or CMS Certification Number (CCN). This would include, but is not limited to surgery centers, free-standing hospital outpatient departments, as well as outpatient departments that are located in your hospital or are [co-located](#)³¹ with your hospital. Hospitals should only include hospital outpatient departments or areas of the hospital that perform the procedures listed in Section 9C in an [operating room](#)⁵³ or [procedure room](#)⁵⁴.

Note 4: Hospitals should only report on procedures they electively perform. If your hospital does not perform the procedure on an outpatient basis or ONLY does so when a procedure is urgent, you should answer "no" and not report on those procedures.

Specifications: See [Volume of Procedures Measure Specifications](#) in the Reference Information beginning on page 321.

Reporting Period: 12 months

- 01/01/2024 – 12/31/2024

Note: As a reminder, the [Corrections Period](#) (December 1-January 31) is reserved for corrections to previously submitted Surveys only. Any updates made to reflect a change in performance must be made prior to the November 30 Late Submission and Performance Update Deadline. Updates made to reflect a change in performance after November 30 will not be scored or publicly reported.

1) 12-month reporting period used:

*No response required here.
Reporting period
automatically 01/01/2024 –
12/31/2024.*

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Section 9: Outpatient Procedures

2) During the reporting period, were one or more of the following ophthalmology procedures performed at your hospital outpatient department(s) on <u>adult</u> and/or <u>pediatric</u> patients: • Anterior segment eye procedures, • Posterior segment eye procedures, or • Ocular adnexa and other eye procedures? <i>If “no” or “yes, but no longer performs these procedures,” skip questions #11-13 below.</i>	☐ Yes ☐ Yes, but no longer performs these procedures ☐ No
3) During the reporting period, were one or more of the following orthopedic procedures performed at your hospital outpatient department(s) on <u>adult</u> and/or <u>pediatric</u> patients: • Finger, hand, wrist, forearm, and elbow procedures; • Shoulder procedures; • Spine procedures; • Hip procedures; • Knee procedures; • Toe, foot, ankle, and leg procedures; or • General orthopedic procedures? <i>If “no” or “yes, but no longer performs these procedures,” skip questions #14-16 below.</i>	☐ Yes ☐ Yes, but no longer performs these procedures ☐ No
4) During the reporting period, were one or more of the following otolaryngology procedures performed at your hospital outpatient department(s) on <u>adult</u> and/or <u>pediatric</u> patients: • Ear procedures; • Mouth procedures; • Nasal/sinus procedures; or • Pharynx/adenoid/tonsil procedures? <i>If “no” or “yes, but no longer performs these procedures,” skip questions #17-19 below.</i>	☐ Yes ☐ Yes, but no longer performs these procedures ☐ No
5) During the reporting period, were one or more of the following gastroenterology procedures performed at your hospital outpatient department(s) on <u>adult</u> patients: • Upper GI endoscopy, or • Lower GI endoscopy? <i>If “no” or “yes, but no longer performs these procedures,” skip questions #20-22 below.</i>	☐ Yes ☐ Yes, but no longer performs these procedures ☐ No

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Section 9: Outpatient Procedures

6) During the reporting period, were one or more of the following general surgery procedures performed at your hospital outpatient department(s) on <u>adult</u> patients: • Cholecystectomy and common duct exploration; • Hemorrhoid procedures; • Inguinal and femoral hernia repair; • Other hernia repair; • Laparoscopy; • Lumpectomy or quadrantectomy of breast; or • Mastectomy? <i>If “no” or “yes, but no longer performs these procedures,” skip questions #23-25 below.</i>	☐ Yes ☐ Yes, but no longer performs these procedures ☐ No
7) During the reporting period, were one or more of the following urology procedures performed at your hospital outpatient department(s) on <u>adult</u> patients: • Circumcision; • Cystourethroscopy; • Male genital procedures; • Urethra procedures; or • Vaginal repair procedures? <i>If “no” or “yes, but no longer performs these procedures,” skip questions #26-28 below.</i>	☐ Yes ☐ Yes, but no longer performs these procedures ☐ No
8) During the reporting period, was the following neurological surgery procedure performed at your hospital outpatient department(s) on <u>adult</u> patients: • Spinal fusion procedures? <i>If “no” or “yes, but no longer performs this procedure,” skip questions #29-31 below.</i>	☐ Yes ☐ Yes, but no longer performs this procedure ☐ No
9) During the reporting period, were one or more of the following obstetrics and gynecology procedures performed at your hospital outpatient department(s) on <u>adult</u> patients: • Cervix procedures, • Hysteroscopy, or • Uterus and adnexa laparoscopies? <i>If “no” or “yes, but no longer performs these procedures,” skip questions #32-34 below.</i>	☐ Yes ☐ Yes, but no longer performs these procedures ☐ No
10) During the reporting period, were one or more of the following plastic and reconstructive surgery procedures performed at your hospital outpatient department(s) on <u>adult</u> patients: • Breast repair or reconstruction, or • Skin graft/reconstruction procedures? <i>If “no” or “yes, but no longer performs these procedures,” skip questions #35-37 below.</i>	☐ Yes ☐ Yes, but no longer performs these procedures ☐ No

Ophthalmology

11) Total adult and/or pediatric volume for each of the following applicable procedures performed at your hospital outpatient department(s) during the reporting period.

*You cannot leave any blank. If you did not perform one or more of the procedures listed below enter 0 (zero). If you had zero volume for **all** procedures, go back to question #2 and update your response from “yes” to “no.”*

	(a) Adult Volume	(b) Pediatric Volume
Anterior segment eye procedures	_____	
Posterior segment eye procedures	_____	
Ocular adnexa and other eye procedures	_____	_____

12) Where were these **ophthalmology** procedures performed?

Select all that apply.

If only “hospital” is selected, skip question #13 and continue to question #14.

- ☐ Hospital
☐ Surgery center or free-standing hospital outpatient department

13) Please provide the name and city location of each surgery center or free-standing hospital outpatient department performing **ophthalmology** procedures:

	Name	City
Surgery Center/Free-Standing Hospital Outpatient Department 1		
Surgery Center/Free-Standing Hospital Outpatient Department 2		
Surgery Center/Free-Standing Hospital Outpatient Department 3		
Surgery Center/Free-Standing Hospital Outpatient Department 4		
Surgery Center/Free-Standing Hospital Outpatient Department 5		

Orthopedic

14) Total adult and/or pediatric volume for each of the following applicable procedures performed at your hospital outpatient department(s) during the reporting period.

*You cannot leave any blank. If you did not perform one or more of the procedures listed below enter 0 (zero). If you had zero volume for **all** procedures, go back to question #3 and update your response from “yes” to “no.”*

	(a) Adult Volume	(b) Pediatric Volume
Finger, hand, wrist, forearm, and elbow procedures	_____	_____
Shoulder procedures	_____	_____
Spine procedures	_____	
Hip procedures	_____	
Knee procedures	_____	_____
Toe, foot, ankle, and leg procedures	_____	_____
General orthopedic procedures	_____	_____

15) Where were these **orthopedic** procedures performed?

Select all that apply.

If only “hospital” is selected, skip question #16 and continue to question #17.

- ☐ Hospital
☐ Surgery center or free-standing hospital outpatient department

16) Please provide the name and city location of each surgery center or free-standing hospital outpatient department performing **orthopedic** procedures:

	Name	City
Surgery Center/Free-Standing Hospital Outpatient Department 1		
Surgery Center/Free-Standing Hospital Outpatient Department 2		
Surgery Center/Free-Standing Hospital Outpatient Department 3		
Surgery Center/Free-Standing Hospital Outpatient Department 4		
Surgery Center/Free-Standing Hospital Outpatient Department 5		

Otolaryngology

17) Total adult and/or pediatric volume for each of the following applicable procedures performed at your hospital outpatient department(s) during the reporting period.

*You cannot leave any blank. If you did not perform one or more of the procedures listed below enter 0 (zero). If you had zero volume for **all** procedures, go back to question #4 and update your response from “yes” to “no.”*

	(a) Adult Volume	(b) Pediatric Volume
Ear procedures	_____	_____
Mouth procedures	_____	_____
Nasal/sinus procedures	_____	_____
Pharynx/adenoid/tonsil procedures	_____	_____

18) Where were these **otolaryngology** procedures performed?

Select all that apply.

If only “hospital” is selected, skip question #19 and continue to question #20.

- ☐ Hospital
- ☐ Surgery center or free-standing hospital outpatient department

19) Please provide the name and city location of each surgery center or free-standing hospital outpatient department performing **otolaryngology** procedures:

	Name	City
Surgery Center/Free-Standing Hospital Outpatient Department 1		
Surgery Center/Free-Standing Hospital Outpatient Department 2		
Surgery Center/Free-Standing Hospital Outpatient Department 3		
Surgery Center/Free-Standing Hospital Outpatient Department 4		
Surgery Center/Free-Standing Hospital Outpatient Department 5		

Gastroenterology

20) Total adult volume for each of the following applicable procedures performed at your hospital outpatient department(s) during the reporting period.

You cannot leave any blank. If you did not perform one or more of the procedures listed below enter 0 (zero). If you had zero volume for all procedures, go back to question #5 and update your response from “yes” to “no.”

	Adult Volume
Upper GI endoscopies	_____
Lower GI endoscopies	_____

21) Where were these **gastroenterology** procedures performed?

Select all that apply.

If only “hospital” is selected, skip question #22 and continue to question #23.

- ☐ Hospital
☐ Surgery center or free-standing hospital outpatient department

22) Please provide the name and city location of each surgery center or free-standing hospital outpatient department performing **gastroenterology** procedures:

	Name	City
Surgery Center/Free-Standing Hospital Outpatient Department 1		
Surgery Center/Free-Standing Hospital Outpatient Department 2		
Surgery Center/Free-Standing Hospital Outpatient Department 3		
Surgery Center/Free-Standing Hospital Outpatient Department 4		
Surgery Center/Free-Standing Hospital Outpatient Department 5		

General Surgery

23) Total adult volume for each of the following applicable procedures performed at your hospital outpatient department(s) during the reporting period.

You cannot leave any blank. If you did not perform one or more of the procedures listed below enter 0 (zero). If you had zero volume for all procedures, go back to question #6 and update your response from “yes” to “no.”

	Adult Volume
Cholecystectomies and common duct explorations	_____
Hemorrhoid procedures	_____
Inguinal and femoral hernia repairs	_____
Other hernia repairs	_____
Laparoscopies	_____
Lumpectomies or quadrantectomy of breast procedures	_____
Mastectomies	_____

24) Where were these **general surgery** procedures performed?

Select all that apply.

If only “hospital” is selected, skip question #25 and continue to question #26.

- ☐ Hospital
☐ Surgery center or free-standing hospital outpatient department

25) Please provide the name and city location of each surgery center or free-standing hospital outpatient department performing **general surgery** procedures:

	Name	City
Surgery Center/Free-Standing Hospital Outpatient Department 1		
Surgery Center/Free-Standing Hospital Outpatient Department 2		
Surgery Center/Free-Standing Hospital Outpatient Department 3		
Surgery Center/Free-Standing Hospital Outpatient Department 4		
Surgery Center/Free-Standing Hospital Outpatient Department 5		

Urology

26) Total adult volume for each of the following applicable procedures performed at your hospital outpatient department(s) during the reporting period.

*You cannot leave any blank. If you did not perform one or more of the procedures listed below enter 0 (zero). If you had zero volume for **all** procedures, go back to question #7 and update your response from “yes” to “no.”*

	Adult Volume
Circumcisions	_____
Cystourethroscopies	_____
Male genital procedures	_____
Urethra procedures	_____
Vaginal repair procedures	_____

27) Where were these **urology** procedures performed?

Select all that apply.

If only “hospital” is selected, skip question #28 and continue to question #29.

- ☐ Hospital
- ☐ Surgery center or free-standing hospital outpatient department

28) Please provide the name and city location of each surgery center or free-standing hospital outpatient department performing **urology** procedures:

	Name	City
Surgery Center/Free-Standing Hospital Outpatient Department 1		
Surgery Center/Free-Standing Hospital Outpatient Department 2		
Surgery Center/Free-Standing Hospital Outpatient Department 3		
Surgery Center/Free-Standing Hospital Outpatient Department 4		
Surgery Center/Free-Standing Hospital Outpatient Department 5		

Neurological Surgery

29) Total adult volume for the following procedure performed at your hospital outpatient department(s) during the reporting period.

You cannot leave any blank. If you did not perform the procedure listed below, go back to question #8 and update your response from “yes” to “no.”

	Adult Volume
Spinal fusion procedures	_____

30) Where were these **neurological surgery** procedures performed?

Select all that apply.

If only “hospital” is selected, skip question #31 and continue to question #32.

- ☐ Hospital
☐ Surgery center or free-standing hospital outpatient department

31) Please provide the name and city location of each surgery center or free-standing hospital outpatient department performing **neurological surgery** procedures:

	Name	City
Surgery Center/Free-Standing Hospital Outpatient Department 1		
Surgery Center/Free-Standing Hospital Outpatient Department 2		
Surgery Center/Free-Standing Hospital Outpatient Department 3		
Surgery Center/Free-Standing Hospital Outpatient Department 4		
Surgery Center/Free-Standing Hospital Outpatient Department 5		

Obstetrics and Gynecology

32) Total adult volume for each of the following applicable procedures performed at your hospital outpatient department(s) during the reporting period.

*You cannot leave any blank. If you did not perform one or more of the procedures listed below enter 0 (zero). If you had zero volume for **all** procedures, go back to question #9 and update your response from “yes” to “no.”*

	Adult Volume
Cervix procedures	_____
Hysteroscopies	_____
Uterus and adnexa laparoscopies	_____

33) Where were these **obstetrics and gynecology** procedures performed?

Select all that apply.

If only “hospital” is selected, skip question #34 and continue to question #35.

- ☐ Hospital
☐ Surgery center or free-standing hospital outpatient department

34) Please provide the name and city location of each surgery center or free-standing hospital outpatient department performing **obstetrics and gynecology** procedures:

	Name	City
Surgery Center/Free-Standing Hospital Outpatient Department 1		
Surgery Center/Free-Standing Hospital Outpatient Department 2		
Surgery Center/Free-Standing Hospital Outpatient Department 3		
Surgery Center/Free-Standing Hospital Outpatient Department 4		
Surgery Center/Free-Standing Hospital Outpatient Department 5		

Plastic and Reconstructive Surgery

35) Total adult volume for each of the following applicable procedures performed at your hospital outpatient department(s) during the reporting period.

*You cannot leave any blank. If you did not perform one or more of the procedures listed below enter 0 (zero). If you had zero volume for **all** procedures, go back to question #10 and update your response from “yes” to “no.”*

	Adult Volume
Breast repair or reconstructive procedures	_____
Skin graft/reconstruction procedures	_____

36) Where were these **plastic and reconstructive surgery** procedures performed?

Select all that apply.

If only “hospital” is selected, skip question #37 and continue to the next subsection.

- ☐ Hospital
☐ Surgery center or free-standing hospital outpatient department

37) Please provide the name and city location of each surgery center or free-standing hospital outpatient department performing **plastic and reconstructive surgery** procedures:

	Name	City
Surgery Center/Free-Standing Hospital Outpatient Department 1		
Surgery Center/Free-Standing Hospital Outpatient Department 2		
Surgery Center/Free-Standing Hospital Outpatient Department 3		
Surgery Center/Free-Standing Hospital Outpatient Department 4		
Surgery Center/Free-Standing Hospital Outpatient Department 5		

9D: Safety of Procedures

Hospitals that share a CMS Certification Number are required to report by facility. Please carefully review [Leapfrog's Multi-Campus Reporting Policy](#).

Important Note: The term “hospital outpatient department” is used to refer to all hospital outpatient departments or areas of the hospital, including areas that are used for **both** inpatient and outpatient procedures, that perform the outpatient procedures listed in Section 9C and that share your hospital's license or CMS Certification Number (CCN). This would include, but is not limited to surgery centers, free-standing hospital outpatient departments, as well as outpatient departments that are located in your hospital or are [co-located](#)³¹ with your hospital. Hospitals should only include hospital outpatient departments or areas of the hospital that perform the procedures listed in Section 9C in an [operating room](#)⁵³ or [procedure room](#)⁵⁴.

Patient Follow-up

This section is not applicable to pediatric hospitals.

Specifications: See the [Patient Follow-up Measure Specifications](#) in the Reference Information beginning on page 327.

Reporting Period: 24 months

Most recent 24-month reporting period published by CMS.

Leapfrog will update data three times per Survey Cycle for hospitals that have provided an accurate CCN in the Hospital Profile and submitted Section 9 of the Leapfrog Hospital Survey.

Leapfrog obtains data for one CMS Hospital Quality Star Rating Program measure directly from CMS' [website](#):

- OP-32: Rate of Unplanned Hospital Visits After an Outpatient Colonoscopy

In order for Leapfrog to obtain the data for this measure, hospitals must provide a valid CMS Certification Number (CCN) in the Hospital Profile and submit Section 9 of the Leapfrog Hospital Survey.

Hospitals that do not perform adult colonoscopy procedures will be scored and publicly reported as “Does Not Apply.” Hospitals that do not provide an accurate CCN in the Hospital Profile or do not report data to CMS will be scored and publicly reported as “Unable to Calculate Score.” Hospitals that do not respond to questions in Section 9 or do not submit a Leapfrog Hospital Survey will be scored and publicly reported as “Declined to Respond.”

Please refer to the [Deadlines and Reporting Periods](#) table in the [Patient Follow-up Measure Specifications](#).

Safe Surgery Checklist for Adult and Pediatric Outpatient Procedures**Important Notes:**

Note 1: The elements required for each stage of the safe surgery checklist in questions #5-12 are adapted from the [WHO Surgical Safety Checklist](#) and the [AHRQ Endoscopy Checklist](#).

Note 2: Question #7 will not be used in scoring or public reporting. Hospitals that do not perform outpatient procedures on adult or pediatric patients will be scored and publicly reported as “Does Not Apply.”

Note 3: Hyperlinks throughout these questions refer to the [Safe Surgery Checklist for Adult and Pediatric Outpatient Procedures FAQs](#) beginning on page 328, not to endnotes. These hyperlinks are not included in the Online Survey Tool.

Specifications: See the [Safe Surgery Checklist for Adult and Pediatric Outpatient Procedures Measure Specifications](#) in the Safety of Procedures Reference Information beginning on page 326.

Reporting Period: 12 months

Answer questions #1-9 for the latest 12-month period prior to submission of this section of the Survey.

Note: As a reminder, the [Corrections Period](#) (December 1-January 31) is reserved for corrections to previously submitted Surveys only. Any updates made to reflect a change in performance must be made prior to the November 30 Late Submission and Performance Update Deadline. Updates made to reflect a change in performance after November 30 will not be scored or publicly reported.

Sufficient Sample: See [Safe Surgery Checklist for Adult and Pediatric Outpatient Procedures Measure Specifications](#) for instructions on identifying a sufficient sample for questions #6-9.

1) What is the latest 12-month reporting period for which your hospital is submitting responses to questions #2-9? 12-month reporting period ending:	<u> </u> Format: Month/Year
2) Does your hospital utilize a safe surgery checklist on <u>every</u> patient, <u>every</u> time one of the applicable procedures in Section 9C is performed? <i>Hospitals with more than one hospital outpatient department, including a surgery center or free-standing hospital outpatient department, should respond based on the location with the fewest processes in place.</i> <i>If “no” to question #2, skip the remaining questions in Section 9D and continue to the next subsection. The hospital will be scored as “Limited Achievement.”</i>	☐ Yes ☐ No
3) Before the induction of anesthesia, is a safe surgery checklist that includes <u>all</u> the following elements <u>read aloud</u> in the presence of the <u>anesthesia professional and nursing personnel</u>: • Patient ID; • Confirmation of procedure; • Patient consent; • Site marked, if applicable; • Anesthesia/medication check; • Allergies assessed; • Difficult airway/aspiration risk; • Risk of blood loss (only applicable if risk of blood loss is >500ml for adults or >7ml/kg for children); and	☐ Yes ☐ No

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• Availability of devices (applicable to endoscopy procedures only)?	
4) Before the skin incision and/or before the procedure begins, is a safe surgery checklist that includes <u>all</u> the following elements <u>read aloud</u> in the presence of the <u>whole surgical team</u>: • <u>Clinical team introduction</u>; • Confirmation of patient name, procedure, and, if applicable, surgical/incision site; • Antibiotic prophylaxis, if applicable; • Anticipated Critical Events (i.e., non-routine steps, length of procedure, blood loss, patient-specific concerns, sterility); • Equipment check/concerns; and • Essential imaging available, if applicable?	○ Yes ○ No
5) Before the patient leaves the operating room and/or procedure room, is a safe surgery checklist that includes <u>all</u> the following elements <u>read aloud</u> in the presence of the <u>whole surgical team</u>: • Confirmation of procedure performed; • Instrument/supply counts, if applicable; • Specimen labeling, if applicable; • Equipment concerns; and • Patient recovery/management concerns?	○ Yes ○ No

If “no” to question #3, #4, or #5, skip the remaining questions in Section 9D and continue to the next subsection. The hospital will be scored as “Limited Achievement.”

Hospitals performing the audit in Section 3B question #6 and the audit in Section 9D question #6 should audit 15 cases who underwent a procedure included in Section 3A and 15 cases who underwent a procedure included in Section 9C. Hospitals only performing the audit in Section 9D question #6 and not in Section 3B question #6 should audit 30 cases who underwent a procedure included in Section 9C.

6) Did your hospital perform an audit (either in-person or via the medical record or other EHR data) on a sufficient sample of patients who underwent a procedure included in Section 9C and measure adherence to the safe surgery checklist? <i>Hospitals with more than one hospital outpatient department, including a surgery center or free-standing hospital outpatient department, should select at least one case from each location.</i> <i>If “no” to question #6, skip the remaining questions in Section 9D and continue to the next subsection. The hospital will be scored as “Limited Achievement.”</i>	○ Yes ○ No
7) How many cases were included in the audit from question #6?	_____ <i>Max value is 100</i>
8) Which method was used to perform the audit on a sufficient sample in question #6?	○ In-person observational audit ○ Retrospective audit of medical records or EHR data ○ Both

9) Based on your hospital's audit (either in-person or via the medical record or other EHR data) on a sufficient sample of patients who underwent a procedure included in Section 9C, what was your hospital's documented rate of adherence to the safe surgery checklist (i.e., what percentage of the sampled cases had all elements in questions #3, #4, and #5 completed)?	○ 90%-100% ○ 75%-89% ○ 50%-74% ○ Less than 50%
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9E: Medication Safety for Outpatient Procedures

Hospitals that share a CMS Certification Number are required to report by facility. Please carefully review [Leapfrog's Multi-Campus Reporting Policy](#).

Important Note: The term “hospital outpatient department” is used to refer to all hospital outpatient departments or areas of the hospital, including areas that are used for **both** inpatient and outpatient procedures, that perform the outpatient procedures listed in Section 9C and that share your hospital's license or CMS Certification Number (CCN). This would include, but is not limited to surgery centers, free-standing hospital outpatient departments, as well as outpatient departments that are located in your hospital or are [co-located](#)³¹ with your hospital. Hospitals should only include hospital outpatient departments or areas of the hospital that perform the procedures listed in Section 9C in an [operating room](#)⁵³ or [procedure room](#)⁵⁴.

Specifications: See [Medication Safety for Outpatient Procedures Measure Specifications](#) in the Reference Information beginning on page 330.

Reporting Period: 12 months

Answer questions #2-7 based on all cases (or a sufficient sample of them),

- Surveys submitted prior to September 1:
 - 01/01/2024 – 12/31/2024
- Surveys (re)submitted on or after September 1:
 - 07/01/2024 – 06/30/2025

Note: As a reminder, the [Corrections Period](#) (December 1-January 31) is reserved for corrections to previously submitted Surveys only. Any updates made to reflect a change in performance must be made prior to the November 30 Late Submission and Performance Update Deadline. Updates made to reflect a change in performance after November 30 will not be scored or publicly reported.

Sufficient Sample: See [Medication Safety for Outpatient Procedures Measure Specifications](#) for instructions on identifying a sufficient sample for questions #2-7.

1) 12-month reporting period used:	○ 01/01/2024 – 12/31/2024 ○ 07/01/2024 – 06/30/2025
2) Did your hospital perform an audit of clinical records for all patients undergoing those procedures included in Section 9C (or a sufficient sample of them) who were discharged from a hospital outpatient department for the reporting period selected and measure adherence to medication documentation guidelines regarding home medications, medications administered during the visit or prescribed at discharge, and medication allergies? <i>If “no” to question #2, skip questions #3-7 and continue to the next subsection. The hospital will be scored as “Did Not Measure.”</i> <i>If “yes, but there were fewer than 30 outpatients discharged for the reporting period,” skip questions #3-7 and continue to the next subsection. The hospital will be scored as “Unable to Calculate Score.”</i>	○ Yes ○ No ○ Yes, but there were fewer than 30 outpatients discharged for the reporting period
3) Number of cases measured (either all cases or a sufficient sample of them):	_____
4) Number of cases in question #3 with a list of all home medication(s) , including dose, route, and frequency, documented in the clinical record:	_____

5) Number of cases in question #3 with a list of all medication(s) administered during the visit and new medications prescribed at discharge , including the strength, dose, route, date, and time of administration, documented in the clinical record:	_____
6) Number of cases in question #3 with a list of all medication allergies and adverse reaction(s) documented in the clinical record:	_____
7) Do the responses in questions #3-6 represent a sample of cases?	☐ Yes ☐ No

9F: Patient Experience (OAS CAHPS)

This section is not applicable to pediatric hospitals.

Hospitals that share a CMS Certification Number are required to report by facility. Please carefully review [Leapfrog's Multi-Campus Reporting Policy](#).

Important Note: The term “hospital outpatient department” is used to refer to all hospital outpatient departments or areas of the hospital, including areas that are used for **both** inpatient and outpatient procedures, that perform the outpatient procedures listed in Section 9C and that share your hospital's license or CMS Certification Number (CCN). This would include, but is not limited to surgery centers, free-standing hospital outpatient departments, as well as outpatient departments that are located in your hospital or are [co-located](#)³¹ with your hospital. Hospitals should only include hospital outpatient departments or areas of the hospital that perform the procedures listed in Section 9C in an [operating room](#)⁵³ or [procedure room](#)⁵⁴.

Specifications: See [Patient Experience \(OAS CAHPS\) Measure Specifications](#) in the Reference Information beginning on page 337.

Reporting Period: 12 months

Answer questions #1-10 for the latest 12-month period prior to the submission of this section of the Survey.

Note: As a reminder, the [Corrections Period](#) (December 1-January 31) is reserved for corrections to previously submitted Surveys only. Any updates made to reflect a change in performance must be made prior to the November 30 Late Submission and Performance Update Deadline. Updates made to reflect a change in performance after November 30 will not be scored or publicly reported.

1) What is the latest 12-month reporting period for which your hospital is submitting responses to this section? 12-month reporting period ending:	_____ Format: Month/Year
2) Did your hospital have at least 300 eligible discharges ⁵⁶ during the 12-month period referenced above? <i>If “no” to question #2, skip the remaining questions in Section 9F and go to the Affirmation of Accuracy. The hospital will be scored as “Does Not Apply.”</i>	☐ Yes ☐ No
3) Has your hospital administered, or started to administer, the entire OAS CAHPS Survey during the reporting period? <i>Hospitals not currently administering the OAS CAHPS Survey should select “no,” skip the remaining questions in Section 9F, and go to the Affirmation of Accuracy. The hospital will be scored as “Did Not Measure.”</i>	☐ Yes ☐ No
4) Total number of months in which your hospital administered the OAS CAHPS Survey during the reporting period.	_____
5) Total number of returned surveys during the reporting period. <i>If less than 100, skip the remaining questions in Section 9F and go to the Affirmation of Accuracy. The hospital will be scored as “Unable to Calculate Score.”</i>	_____

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6) Do the responses to the questions in this subsection include discharges from more than one location (e.g., hospital and surgery center or free-standing hospital outpatient department, hospital and multiple free-standing hospital outpatient departments, etc.)?	☐ Yes ☐ No
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In questions #7-10, report your hospital's [Top Box Score](#)⁵² (rounded to the nearest whole number) from each of the following patient experience **domains** from your vendor report that matches the reporting period that you selected in question #1.

7) Facilities and Staff	_____ Format: Whole numbers only
8) Communication About Your Procedure	_____ Format: Whole numbers only
9) Patients' Rating of the Facility	_____ Format: Whole numbers only
10) Patients Recommending the Facility	_____ Format: Whole numbers only

Affirmation of Accuracy

As the hospital CEO or as an employee of the hospital to whom the hospital CEO has delegated responsibility, I have reviewed this information pertaining to the Outpatient Procedures Section at our hospital, and I hereby certify that this information is true, accurate, and reflects the current, normal operating circumstances at our hospital. I am authorized to make this certification on behalf of our hospital.

The hospital and I understand that The Leapfrog Group, its members, the public and entities and persons who contract or have other business dealings with The Leapfrog Group are relying on the truth and accuracy of this information. The hospital and I also understand that The Leapfrog Group will make this information and/or analyses of this information public through the Survey Results public reporting website, The Leapfrog Group's Hospital Safety Grade, and/or other Leapfrog Group products and services. This information and/or analyses and all intellectual property rights therein shall be and remain the sole and exclusive property of The Leapfrog Group in which The Leapfrog Group retains exclusive ownership. This information does not infringe upon any third-party intellectual property rights or any other third-party rights whatsoever and is free and clear of all encumbrances and liens of any kind. The hospital and I acknowledge that The Leapfrog Group may use this information in a commercial manner for profit. The hospital shall be liable for and shall hold harmless and indemnify The Leapfrog Group from any and all damages, demands, costs, or causes of action resulting from any inaccuracies in the information or any misrepresentations in this Affirmation of Accuracy. The Leapfrog Group and its members and entities and persons who contract or have other business dealings with The Leapfrog Group reserve the right to omit or disclaim information that is not current, accurate or truthful.

Affirmed by _____, the hospital's _____,
(first name and last name) (title)
on _____.
(date)

Section 9: Outpatient Procedures Reference Information

What's New in the 2025 Survey

Section 9A: Basic Outpatient Department Information

There are no changes to this subsection.

Section 9B: Medical, Surgical, and Clinical Staff

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

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

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

Section 9C: Volume of Procedures

Leapfrog is adding back five anterior segment eye procedure CPT codes and four lumpectomy or quadrantectomy of breast CPT codes for adult patients that were previously removed in 2024, due to feedback that the procedures continue to be performed in both ambulatory surgery centers and hospital outpatient departments. In addition, Leapfrog is adding three new CPT codes for spinal fusion for adult patients, two new CPT codes for nasal/sinus procedures for both adult and pediatric patients, and one new CPT code for cystourethroscopy for adult patients.

Section 9D: Safety of Procedures

Patient Follow-up

There are no changes to these questions.

Safe Surgery Checklist for Adult and Pediatric Outpatient Procedures

There are no changes to these questions.

Section 9E: Medication Safety for Outpatient Procedures

There are no changes to these questions.

Section 9F: Patient Experience (OAS CAHPS)

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

Change Summary Since Release

None. If substantive changes are made to this section of the Survey after release on April 1, 2025, they will be documented in this Change Summary section.

Basic Outpatient Department Information Frequently Asked Questions (FAQs)

- 1. Our hospital shares a CMS Certification Number (CCN) with other hospitals, and we have many hospital outpatient department locations (e.g., surgery centers, endoscopy centers, free-standing hospital outpatient departments, etc.) all under the same CCN. How should we report on Section 9: Outpatient Procedures?**

As per Leapfrog's [Multi-Campus Reporting Policy](#), all hospital campuses will need to complete their own Leapfrog Hospital Survey unless they are co-located.

For Section 9: Outpatient Procedures, each hospital campus will need to indicate in Section 9A if they are performing the outpatient procedures listed in Section 9C at their hospital and/or at a surgery center or free-standing hospital outpatient department that shares their hospital's CMS Certification Number (CCN). You should only include those hospital outpatient departments that your hospital refers patients to. The remainder of the questions in Section 9 will need to be answered based on:

- all hospital outpatient departments in your hospital, including any areas such as inpatient units, where outpatient procedures are performed (as reported in Section 9A question #2); and,
- all surgery centers and free-standing hospital outpatient departments that share your hospital's CCN (as reported in Section 9A question #3)

In Section 9C, you will be able to provide total volume across all hospital outpatient department locations (as reported in Section 9A questions #2 and #3) and information for the different outpatient locations where the specific outpatient procedures are performed. All other questions should be answered based on all outpatient locations. If you have different adherence across locations, you should answer based on the least adherent location.

If all hospital campuses are referring patients to the same surgery centers and free-standing hospital outpatient departments, you would include the information and volume for these locations when responding to Section 9 on all their Leapfrog Hospital Surveys.

- 2. How should our hospital report on the number of operating rooms and endoscopic procedure rooms in questions #4-5 if our operating/procedure rooms are used for both inpatient and outpatients? How should we report if we have multiple hospital outpatient departments?**

Hospitals should report on the total number of adult and pediatric operating rooms or procedure rooms if these rooms are used for both inpatient and outpatient procedures. Otherwise, hospitals should only report on the number of operating/procedure rooms that are used for outpatient procedures. If your hospital has multiple hospital outpatient departments, report the total number of adult and pediatric outpatient operating rooms or procedure rooms across all locations. You should only be reporting on operating rooms and procedure rooms that are used to perform the outpatient procedures listed in Section 9C Volume of Procedures.

Medical, Surgical, and Clinical Staff Frequently Asked Questions (FAQs)

1. How does Leapfrog define “immediately available” and “in the building” as it pertains to ACLS and/or PALS trained clinicians?

“Immediately available” is defined as being physically present in the building and not engaged in an activity or procedure that cannot be interrupted if hands-on intervention is needed for a patient.

Leapfrog defines “in the building” as within the hospital outpatient department or surgery center or in an area co-located with the hospital outpatient department or surgery center. Leapfrog defines co-located as a location within “immediate physical proximity,” meaning the two locations are physically connected, either by a tunnel, an enclosed bridge, or the locations abut each other so that hallways readily connect.

2. If a hospital did not perform any outpatient pediatric procedures during the reporting period selected in Section 9C, should they still report on PALS-trained clinicians in Section 9B question #2?

No. If your hospital did not report any pediatric discharges for the procedures listed in Section 9C during the reporting period, then you should select “Not applicable; adult patients only” in question #2.

3. Is the PEARS certification the equivalent of PALS certification for the purposes of responding to question #2?

No. PEARS is not the equivalent of or substitution for PALS certification. The PEARS curriculum is focused on recognition of and steps to mitigate pediatric respiratory emergencies, whereas the PALS curriculum informs clinicians how to manage these emergencies, with emphasis on leadership of the care team, and how to perform key air management techniques. Additionally, the PALS curriculum instructs providers on multiple ways to obtain IV access to improve circulatory issues.

4. How should hospitals report on ACLS/PALS certification if they have more than one hospital outpatient department performing the procedures listed in Section 9C Volume of Procedures?

Hospitals with more than one hospital outpatient department are instructed to respond to questions #1-2 based on the location with the least intensive staffing. For example, if one hospital outpatient department has an ACLS trained clinician, as well as a second clinician present at all times and immediately available in the building when adult patients are in the hospital outpatient department, but another hospital outpatient department does not, you should answer “no” to question #1.

5. If a free-standing pediatric hospital has clinicians trained in PALS but a small percentage of the patient population is over 13, should these clinicians also have ACLS training, or would the PALS training be sufficient?

If your hospital outpatient departments are performing procedures on adult and pediatric patients, there should be at least one clinician with ACLS training when adult patients (13 years and older) are recovering and one clinician with PALS training when pediatric patients (infant to 12 years) are recovering. This could mean that some clinicians maintain both certifications or some maintain ACLS, and others maintain PALS.

Volume of Procedures Measure Specifications

Important Notes:

Note 1: Hospitals that share a CMS Certification Number are required to report by facility. Please carefully review [Leapfrog's Multi-Campus Reporting Policy](#).

Note 2: CPT Codes are provided in downloadable Excel files on the Survey Dashboard. To access the files, click the CPT Code Workbook button next to Section 9. You will be required to complete the American Medical Association's Terms of Use before downloading the Excel file and using the individual CPT codes to query your EHR or billing system. You are only required to complete the Terms of Use once per Survey Cycle (April 1 – November 30).

The CPT Code Workbooks (Excel files) are labeled for Section 3A: Total Hip Replacement, Total Knee Replacement, and Bariatric Surgery for Weight Loss and Section 9C: Volume of Procedures. Please note, if you are part of a hospital system, each hospital will need to complete the Terms of Use. This is a requirement of the American Medical Association.

Note 3: When counting patients for the purposes of identifying total volume in Section 9C, you should only include scheduled outpatient (i.e., admitted and discharged on the same day) procedures performed at your hospital outpatient departments within the reporting period. Include scheduled outpatient procedures with a planned observation or extended recovery stay. Exclude scheduled outpatient procedures with a planned inpatient admission. Exclude emergent/urgent cases, such as procedures for patients that come through the emergency department. To count patient discharges, use the Volume of Procedures Measure Specifications below and the CPT codes available in the Library on the Survey Dashboard.

Source: The Leapfrog Group, American Medical Association, The Health Care Cost Institute
Reporting Period: 12 months 01/01/2024 – 12/31/2024
Questions #2-10: Respond "yes" or "no" based on whether your hospital outpatient department(s) performed any of the procedures during the reporting period on adult and/or pediatric patients. The procedures fall within nine specialty areas: Adult Procedures Ophthalmology procedures: anterior segment eye procedures; posterior segment eye procedures; and ocular adnexa and other eye procedures Orthopedic procedures: finger, hand, wrist, forearm, and elbow procedures; shoulder procedures; spine procedures; hip procedures; knee procedures; toe, foot, ankle, and leg procedures; and general orthopedic procedures Otolaryngology procedures: ear procedures; mouth procedures; and nasal/sinus procedures Gastroenterology procedures: upper GI endoscopy; and lower GI endoscopy General surgery procedures: cholecystectomy and common duct exploration; hemorrhoid procedures; inguinal and femoral hernia repairs; other hernia repairs; laparoscopy; lumpectomy or quadrantectomy of breast; and mastectomy Urology procedures: circumcisions; cystourethroscopy; male genital procedures; urethra procedures; and vaginal repair procedures Neurological surgery procedures: spinal fusion procedures Obstetrics and gynecology procedures: cervix procedures; hysteroscopy; and uterus and adnexa laparoscopies Plastic and reconstructive surgery procedures: breast repair or reconstructive procedures; and skin graft/reconstruction procedures Pediatric Procedures Ophthalmology procedures: ocular adnexa and other eye procedures Orthopedic procedures: finger, hand, wrist, forearm, and elbow procedures; shoulder procedures; knee procedures; toe, foot, ankle, and leg procedures; and general orthopedic procedures

3. [Otolaryngology procedures](#): ear procedures; mouth procedures; nasal/sinus procedures; pharynx/adenoid/tonsil procedures

Respond “yes” if:

- One or more of your hospital outpatient departments performed the procedure on an outpatient basis for the entire reporting period (12 months) and continues to do so
- One or more of your hospital outpatient departments performed the procedure on an outpatient basis during part of the reporting period (less than 12 months) and continues to perform the procedure

Respond “yes, but no longer perform these procedures” if your hospital outpatient departments performed the procedure for all or some of the reporting period, but NO longer performs the procedure

Respond “no” if your hospital outpatient departments do not perform the procedure.

Questions #11-37: Based on your responses to questions #2-10, report on the total (a) adult and/or (b) pediatric volume for each procedure (from questions #2-10) during the reporting period:

Adult Procedures

1. [Ophthalmology procedures](#): anterior segment eye procedures; posterior segment eye procedures; and ocular adnexa and other eye procedures
2. [Orthopedic procedures](#): finger, hand, wrist, forearm, and elbow procedures; shoulder procedures; spine procedures; hip procedures; knee procedures; toe, foot, ankle, and leg procedures; and general orthopedic procedures
3. [Otolaryngology procedures](#): ear procedures; mouth procedures; and nasal/sinus procedures
4. [Gastroenterology procedures](#): upper GI endoscopy; and lower GI endoscopy
5. [General surgery procedures](#): cholecystectomy and common duct exploration; hemorrhoid procedures; inguinal and femoral hernia repairs; other hernia repairs; laparoscopy; lumpectomy or quadrantectomy of breast; and mastectomy
6. [Urology procedures](#): circumcisions; cystourethroscopy; male genital procedures; urethra procedures; and vaginal repair procedures
7. [Neurological surgery procedures](#): spinal fusion procedures
8. [Obstetrics and gynecology procedures](#): cervix procedures; hysteroscopy; and uterus and adnexa laparoscopies
9. [Plastic and reconstructive surgery procedures](#): breast repair or reconstructive procedures; and skin graft/reconstruction procedures

Pediatric Procedures

1. [Ophthalmology procedures](#): ocular adnexa and other eye procedures
2. [Orthopedic procedures](#): finger, hand, wrist, forearm, and elbow procedures; shoulder procedures; knee procedures; toe, foot, ankle, and leg procedures; and general orthopedic procedures
3. [Otolaryngology procedures](#): ear procedures; mouth procedures; nasal/sinus procedures; pharynx/adenoid/tonsil procedures

When calculating total **hospital outpatient department volume for (a) adult and/or (b) pediatric patients** count the number of **patients** discharged from your hospital outpatient department(s) within the reporting period with any one or more of the codes specified for each procedure, subject to the criteria below:

- Only include scheduled outpatient (i.e., admitted and discharged on the same day) procedures performed at your hospital outpatient departments within the reporting period. Include scheduled outpatient procedures with a planned observation or extended recovery stay.
- Exclude scheduled outpatient procedures with a planned inpatient admission. Exclude emergent/urgent cases, such as procedures for patients that come through the emergency department.
- Only the procedure codes provided by Leapfrog should be used to report on the questions in Section 9C.

- If a patient had more than one of the listed procedures performed on the same visit (i.e., repair of dislocating knee cap (CPT: 27422) and repair of superior labrum anterior/posterior (SLAP) lesion (CPT: 29807)), include the patient in the total volume for both procedures.

Ophthalmology Measure Specifications

For ophthalmology procedures, use the CPT codes available via the [Survey Dashboard](#) to count **patients** discharged from your hospital outpatient departments who have undergone any of the 3 procedures during the reporting period.

One procedure applies to **both adult and pediatric patients**:

- Ocular adnexa and other eye procedures

Two procedures apply to **adult patients only**:

- Anterior segment eye procedures
- Posterior segment eye procedures

Using the “Ophthalmology_adult” sheet, count the total number of adult (18 years of age or older) patients discharged for each procedure with any of the CPT codes listed. The CPT code can be in any procedure field.

Using the “Ophthalmology_ped” sheet, count the total number of pediatric (17 years of age and younger) patients discharged for each procedure with any of the CPT codes listed. The CPT code can be in any procedure field.

Orthopedic Measure Specifications

For orthopedic procedures, use the CPT codes available via the [Survey Dashboard](#) to count **patients** discharged from your hospital outpatient departments who have undergone any of the 7 procedures during the reporting period.

Five procedures apply to **both adult and pediatric patients**:

- Finger, hand, wrist, forearm, and elbow procedures
- Shoulder procedures
- Knee procedures
- Toe, foot, ankle, and leg procedures
- General orthopedic procedures

Two procedures apply to **adult patients only**:

- Spine procedures
- Hip procedures

Using the “Orthopedic_adult” sheet, count the total number of adult (18 years of age or older) patients discharged for each procedure with any of the CPT codes listed. The CPT code can be in any procedure field.

Using the “Orthopedic_ped” sheet, count the total number of pediatric (17 years of age and younger) patients discharged for each procedure with any of the CPT codes listed. The CPT code can be in any procedure field.

Otolaryngology Measure Specifications

For otolaryngology procedures, use the CPT codes available via the [Survey Dashboard](#) to count **patients** discharged from your hospital outpatient departments who have undergone any of the 4 procedures during the reporting period.

Three procedures apply to **both adult and pediatric patients**:

- Ear procedures

- Mouth procedures
- Nasal/sinus procedures

One procedure applies to **pediatric patients only**:

- Pharynx/adenoid/tonsil procedures

Using the “Otolaryngology_adult” sheet, count the total number of adult (18 years of age or older) patients discharged for each procedure with any of the CPT codes listed. The CPT code can be in any procedure field.

Using the “Otolaryngology_ped” sheet, count the total number of pediatric (17 years of age and younger) patients discharged for each procedure with any of the CPT codes listed. The CPT code can be in any procedure field.

Gastroenterology Measure Specifications

For gastroenterology procedures, use the CPT codes available via the [Survey Dashboard](#) to count **patients** discharged from your hospital outpatient departments who have undergone either of the 2 procedures during the reporting period.

Both procedures apply to **adult patients only**:

- Upper GI endoscopy
- Lower GI endoscopy

Using the “Gastroenterology_adult” sheet, count the total number of adult (18 years of age or older) patients discharged for each procedure with any of the CPT codes listed. The CPT code can be in any procedure field.

General Surgery Measure Specifications

For general surgery procedures, use the CPT codes available via the [Survey Dashboard](#) to count **patients** discharged from your hospital outpatient departments who have undergone any of the 7 procedures during the reporting period.

All seven procedures apply to **adult patients only**:

- Cholecystectomy and common duct exploration
- Hemorrhoid procedure
- Laparoscopy
- Lumpectomy or quadrantectomy of breast
- Mastectomy
- Inguinal and femoral hernia repair
- Other hernia repair

Using the “General surgery_adult” sheet, count the total number of adult (18 years of age or older) patients discharged for each procedure with any of the CPT codes listed. The CPT code can be in any procedure field.

Urology Measure Specifications

For urology procedures, use the CPT codes available via the [Survey Dashboard](#) to count **patients** discharged from your hospital outpatient departments who have undergone any of the 5 procedures during the reporting period.

All five procedures apply to **adult patients only**:

- Circumcision
- Cystourethroscopy

- Male genital procedures
- Urethra procedures
- Vaginal repair procedures

Using the “Urology_adult” sheet, count the total number of adult (18 years of age or older) patients discharged for each procedure with any of the CPT codes listed. The CPT code can be in any procedure field.

Neurological Surgery Measure Specifications

For neurological surgery procedures, use the CPT codes available via the [Survey Dashboard](#) to count **patients** discharged from your hospital outpatient departments who have undergone the procedure during the reporting period.

One procedure applies to **adult patients only**:

- Spinal fusion procedures

Using the “Neurological surgery_adult” sheet, count the total number of adult (18 years of age or older) patients discharged with any of the CPT codes listed. The CPT code can be in any procedure field.

Obstetrics and Gynecology Measure Specifications

For obstetrics and gynecology procedures, use the CPT codes available via the [Survey Dashboard](#) to count **patients** discharged from your hospital outpatient departments who have undergone any of the 3 procedures during the reporting period.

Three procedures apply to **adult patients only**:

- Cervix procedures
- Hysteroscopy
- Uterus and adnexa laparoscopies

Using the “Obstetrics and gynecology_adult” sheet, count the total number of adult (18 years of age or older) patients discharged for each procedure with any of the CPT codes listed. The CPT code can be in any procedure field.

Plastic and Reconstructive Surgery Measure Specifications

For plastic and reconstructive surgery procedures, use the CPT codes available via the [Survey Dashboard](#) to count **patients** discharged from your hospital outpatient departments who have undergone either of the 2 procedures during the reporting period.

Two procedures apply to **adult patients only**:

- Breast repair or reconstruction
- Skin graft/reconstruction procedures

Using the “Plastic_reconstruct surg_adult” sheet, count the total number of adult (18 years of age or older) patients discharged for each procedure with any of the CPT codes listed. The CPT code can be in any procedure field.

See [FAQs](#) for additional information about responding to questions in this section.

Volume of Procedures Frequently Asked Questions (FAQs)

1. How did Leapfrog select these 9 specialties and the procedures in this section of the Survey?

Leapfrog worked with the Health Care Cost Institute (HCCI) to identify the most commonly billed surgical procedures in ambulatory surgery centers and hospital outpatient departments for commercially insured adult and pediatric patients. Leapfrog's technical experts then assessed the list of procedures based on their frequency and type of anesthesia used during the procedure. Those selected for the Survey represent the highest volume procedures nationally requiring moderate to general anesthesia (including nerve blocks).

Please reach out to the [Leapfrog Help Desk](#) if you believe additional CPT Codes should be added to the Survey; Leapfrog will take these suggestions to our technical experts.

2. Should we count patients discharged with a G code for colonoscopy?

No. A "G" (HCPCS II) code is used to differentiate between colonoscopies performed for screening purposes rather than for a diagnostic or therapeutic procedure. The Survey only includes major diagnostic and therapeutic procedures.

Safety of Procedures Measure Specifications

Patient Follow-up

Leapfrog obtains data for one CMS Hospital Outpatient measures directly from CMS' [website](#):

- OP-32: Rate of Unplanned Hospital Visits After an Outpatient Colonoscopy

In order for Leapfrog to obtain the data for this measure, hospitals must provide a valid CMS Certification Number (CCN) in the Hospital Profile and submit Section 9 of the Leapfrog Hospital Survey.

Deadlines and Reporting Periods

Data downloaded from CMS will be scored and publicly reported for Hospitals that have submitted Section 9 by	CMS Reporting Period	Available on Hospital Details Page and Public Reporting Website on
June 30, 2025	Most recent 24-month reporting period	July 12, 2025 Details Page July 25, 2025 Public Reporting Website
August 31, 2025	Most recent 24-month reporting period	September 10, 2025
November 30, 2025	Most recent 24-month reporting period	December 9, 2025

Review your CMS data for OP-32

- Once Leapfrog has published your hospital's Survey Results on the [Hospital Details Page](#), hospitals are urged to compare the CMS data Leapfrog has obtained with the data published on CMS' [website](#).
- Dates on which the Survey Results will be available on the Hospital Details page are listed in the "Deadlines and Reporting Periods" table above.

If you find a discrepancy while comparing your hospital's data published on the CMS [website](#) to the data published on the Hospital Details page, contact [Leapfrog's Help Desk](#) immediately.

Safe Surgery Checklist for Adult and Pediatric Outpatient Procedures

Important Note: Hospitals that share a CMS Certification Number are required to report by facility. Please carefully review [Leapfrog's Multi-Campus Reporting Policy](#).

Source: The Leapfrog Group, WHO Surgical Safety Checklist and Implementation Manual , AHRQ Endoscopy Checklist
Reporting Period: 12 months Latest 12-month period prior to submission of this section of the Survey
Safe Surgery Checklist Workbook (Excel) To complete the data collection and respond to questions #6-9, hospitals should download the Safe Surgery Checklist Workbook (Excel). This workbook includes five tabs: Instructions, Section 3B (Complex Surgery), Section 3B – Data Entry, Section 9D (Outpatient Procedures), and Section 9D – Data Entry. The Section 9D tabs can be used to complete the safe surgery checklist audits for this subsection and to calculate the response for question #9. The workbook is available on the Survey Materials Webpage .
Sampling: For hospitals with one hospital outpatient department that performs the procedures listed in Section 9C and Section 3A and submit both Section 9 and 3: Hospitals can randomly sample 15 patients (who had one of the procedures included in Section 9C) and measure and report adherence to the safe surgery checklist based on that sample. When sampling from a larger population of cases, hospitals that perform procedures across multiple surgical specialties (e.g., general surgery, orthopedics, urology, etc.) included in Section 9C and facilities that perform procedures for both adult and pediatric patients should obtain a representative sample (i.e., include patients who underwent procedures in different surgical specialties and include both adult and pediatric patients, if applicable). For hospitals with multiple hospital outpatient departments that perform the procedures listed in Section 9C and Section 3A and submit both Section 9 and 3: Hospitals can randomly sample 15 patients (who had one of the procedures included in Section 9C) and measure and report adherence to the safe surgery checklist based on that sample. However, hospital must sample across the various locations where the procedures are being performed, including freestanding hospital outpatient departments or surgery centers, in addition to ensuring that the sample includes patients who underwent procedures in different surgical specialties and both adult and pediatric patients, if applicable. For hospitals with one or multiple hospital outpatient departments that ONLY perform the procedures in Section 9C or that ONLY submit Section 9: Hospitals must randomly sample 30 patients who had one of the procedures included in Section 9C and report adherence to the safe surgery checklist on that sample. Hospitals that perform the procedures listed in Section 9C and 3A should follow the guidance above.
Question #6: Did your hospital perform an audit (either in-person or via the medical record or other EHR data) on a sufficient sample of patients who underwent a procedure included in Section 9C and measure adherence to the safe surgery checklist? To respond “yes” to question #6, hospitals must measure and document whether all the elements in questions #3, #4, and #5 were verbalized in the presence of the appropriate personnel for each sampled case. Hospitals that completed the audit should respond “yes” to this question regardless of whether the adherence to the checklist was 100%. Hospitals will report on adherence to the checklist in question #9.

Question #7: How many cases were included in the audit from question #6?

Hospitals that perform procedures in both Section 3A and Section 9C, and submit both Section 3 and 9, can randomly sample 15 patients (who had one of the procedures included in Section 9C) and measure and report adherence to the safe surgery checklist based on that sample.

Hospitals that ONLY perform the procedures in Section 3AC, or that ONLY submit Section 9, must randomly sample 30 patients (who had one of the procedures included in Section 9C) and measure and report adherence to the safe surgery checklist based on that sample.

Question #8: What method was used to perform the audit on a sufficient sample in question #6?

Hospitals can only perform a retrospective audit by reviewing medical records or EHR data if adherence to the safe surgery checklist is clearly documented in the medical record or EHR and the documentation clearly demonstrates that each element was verbalized in the presence of the appropriate personnel. If hospitals cannot clearly determine whether (a) the checklist element was verbalized and (b) that the appropriate personnel were present via a retrospective audit, an in-person observational audit must be completed.

Hospitals performing in-person observational audits must do so in the latest 12 months prior to Survey submission.

Hospitals performing retrospective audits must audit cases from the latest 12 months prior to Survey submission but can also review any case from Section 9C that was performed in the latest calendar year prior to Survey submission.

Question #9: Based on your hospital's audit (either in-person or via the medical record or other EHR data) on a sufficient sample of patients who underwent a procedure included in Section 9C, what was your hospital's documented rate of adherence to the safe surgery checklist (e.g., what percentage of the sampled cases had all elements in questions #3, #4, and #5 completed)?

Based on the audit completed for question #6, determine the total number of patient audits where all elements of the safe surgery checklist (included in questions #3, #4, and #5) were read aloud in the presence of the appropriate personnel 1) before the induction of anesthesia, 2) before the skin incision and/or the procedure began, and 3) before the patient left the operating and/or procedure room.

Included cases:

- The patient audit shows that all elements of the safe surgery checklist, at all three time points, were read aloud in the presence of the appropriate personnel.

Excluded cases:

- The patient audit does not demonstrate that all elements of the safe surgery checklist were read aloud in the presence of the appropriate personnel (i.e., one or more elements of the checklist were not read aloud, or the appropriate personnel were not present during the checklist).
- The patient audit does not demonstrate that the safe surgery checklist was read aloud in the presence of the appropriate personnel at all three time points (i.e., before anesthesia, before skin incision, and before the patient leaves).

Important Note: If a Safe Surgery Checklist element includes the qualifier “if applicable,” hospitals should determine if that element of the checklist was applicable to the patient and procedure being performed. If the element was determined to be “not applicable” to the patient and procedure, it does not count against the total adherence. For example, if your hospital performed a hernia repair, the availability of a device on-site would not be applicable. Therefore, when completing the Safe Surgery Checklist Workbook for this patient, indicate N/A for that element (device on-site) and your hospital would be able to count that case as adherent.

Safety of Procedures Frequently Asked Questions (FAQs)

General Questions

- 1. How should hospitals report on the processes in Section 9D Safety of Procedures if they have more than one hospital outpatient department performing the procedures listed in Section 9C Volume of Procedures?**

Hospitals with more than one hospital outpatient department are instructed to respond to Section 9D based on the location with the fewest processes in place. For example, if one hospital outpatient department uses a safe surgery checklist on all patients, but another hospital outpatient department does not, you should answer “no” to question #6.

Patient Follow-up FAQs

- 2. Do hospitals need to do anything for Leapfrog to obtain data for the CMS measures?**

Leapfrog will automatically use your hospital's data that are reported to CMS for OP-32 if you provide an accurate CCN in the Hospital Profile and submit Section 9 of the 2025 Leapfrog Hospital Survey. For OP-32, if your hospital does not perform adult lower GI endoscopy procedures, you will be scored as “Does Not Apply.” More information is available in the Leapfrog Hospital Survey [Scoring Algorithms](#).

Safe Surgery Checklist for Adult and Pediatric Outpatient Procedures FAQs

- 3. What 12-month reporting period should be used when reporting on this section?**

When responding to the questions in Section 9D, hospitals should enter the month in which they complete their observational in-person or retrospective EHR review audits. If your hospital does not perform an audit, enter the month in which you are completing the Survey.

- 4. Does the safe surgery checklist referenced in Section 9D questions #1-9 apply to all procedures, including colonoscopies, endoscopies, etc.?**

Yes, it applies to all procedures in Section 9C questions #2-10. If your hospital outpatient department(s) do not utilize a safe surgery checklist for colonoscopy and/or endoscopy, respond “No” to question #2.

- 5. Can different elements of the “Before the induction of anesthesia” checklist (question #3) be performed in different places?**

Yes, hospitals may perform some elements of the pre-anesthesia checklist outside of the operating room. Hospitals may read aloud the following elements in a pre-procedure (preop) area: Patient ID, Confirmation of procedure, Patient consent, Site marked, if applicable, and Allergies assessed.

Hospitals should not remove conversation prompts as it is harmful to the purpose of the checklist and should continue debriefing and requiring participation of the surgical team members in key moments.

- 6. Do we need to perform a “clinical team introduction” if the team already knows each other and/or will be in the operating room together all day?**

Yes. Even if a clinical team knows each other they must perform an introduction stating their name and role at the first procedure of the day. They do not need to reintroduce themselves for the remaining procedures but should confirm everyone was introduced beforehand. However, if any team members change between operations, introductions must be performed again.

7. **Do the Safe Surgery Checklist components included in questions #3, #4, and #5 need to be in one document that would align with the [WHO example](#) or can they be in different documents (i.e., pre-anesthesia notes, surgeon H&P, and pre-surgical checklists, etc.)?**

It is possible to have separate checklists for each phase of the surgical procedure (i.e., before the induction of anesthesia, before the skin incision and/or before the procedure begins, and before the patient leaves the operating or procedure room). However, each individual component included in questions #3, #4, and #5 should be listed on the checklist(s) and hospitals should document whether the components were read aloud at the appropriate time with the appropriate members of the surgical team present.

8. **How is “whole surgical team” defined?**

“Whole surgical team” is comprised of the surgeons, anesthesia professionals, nurses, technicians, and other operating room personnel involved in surgery. This is based off the [World Alliance for Patient Safety Implementation Manual Surgical Safety Checklist \(First Edition\)](#).

Medication Safety for Outpatient Procedures Measure Specifications

Important Note: Hospitals that share a CMS Certification Number are required to report by facility. Please carefully review [Leapfrog's Multi-Campus Reporting Policy](#).

Source: The Leapfrog Group
Reporting Period: 12 months - Surveys submitted prior to September 1: 01/01/2024 – 12/31/2024 - Surveys (re)submitted on or after September 1: 07/01/2024 – 06/30/2025
Medication Safety Documentation Workbook (Excel) To complete the data collection for this subsection and respond to questions #3-7, hospitals should download the Medication Safety Documentation Workbook (Excel). This workbook includes seven tabs: Instructions, 2024 Sampling, 2025 Sampling, Home Meds, Visit Meds, Allergies, and Data Entry and can be used to identify patients to sample in order to complete the three clinical record audits, as well as calculate the responses to enter into the Online Hospital Survey Tool for each of the audits. This workbook is available on the Survey Materials webpage and should be used when completing this subsection.
Sampling: <i>For hospitals with <u>one</u> hospital outpatient department that performs the procedures listed in Section 9C:</i> If you have <u>more than 30 cases</u> that meet the criteria for inclusion in the denominator of the process measures during the time period of the clinical record audit, you may randomly sample 30 of them for the denominator of each documentation guideline, and measure and report adherence based on that sample. When sampling from a larger population of cases, this is the minimum number of cases needed to make a statistically reliable statement of percent adherence to the process guidelines. <i>For hospitals with <u>multiple</u> hospital outpatient departments that perform the procedures listed in Section 9C:</i> If you have <u>more than 30 cases</u> total (across all hospital outpatient departments) that meet the criteria for inclusion in the denominator of the process measure during the time period of the clinical record audit, you may randomly sample a minimum of 10 cases from the hospital (including any co-located hospital outpatient departments or inpatient areas performing outpatient procedures) and each free-standing hospital outpatient department or surgery center. Hospitals will need to report on a total minimum sample size of at least 30, and measure and report adherence based on that sample. When sampling from a larger population of cases, this is the minimum number of cases needed to make a statistically reliable statement of percent adherence to the process guidelines. For example, if you are reporting on your hospital (including multiple areas where outpatient procedures are performed), as well as another hospital outpatient department that is free-standing, you could sample 15 cases from each for a total sample size of 30. If you are reporting on seven locations, you could sample 10 cases from each for a total sample size of 70. Note: Hospitals that share a CMS Certification Number (CCN) with other hospitals may use the same sample for reporting on a shared hospital outpatient department location (e.g., surgery center, endoscopy center, free-standing hospital outpatient department, etc.). For example, Hospital A and Hospital B share a CCN and both refer patients to the same gastroenterology center. Hospital A samples 15 cases from their hospital and 15 cases from the gastroenterology center. Hospital B can use the sample of 15 cases from the gastroenterology center in addition to sampling from their hospital when reporting on their own Leapfrog Hospital Survey.

Medications: For the purposes of this measure, a **medication** is a substance that is taken into, or placed onto, the body of a person for one or more of the following reasons:

- as a placebo
- to prevent a disease (e.g., flu vaccine)
- to make a diagnosis (e.g., contrast dye)
- to test for the possibility of an adverse effect
- to modify a physiological, biochemical or anatomical function or abnormality (e.g., heparin/heparin flushes, statins, antihypertensives, etc.)
- to replace a missing factor (e.g., blood product)
- to ameliorate a symptom (e.g., aspirin)
- to treat a disease or condition (including topicals, nasal sprays, eye drops, compounds, inhalants, injectables, patches, etc.)
- to induce anesthesia
- to stabilize or hydrate during medical treatment or procedures (e.g., IV fluids, normal saline, lactated ringers, etc.)
- to provide nutrition (e.g., enteral nutrition products, parenteral nutrition products, breast milk [breast milk applies to BCMA measure only])
- as a supplement (e.g., iron for a patient with iron deficiency anemia or calcium/vitamin D for a patient with osteoporosis)

For the purposes of this measure, the following are **not** considered medications:

- Pre-filled saline flushes and pre-filled heparin flushes (i.e., saline and heparin flushes that come from the manufacturer already filled and are not filled by the hospital's pharmacy)
- Chlorhexidine and alcohol preparation pads
- Intra-op irrigation solutions

Question #3 (denominator): Number of cases measured (either all cases or a sufficient sample of them).

Your hospital should perform a clinical record audit of either all adult and/or pediatric patients undergoing those procedures included in Section 9C discharged during the reporting period or a sufficient sample of those patients discharged during the reporting period as described above.

This audit of clinical records can be done retrospectively (anytime during the Survey Cycle of April 1 – November 30).

The total number of clinical records included in your audit is reported in question #3.

Excluded cases: Patients discharged from the hospital outpatient departments without having one of the procedures included in Section 9C performed during the reporting period.

Question #4 (numerator): Number of cases in question #3 with a list of **all home medication(s)**, including dose, route, and frequency, documented in the clinical record.

Determine the total number of clinical records included in the audit (in question #3), where a list of all home medication(s), including dose, route, and frequency, was documented in the clinical record either on the day of the procedure or after a pre-screening phone call (i.e., 1-2 days in advance of the procedure). Records that include documentation that the patient had no home medications should be included.

“Home medications” are defined as medications that the patient was taking prior to admission.

The following home medications may be excluded from the clinical record unless they are clinically relevant* (e.g., herbal supplement that is known to interact with anesthesia):

- as needed (PRN) medications
- topical lotions/creams
- saline nasal spray and artificial tear eye drops
- herbals and supplements and vitamins

- medications prescribed for the purpose of operative prep prior to colonoscopy

Home medications that must be included in the clinical record include clinically relevant* PRN medications such as inhalers, nitroglycerin, analgesics (opioid and non-opioid), muscle relaxants, and sedatives.

**Clinically relevant is defined as any PRN medication that treats a medical condition on the patient's problem list and/or condition they are being treated for during the visit (i.e., reason for the hospital stay).*

Included cases:

- The clinical record includes documentation that the patient has no home medications.

Excluded cases:

- The clinical record is missing a list of all home medication(s).
- The clinical record is missing dose, route, or frequency for a home medication

Question #5 (numerator): Number of cases in question #3 with a list of **all medication(s) administered during the visit and new medications prescribed at discharge**, including the strength, dose, route, date, and time of administration, documented in the clinical record.

Determine the total number of clinical records included in the audit (question #3), where a list of all medication(s) administered during the visit and new medications prescribed at discharge, including the strength, dose, route, date, and time of administration, was documented in the clinical record on the day of the procedure.

Local, regional, and general anesthesia medications must only have **total dose, date, and time of administration** documented in the clinical record to be considered complete.

IV solutions must have **strength, dose, route, date, and time of administration** documented in the clinical record to be considered complete. However, if the IV solution only comes in one concentration/strength (such as the LR Injection), the strength can be entered as N/A and the start time and volume of the bag can be documented for dose in order to be considered complete.

New medications prescribed at discharge, but not administered at the hospital must only have **strength, dose, route, and date the medication was prescribed** documented in the clinical record to be considered complete.

Excluded cases:

- The clinical record is missing a medication that was administered or prescribed during the visit or at discharge.
- The clinical record is missing strength, dose, route, date, or time of administration for a medication administered or prescribed during the visit or at discharge except as described above for anesthesia medications, IV solutions, and prescribed medications.
- The clinical record is missing dose for lidocaine jelly.

Question #6 (numerator): Number of cases in question #3 with a list of **all medication allergies and adverse reaction(s)** documented in the clinical record.

Determine the total number of clinical records included in the audit (question #3), where a list of all medication allergies and adverse reaction(s) was documented in the clinical record. Hospitals should only assess medication allergies (i.e., hospitals do not need to assess food or environmental allergies).

Included cases:

- The clinical record includes documentation that the patient reported no known allergies.

Excluded cases:

- The clinical record does **not** include either a list of allergies and adverse reaction(s) nor documentation of no known allergies.

- The clinical record does include a list of allergies but does not include documentation of the adverse reaction(s) for each allergy.

Important Note: In addressing allergies and adverse reaction statuses noted as “unknown” in the clinical record, hospitals should assess if:

- “unknown” is used to indicate that the patient (or patient’s family) was asked for the adverse reaction status, but they indicated it was not known, in which situation the case should be included in the numerator (question #6); or
- “unknown” is used in the clinical record to indicate that the information is not available because it was not requested or documented by the clinician, in which situation the case should be excluded from the numerator (question #6)

See [FAQs](#) for additional information about responding to questions in this section.

Medication Safety for Outpatient Procedures Frequently Asked Questions (FAQs)

1. How often do home medications need to be updated in the clinical record for Section 9E question #4?

Home medications must be recorded in a pre-screening phone call 1-2 days in advance of the procedure or updated on the day of the clinical procedure (for all procedures included in Section 9C of the 2024 Leapfrog Hospital Survey).

Patients who are returning for a second or follow-up procedure within 12 months of the initial procedure are not required to have an updated home medication list in their clinical record in order for the record to be counted in the numerator of the home medication audit (i.e., included in the count in question #4). However, in cases of frequent repeated clinical visits, the home medications list should be updated at least once every 12 months.

2. For medications that only ever have a single route of administration (e.g., orally only), does route have to be documented in the clinical record for questions #4 and #5?

No. If there is a medication that can only ever be given via a single route, route does not have to be documented to count the case when responding to questions #4 and #5.

3. We do medication reconciliation on patients for certain outpatient procedures. Will the medication reconciliation on the procedure day suffice for the "medication audits" requirement in question #4? Or does it have to be a retrospective audit after the procedure day?

Leapfrog specifies that, unless all medical records are audited, the clinical record audit should be conducted on a random sample of discharged patients. If your hospital does not perform medication reconciliation before all patients are discharged to ensure that the correct dose, route, and frequency are documented in the clinical record for all home medications this would not meet the requirements of Section 9E.

Instead, your hospital should randomly sample from all clinical records of discharged outpatients (adults and children) who had the procedures included in Section 9C during the reporting period, not just those records that had medication reconciliation conducted during the same day visit. This audit may occur on the same day as the patient visit or following patient discharge.

Patient Experience (OAS CAHPS) Measure Specifications

Important Note: Hospitals that share a CMS Certification Number are required to report by facility. Please carefully review [Leapfrog's Multi-Campus Reporting Policy](#)

Source: Developed by Centers for Medicare and Medicaid Services (CMS) using Agency for Healthcare Quality and Research (AHRQ) guidelines. More information available at <https://oascahps.org/General-Information/About-OAS-CAHPS-Survey>.

Reporting Period: The latest 12-month period prior to the submission of this section of the Survey. Hospitals can elect to use either survey return date or discharge date to pull reports for this measure.

This section of the Survey asks hospitals about their results from the [OAS CAHPS Survey](#). The first several questions are designed to learn more about the current administration of the survey. The last four questions collect the [Top Box Score](#)⁵² for each of the following four domains:

- Facilities and Staff
- Communication About Your Procedure
- Patient's Rating of the Facility
- Patients Recommending the Facility

Hospitals using Press Ganey, NRC, or PRC to administer the [OAS CAHPS Survey](#) can use the CMS OAS CAHPS crosswalk below to ensure they are reporting on the correct domains. The crosswalk is designed to help translate the standard vendor report to the CMS domains used in questions #7-10.

CMS OAS CAHPS Crosswalk

CMS Domain Name	Press Ganey Domain Name	NRC Domain Name	PRC Domain Name
Facilities and Staff	Facility/Personal Treatment	About Facilities and Staff	Facility and Staff
Communication About Your Procedure	Communication	Communications About Your Procedure	Communication
Patient's Rating of the Facility	Facility Rating 0-10	Overall Rating of Facility	Overall Facility Rating
Patients Recommending the Facility	Recommend the Facility	Would Recommend Facility	Would Recommend

Question #2: Did your hospital have at least 300 [eligible discharges](#)⁵⁶ during the 12-month reporting period?

This section of the Survey is designed for hospitals that discharged at least 300 eligible patients during the reporting period. Hospitals that discharged fewer than 300 eligible patients should respond "no," skip the rest of the questions, and move on to the Affirmation of Accuracy.

Eligible discharges include discharges for adult patients (ages 18 years and older) who had both medically and non-medically necessary outpatient surgeries and/or procedures. A detailed description of patient sampling criteria, including a list of OAS CAHPS-eligible surgeries and procedures, is available in the Protocols and Guidelines Manual, version 9.0 at <https://oascahps.org/Survey-Materials>.

Question #3: Has your hospital administered, or started to administer, the entire OAS CAHPS Survey, during the reporting period?

The OAS CAHPS survey includes questions about patients' experiences with their preparation for the surgery or procedure, check-in processes, cleanliness of the facility, communications with the facility staff, discharge from the facility, and preparation for recovering at home. The survey also includes questions about whether patients received information about what to do if they had possible side effects during their recovery. OAS CAHPS is designed to be national in scope and requires standardized administration protocols.

If your hospital shares a CMS Certification Number (CCN) with another hospital that administers the OAS CAHPS survey, only include results from hospital outpatient departments used to report on Section 9: Outpatient Procedures.

Question #4: Total number of months in which your hospital administered the OAS CAHPS Survey during the reporting period.

It is recommended that hospitals (or their survey vendor) sample over a 12-month period and ensure an even distribution of patients is sampled over the 12-month period. However, Leapfrog will accept OAS CAHPS results from hospitals that have administered the survey over a period of time less than 12 months if they have at least 100 returned surveys.

Question #5: Total number of returned surveys during the reporting period.

It is recommended that hospitals (or their survey vendor) administer the survey to a large enough sample in order to achieve 300 returned surveys in a 12-month reporting period. However, Leapfrog will accept OAS CAHPS results from hospitals that have at least 100 returned surveys. All returned surveys from eligible patient discharges, regardless of completeness and date of return, should be included.

Question #6: Do the responses to the questions in this subsection include discharges from more than one location (e.g., hospital and surgery center or free-standing hospital outpatient department, hospital and multiple free-standing hospital outpatient departments, etc.)?

Indicate "yes" if your OAS CAHPS results include eligible patient discharges from multiple locations (e.g., hospital and surgery center or free-standing hospital outpatient department, hospital and multiple free-standing hospital outpatient departments, etc.). Otherwise indicate "no."

Questions #7-10: In questions #7-10, report your hospital's [Top Box Score](#)⁵² (rounded to the nearest whole number) from each of the following patient experience domains from your 12-month vendor report that matches the reporting period selected in question #1. Hospitals should not use domain scores that are publicly reported on the CMS Hospital Compare [website](#) as these scores have been risk adjusted. Hospitals should report results from all hospital outpatient departments.

These four questions capture the Top Box Score for each of the four domains of patient experience: facilities and staff, communication about your procedure, patients' rating of the facility, and patients recommending the facility.

The following questions from the OAS CAHPS Survey are included in each domain:

Facilities and Staff

Q3: Did the check-in process run smoothly?

Q4: Was the facility clean?

Q5: Were the clerks and receptionists at the facility as helpful as you thought they should be?

Q6: Did the clerks and receptionists at the facility treat you with courtesy and respect?

Q7: Did the doctors and nurses treat you with courtesy and respect?

Q8: Did the doctors and nurses make sure you were as comfortable as possible?

Communication About Your Procedure

Q1: Before your procedure, did your doctor or anyone from the facility give you all the information you needed about your procedure?

Q2: Before your procedure, did your doctor or anyone from the facility give you easy to understand instructions about getting ready for your procedure?

Q9: Did the doctors and nurses explain your procedure in a way that was easy to understand?

Q10: Anesthesia is something that would make you feel sleepy or go to sleep during your procedure. Were you given anesthesia?

Q11: (If 'Yes' to Q10) Did your doctor or anyone from the facility explain the process of giving anesthesia in a way that was easy to understand?

Q12: (If 'Yes' to Q10) Did your doctor or anyone from the facility explain the possible side effects of the anesthesia in a way that was easy to understand?

Patients' Rating of the Facility

Q23: Using any number from 0 to 10, where 0 is the worst facility possible and 10 is the best facility possible, what number would you use to rate this facility?

Patients Recommending the Facility

Q24: Would you recommend this facility to your friends and family?

Please note that question numbers are taken from the OAS CAHPS Survey, which you can download at <https://oascahps.org/Survey-Materials>.

See [FAQs](#) for additional information about responding to questions in this section.

Patient Experience (OAS CAHPS) Frequently Asked Questions (FAQs)

- 1) We share a CMS Certification Number (CCN) with another hospital that participates in the OAS CAHPS Survey. How can we report on results from the OAS CAHPS Survey that are specific to our outpatient department?**

While OAS CAHPS results are reported to CMS using a single CMS Certification Number, hospitals with more than one location (i.e., components, strata) must specify to their vendor where eligible surgeries occurred, so the vendor can properly sample patients. Vendors have the ability to provide OAS CAHPS results for a particular set of locations upon request. Hospitals should report results to Leapfrog from only those components included in their Section 9 responses.

- 2) Isn't 300 returned surveys the minimum sample size recommended by CMS?**

Yes, however, Leapfrog has received feedback that many hospitals and ambulatory surgery centers have only recently started to administer the survey. In order to ensure as many hospitals and ambulatory surgery centers as possible are able to report on this subsection, we have reduced the minimum sample size for reporting results to the Leapfrog Hospital and ASC Surveys to 100 returned surveys. This will help ensure that hospitals and ASCs that have made the investment to administer the Survey are able to earn credit for doing so. Additionally, this minimum sample size aligns with Section 8A of the Leapfrog Hospital Survey, which asks about the CAHPS Child Hospital Survey, and with the CMS requirement for the CAHPS Child Hospital Survey.

If possible, however, it is recommended that hospitals (or their survey vendor) administer the survey to a large enough sample in order to achieve 300 returned surveys in a 12-month reporting period.

- 3) We administer our own patient experience survey to collect specific information about our patient's experience. Can we report the results from our hospital's patient experience survey?**

No, hospitals can only report the results of the official OAS CAHPS Survey on Section 9F of the Leapfrog Hospital Survey.

However, according to the OAS CAHPS Protocols and Guidelines Manual, survey vendors and ASCs/HOPDs may choose to add up to 15 supplemental questions after the 'core' OAS CAHPS Survey questions that are personalized to the hospital/vendor. More information on these supplemental questions, including restrictions and required approval, may be reviewed on pages 20-22 of the CMS OAS CAHPS Survey Protocols and Guidelines Manual, which is available for download here: <https://oascahps.org/Survey-Materials>. Please note, the responses to these supplemental questions will not be reported on the Leapfrog Hospital Survey.

Endnotes

¹ **Acute-Care Units**

Include units used for short-term, acute-care medical, surgical, medical/surgical (including telemetry), as well as obstetrical, intensive, and step-down/progressive care.

Exclude units used for short and long-term psychiatric care, rehabilitation, observation, or sub-acute care (e.g., skilled nursing facility, hospice extended care, sub-acute eating disorder treatment, extended care facility, or residential substance abuse treatment), and swing bed units.

² **CMS Certification Number (CCN)**

A CMS Certification Number (CCN) is issued by the Centers for Medicare and Medicaid Services (CMS) to financial reporting entities, which may be individual hospitals or a group of hospitals, for the purpose of reimbursement. While Leapfrog does ask each campus of a multi-hospital system to submit an individual Survey, hospitals within the system may be assigned the same CMS Certification Number and therefore should have the same CCN reported in this field. CCNs are six digits; with the first two digits representing the state in which the hospital is located. Hospitals that do not receive Medicare reimbursement may not have a CMS Certification Number and should not have a CCN reported in this field. Leapfrog pre-populates this field in the Online Hospital Survey Tool. If the hospital's CCN is different from the one shown online, please contact the [Help Desk](#).

³ **National Health Safety Network (NHSN) ID**

A NHSN ID is issued by the Centers for Disease Control and Prevention and is used as a unique identifier for facilities participating in NHSN surveillance activities. Each hospital within a system, even if they share a CCN, must report separately to NHSN and should have their own NHSN ID if they are located separately. Please see the NHSN instructions available at <http://www.leapfroggroup.org/survey-materials/join-nhsn>. NHSN IDs are five digits. Leapfrog pre-populates this field in the Online Hospital Survey Tool for hospitals that provided a valid NHSN ID, joined our NHSN Group, and submitted the 2024 Leapfrog Hospital Survey. If the hospital NHSN ID is different from the one shown online, please update accordingly.

In order to be scored and publicly reported for any of the five applicable infection measures and to have the hospital's teaching status represented, hospitals must: (1) provide an accurate NHSN ID in the Profile, (2) join Leapfrog's NHSN Group by the appropriate [deadline](#), and (3) submit the 2025 Leapfrog Hospital Survey by the appropriate [deadline](#).

⁴ **Vermont Oxford Network (VON) Transfer Code**

A Vermont Oxford Network (VON) Transfer Code is issued by the Vermont Oxford Network and is used as a unique identifier for hospitals reporting data through the VON Nightingale Internet Reporting System. Each hospital has their own VON Transfer Code, which can be found at <https://public.vtoxford.org/transfer-codes/>. VON Transfer Codes are four, five, or seven digits. Leapfrog pre-populates this field in the Online Hospital Survey Tool Profile for hospitals that provided a valid VON Transfer Code in 2024. If the hospital's VON Transfer Code is different from the one shown online, please update accordingly.

⁵ **Federal Tax Identification Number (TIN)**

Enter the TIN that your hospital uses for billing purposes. *The number is a nine-digit number (e.g., 098765432) and must conform precisely to this format – be sure to enter any leading 0.* If your hospital has more than one TIN, use the one that would most typically be used for UB-04 claims filed with commercial health insurance plans for inpatient hospital stays.

⁶ National Provider Identifier (NPI)

The NPI is a Health Insurance Portability and Accountability Act (HIPAA) Administrative Simplification Standard. The NPI is a unique identification number of covered health care providers. The NPI is a 10-position, intelligence-free numeric identifier (10-digit number). This means that the numbers do not carry other information about healthcare providers, such as the state in which they live or medical specialty. Leapfrog pre-populates this field in the Online Hospital Survey Tool. If the hospital's NPI is different from the one shown online, please contact the [Help Desk](#).

⁷ State

Your hospital is assigned to a state based on the CMS Certification Number assigned (or identifier specially issued by the Leapfrog Help Desk) to your hospital. If your hospital is incorrectly assigned to a state, contact the [Help Desk](#) to resolve the discrepancy.

⁸ Tips for Entering Web Addresses

This address becomes the link attached to your hospital's name in the public release of Survey Results. Enter it exactly as you wish it to be and test it.

- Do not exit out of the Online Hospital Survey Tool to go to the Web page of interest while you are entering data into the Survey or some of your Survey entries may be lost.
- Instead, minimize (but don't close) the Survey window and any other windows that are open, then open your internet browser in a separate window. Find the Web page whose address you wish to enter and Copy/Paste the entire address into the Survey entry. **The http:// prefix needs to be included.**
- If entering the Web page address manually, be careful to type it correctly, without embedded spaces. Forward (/) or backward (\) slashes may be used. Don't forget the "www." if that is part of the address. **The http:// prefix needs to be included.**
- Make sure to use .org, rather than .com, if that's the domain for your hospital's website.
- Although many hospitals elect to enter the address for the home page of their hospital website, consider pointing it to a page specific to patient safety, the Leapfrog safety practices, or other quality improvement activities that you want to communicate to your community.

⁹ Healthcare System or Integrated Delivery Network

Healthcare Systems or Integrated Delivery Networks (IDN) are central organizations that own, lease, or sponsor two or more hospitals with the goal of providing coordinated patient care. Pediatric, specialty, and rehabilitation hospitals are included as hospitals in this definition. IDNs may belong to a larger parent system. Leapfrog pre-populates this field in the Online Hospital Survey Tool and only uses the field internally (e.g., it will not be shared publicly). If the IDN displayed in the Online Survey Tool is incorrect, please contact the [Help Desk](#).

¹⁰ Licensed Acute-Care Beds

If your state does not license bed types or if acute-care beds are currently staffed higher than the number of licensed beds, enter the number of staffed beds from question #3. If the number of licensed beds has changed in the last year, indicate the average or other number most representative of your operating bed capacity over the last year.

Include short-term, acute-care medical, surgical, medical/surgical (including telemetry), obstetrical, and intensive care beds, as well as step-down/progressive care beds as licensed by your state.

Exclude beds licensed or used for short and long-term psychiatric care, rehabilitation, observation, or sub-acute care (e.g., skilled nursing facility, hospice extended care, sub-acute eating disorder treatment, extended care facility, or residential substance abuse treatment) and swing beds.

¹¹ Staffed Acute-Care Beds

Include licensed beds regularly in operation, whether currently occupied by a patient or not. If the number has changed over the last year, indicate the average or other number most representative of your operating bed capacity over the last year.

¹² Total Adult Acute-Care Admissions

Include adult (aged 18 years and older) acute-care medical, surgical, and medical/surgical (including telemetry), obstetrical, and intensive care admissions. Include transfers from other hospitals. Include admissions directly to an ICU, even if counted in question #9. Include admissions to step-down/progressive units.

Exclude short and long-term psychiatric care, rehabilitation, observation, or sub-acute care (e.g., skilled nursing facility, hospice extended care, sub-acute eating disorder treatment, extended care facility, or residential substance abuse treatment) admissions and admissions to swing units.

¹³ Total Pediatric Acute-Care Admissions

Include pediatric (ages 17 years and younger) acute-care medical, surgical, medical/surgical (including telemetry), and intensive care admissions. Include transfers from other hospitals. Include admissions directly to an ICU or neonatal ICU (NICU), even if counted in question #10 or #13. Include admissions to step-down/progressive units.

Exclude newborn admissions to the nursery and pediatric patients admitted for maternity care, short and long-term psychiatric care, rehabilitation, observation, or sub-acute care (e.g., skilled nursing facility, hospice extended care, sub-acute eating disorder treatment, extended care facility, or residential substance abuse treatment) and admissions to swing units. Exclude admissions for patients that were transferred to another facility.

¹⁴ General Medical, Surgical, Medical/Surgical, and Neuro ICUs

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

For the purposes of reporting on adult and pediatric ICU admissions in Section 1A: Basic Hospital Information questions #9 and #10, include admissions to general medical, surgical, medical/surgical, and neuro ICUs (medical and surgical), whether directly admitted to the unit or transferred to the unit from another area of your hospital (e.g., post-operatively). Include transfers from other hospitals as admissions to your hospital. Include the number of admissions that include an ICU stay, not the number of patient trips to the ICU.

¹⁵ Licensed ICU Beds

If your state separately designates ICU beds, indicate the number of licensed beds in adult and pediatric general medical, surgical, medical/surgical, and neuro ICUs (medical and surgical). If your state does not license ICU beds or if the number of staffed ICU beds is currently higher than the number of licensed ICU beds, enter the number of staffed ICU beds from question #8. See endnote #14 for more information.

Exclude beds “dedicated exclusively” to patients with specialized conditions (e.g., cardiac, burn, trauma, neonatal). “Dedicated exclusively” means that general medical, surgical, medical/surgical, or neuro intensive care patients are not also cared for in these specialized units (except in rare overflow situations). Exclude beds used for step-down/progressive care.

¹⁶ **Staffed ICU Beds**

Indicate the number of ICU beds from question #7 that are regularly in operation, whether currently occupied by a patient or not. If the number has changed over the last year, indicate the average or other number most representative of your operating ICU capacity over the last year. See endnote #14 for more information.

¹⁷ **Neonatal ICUs**

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

https://www.cdc.gov/nhsn/pdfs/pscmanual/pcsmanual_current.pdf.

For the purposes of reporting on NICU admissions in Section 1A: Basic Hospital Information question #13, include admissions to any level NICU, even if counted in question #5. Include transfers from other hospitals as admissions to your hospital. Exclude admissions for patients that were transferred to another facility.

¹⁸ **CPOE Linked to Pharmacy, Laboratory, ADT Information**

The ability of a CPOE system to catch the majority of common, serious prescribing errors depends on proper identification of patients (ADT information), current and recent pharmacy orders and drug dispensing history, and access and integration of key laboratory results for the patient. CPOE systems that are not linked to those other systems or do not reflect that current information accurately about the patient are not likely to catch serious prescribing errors.

¹⁹ **Medical, Surgical, and Medical/Surgical Units**

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

For the purposes of reporting on Sections 2C: BCMA and 6C: Hand Hygiene, include both single and mixed acuity medical, surgical, medical/surgical, and telemetry units, as well as step-down/progressive beds in a dedicated medical, surgical, or medical/surgical unit.

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

²⁰ **Step-down/Progressive Units**

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

²¹ **Labor and Delivery Units**

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

²² Pre-Operative or Post-Anesthesia Care Units

For reporting on Section 2C: BCMA include all pre-operative and post-anesthesia care units (PACUs) located in or co-located with your hospital. For reporting on Section 6C: Hand Hygiene, include all pre-operative and post-anesthesia care units (PACUs) located in or co-located with your hospital, as well as those located in free-standing hospital outpatient departments that perform the outpatient procedures listed in Section 9: Outpatient Procedures and that share your hospital's license or CMS Certification Number. This includes combined pre-operative and post-anesthesia care units as well. If the hospital distinguishes between [post-anesthesia phases](#) within its PACU(s) (i.e., Phase I, Phase II, and Phase III recovery), all phases must be included when reporting.

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

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

²³ Certified Pharmacy Technician

A certified pharmacy technician would include a pharmacy technician that has earned either the [ASHP Medication History-Taking Certificate](#) or the [Pharmacy Technicians Certification Board's \(PTCB\) Medication History Certificate](#).

²⁴ Sampling for Medication Reconciliation

The sample must contain at least 30 patients from a 6-month reporting period. Sampling is limited to medical, medical/surgical units and step-down/progressive units (adult only). Patients that were discharged or expired before the Gold Standard Medication History could be obtained must be excluded from the sample. Patients that do not have discharge orders written during the reporting period must also be excluded from the sample. A sampling worksheet is available in the [Medication Reconciliation Workbook](#) for those who would like assistance in obtaining a random sample of patients.

²⁵ Gold Standard Medication History

The Gold Standard Medication History is the list of medications that the patient was taking prior to admission. Within 24 hours after admission, a trained pharmacist, pharmacy resident, or certified pharmacy technician must interview each patient selected for the 6-month sample and obtain the Gold Standard Medication History. Note that this is in addition to, and separate from, any pre-admission medication list that was created as part of normal care. Best practices for collecting the Gold Standard Medication History can be found in the "Other Supporting Materials" for Section 2 on our [website](#).

²⁶ Discrepancies in Gold Standard Medications

For each Gold Standard Medication, there may be up to two unintentional discrepancies: a discrepancy in admission orders and a discrepancy in discharge orders. For example, if a medication on the Gold Standard Medication History is ordered for a patient on admission with the incorrect dose, this counts as one discrepancy. If this medication is ordered on discharge for the same incorrect dose, this counts as a second discrepancy. The number of unintentional discrepancies is a count of medication orders where an unintentional discrepancy occurred. You should not count the number of errors associated with the same medication order (e.g., a discrepancy in the dose and frequency in the same medication in admission orders counts as one discrepancy).

27 Unintentionally Ordered Additional Medications

Count medications where a patient was not taking (and was not supposed to be taking) a certain medication, but the medical team incorrectly thought the patient was taking the medication and therefore ordered it on admission and/or discharge. Count each medication once, regardless of whether it was ordered on admission, discharge, or both.

28 Discrepancies Due to Unintentionally Ordered Additional Medications

For each unintentionally ordered additional medication, there may be up to two discrepancies: unintentionally ordered at admission, unintentionally ordered at discharge, or both. For example, if a medication is unintentionally ordered at admission, then this counts as one discrepancy. If the same medication is also ordered at discharge, then this counts as a second discrepancy.

29 Data Completeness Requirement for the STS Mitral Valve Repair/Replacement (MVRR) Composite Score

Participants are excluded from the analysis if they have fewer than 36 isolated MVRR procedures in the patient population. Please find more information in the NQF-endorsed measure specifications, available at <https://www.sts.org/quality-safety/performance-measures/descriptions#MVRRComposite>.

30 High-Risk Deliveries Electively Admitted

Includes deliveries with:

- expected birth weight <1500 grams; or
- gestational age at least 22 weeks but <32 weeks.

Not all women at risk for delivery of babies with these conditions are known beforehand to be at risk. Therefore, deliveries in which these high-risk conditions were unknown prior to admission are not considered electively admitted high-risk deliveries.

If your hospital admits deliveries where these conditions are known prior to admission, then your hospital electively admits high-risk deliveries and you must answer “yes” to question #1; otherwise, answer “no.”

31 Co-located

A location within “immediate physical proximity” of the hospital would be considered a co-located location or unit, e.g., a co-located neonatal ICU (NICU) or co-located hospital outpatient location. “Immediate physical proximity” means the two locations must be physically connected, either by a tunnel, an enclosed bridge, or the locations abut each other so that the hallways readily connect.

32 Very low birth weight babies

Complicated newborns are those infants with a birth weight <1500 grams. If your hospital has a neonatal ICU (or is co-located with a hospital that has a neonatal ICU) that admits or accepts transfers of neonates with these conditions, you must answer “yes” to question #2.

33 VON's Death or Morbidity Measure

This measure is collected and calculated by the Vermont Oxford Network and includes patients who have died or are known to have one or more of the following: severe intraventricular hemorrhage (SIVH); chronic lung disease (CLD); necrotizing enterocolitis (NEC); pneumothorax; any late infection (bacterial, fungal, or coagulase negative staph); or cystic periventricular leukomalacia (PVL).

34 All Critical Care Patients

“All critical care patients” means all general medical, surgical, medical/surgical, and neuro ICU patients including critical care patients in mixed acuity units.

³⁵ **Managed or Co-Managed**

The intensivist, when present (whether on-site or via telemedicine), is authorized to diagnose, treat, and write orders for a patient in the ICU on the intensivist's own authority. Examples of co-management include, but are not limited to, communication on patient status between the intensivist and hospitalist on a daily basis, intensivists co-develop care plans for all ICU patients, etc. Mandatory consults or daily rounds by an intensivist are not sufficient to meet the managed/co-managed requirement. However, an ICU need not be closed to meet this requirement.

³⁶ **Certified in Critical Care Medicine**

A physician who is “certified in Critical Care Medicine” is a board-certified physician who is additionally certified in the subspecialty of Critical Care Medicine. Certification in Critical Care Medicine is awarded by the American Boards of Internal Medicine, Surgery, Anesthesiology, Pediatrics, and Emergency Medicine, as well as the American Osteopathic Board (AOS).

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

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

Expanded Definition of Certified in Critical Care Medicine

On an interim basis, three other categories of physicians are considered by Leapfrog to be equivalent to a physician “certified in Critical Care Medicine” for the purpose of meeting the standard:

- Physicians who completed training prior to availability of subspecialty certification in critical care in their specialty (1987 for Internal Medicine, Surgery, Anesthesiology, Pediatrics and 2013 for Emergency Medicine), who are board-certified in their specialty, and who have provided at least six weeks of full-time ICU care annually. (The weeks need not be consecutive weeks.)
- Physicians who have finished their fellowship in Critical Care Medicine, but have not yet passed an existing board-certifying exam, are considered to be equivalent to a physician “Certified in Critical Care Medicine” for up to three years after completion of the fellowship. This provides the physician an adequate window to take her/his boards and re-take if necessary.
- Physicians who are board-certified in their primary specialty and have completed a critical care fellowship at an ACGME-accredited program, but are ineligible to sit for a board-certifying exam in Critical Care in either their primary specialty or subspecialty because their training occurred under two separate certifying boards, are considered to be equivalent to a physician “Certified in

Critical Care Medicine” if they are board-certified in their primary specialty and have provided at least six weeks of full-time ICU care annually. (The weeks need not be consecutive weeks.)

Physicians who have let their board certification lapse are not considered to be “Certified in Critical Care Medicine.”

³⁷ **Ordinarily and Exclusively Present in the ICU**

“Ordinarily present in the ICU” refers to direct on-site presence in the ICU of an intensivist during the 4-hour or 8-hour period. While it need not be the same intensivist for the entire 4-hour or 8-hour period, it is expected that the ICU(s) are primarily staffed by dedicated ICU intensivists who are ordinarily and exclusively present in the ICU(s). “Presence” does *not* mean staffed part-time by multiple physicians who are not ordinarily and exclusively dedicated to the ICU, *nor* does it mean the cumulative time that one or more intensivists spend in the unit visiting, rounding, consulting, or responding to pages.

The standard allows for normally expected intensivist activities outside of the ICU related to their responsibilities in the ICU (e.g., evaluating patients proposed for ICU admission), as long as intensivists are ordinarily present in the ICU and return immediately when paged. An intensivist present in one ICU immediately adjacent to another can be considered present in both units as long as they can respond to demands in both units as if they would if both units were one larger unit. For the purposes of this Survey, “adjacent” units are those units that can be reached within 5 minutes. While tele-intensivists can be used to meet the presence requirement, some on-site intensivist presence is still necessary to meet the Leapfrog specifications.

“Exclusively” means that when the physician is in the ICU, they have no concurrent clinical responsibilities to non-ICU patients.

³⁸ **Intensivist Presence via Telemedicine**

To meet the Leapfrog ICU requirement for intensivist presence in the ICU via telemedicine, a hospital must be able to document that it fulfills **all** the following 10 key features based on a modification of the approach reported in Critical Care Medicine (Rosenfeld, B. et al. “Intensive care unit telemedicine: Alternate paradigm for providing continuous intensivist care,” *Critical Care Medicine*, Vol. 28, No. 1, pp. 3925-3931).

1. A physician certified in critical care medicine (see endnote #36) who is physically present in the ICU (“on-site intensivist”) performs a comprehensive review of each ICU patient each day and establishes and/or revises the care plan. The on-site intensivist must be available by phone to answer any questions from the tele-intensivist related to the established or revised care plan.

The tele-intensivist, who must also be a physician certified in critical care medicine (see endnote #36), has immediate access to information regarding the on-site intensivist’s care plan at the time the management responsibility is transferred to the tele-intensivist by the on-site intensivist.

When care is transferred back to the on-site intensivist, the tele-intensivist must communicate any changes to the care plan to the on-site intensivist. Hospitals relying on electronic hand-offs must ensure that physician sign-in and sign-out of reports is being recorded. In addition, these reports should be monitored as one way to audit compliance with the hand-off process described above.

2. When an intensivist is not on-site in the ICU managing or co-managing all ICU patients, a tele-intensivist is continuously monitoring and able to manage all ICU patients for the remaining 24 hours per day, 7 days per week. “Continuously monitoring” means the tele-intensivist has no other concurrent responsibilities, is immediately available to communicate with ICU staff, and is continuously in the physical presence of the tele-ICU’s patient monitoring and communications equipment. “Manage” means authorized to diagnose, treat, and write orders for a patient in the ICU

on the intensivist's own authority.

3. The tele-intensivist's care is proactive, with routine visualization and physiological review of all patients at a frequency appropriate to their severity of illness.
4. The tele-intensivist has immediate access to key patient data, including:
 - a) physiologic bedside monitor data (in real-time);
 - b) laboratory orders and results;
 - c) medications ordered and administered; and,
 - d) notes, radiographs, ECGs, etc. on demand.
5. Bedside cameras are physically available in each ICU. If cameras are not mounted in each patient room within the unit, then at least one dedicated bedside camera must be available for every five beds in the ICU, plus a dedicated back-up camera in each ICU. If ICUs are located on different floors of the hospital, each ICU on each floor must have its own set of dedicated cameras if they are not mounted in every room. "Dedicated" means that the cameras are on the unit for the sole purpose of patient care. Personal devices (e.g., personal phones, tablets, etc.) would not meet this requirement.
6. The tele-intensivist must be able to turn on each bedside camera to visualize patients, with sufficient clarity to assess breathing pattern and communicate with on-site personnel at the bedside in real time.
7. Within five minutes of a request for assistance being initiated by hospital staff, the tele-intensivist's patient workload ordinarily permits the tele-intensivist to complete a comprehensive visual and physiological assessment of any patient.
8. Data links between the ICU and the tele-intensivist are reliable (>98% up-time) and secure (HIPAA compliant).
9. Written standards for remote care are established and include, at a minimum:
 - a) tele-intensivists are certified by a national medical specialty board in critical care medicine;
 - b) tele-intensivists are licensed to practice in the legal jurisdiction in which the ICU is located;
 - c) tele-intensivists are credentialed in each hospital to which he/she provides remote care (can be special telemedicine credentialing);
 - d) activities of the tele-intensivist are reviewed within the hospital's quality assurance committee structure;
 - e) there are explicit written policies regarding roles and responsibilities of both the on-site intensivist and the tele-intensivist;
 - f) ICU staff are educated regarding the function, roles, and responsibilities of the tele-intensivist; and
 - g) there is an established written process to ensure effective communication between the ICU staff and the tele-intensivist.
10. The tele-intensivist documents patient care activities and this documentation is incorporated into the patient record.

³⁹ **Quantified Analysis of Response Times**

Hospitals can monitor the response times of intensivists, "effectors," and clinical pharmacists in multiple ways, as long as the data collection process is non-biased and scientific.

As an example, hospitals can have the ICU staff maintain an exception log in the ICU(s) on six randomly sampled days per year. On those days, ICU nurses could record:

- For question #7, the number of calls/pages/texts made to the intensivist when they were not present in the unit (whether on-site or via telemedicine) and the number of times the intensivist's response time exceeded 5 minutes
- For question #8, the number of calls/pages/texts made to a physician, physician assistant, nurse practitioner, or FCCS-certified nurse or intern "effector" and the number of times these individuals did not reach the patient at the bedside within 5 minutes
- For question #13, the number of calls/pages/texts made to the clinical pharmacist on days when they were not rounding on-site in the unit and the number of times the clinical pharmacist's response time exceeded 5 minutes

Hospitals can then estimate whether they meet the 95% timely response standards by dividing the total number of log exceptions by the total number of calls/pages/texts per day.

Hospitals may exclude low-urgency calls/pages/texts, if the notification device system can designate low-urgency calls/pages/texts, or if the hospital has an alternative scientific method for documenting high-urgency calls/pages/texts that are not returned within 5 minutes.

The six randomly selected days can be conducted over the course of a year prior to submission of Section 5 of the Survey. If resubmitting responses to Section 5, six new randomly selected days must be sampled in the three-month reporting period prior to resubmission.

Hospitals that use telemedicine to cover 'call' for the on-site intensivist should review endnote #41. Hospitals that have an effector that is dedicated 24/7 to the ICU (as defined as being within a 5 min walk to the ICU) should review endnote #42.

⁴⁰ **FCCS-Certified Nurse or Intern "Effector"**

FCCS certificates are awarded to nurses and doctors upon their successful completion of a brief course developed by the Society for Critical Care Medicine to improve/confirm critical care knowledge and skills. For more information visit <https://www.sccm.org/Education-Center/Educational-Programming/Fundamentals/Fundamental-Critical-Care-Support>.

At present, this is the only such course recommended by The Leapfrog Group's expert advisory panel. Intensivists and any other physicians who are certified in critical care medicine (or eligible based on residency training or fellowship) need not also be FCCS certified.

Physicians, physician assistants, and nurse practitioners also are not required to be FCCS certified, but they must meet the criteria specified in endnote #42 to serve as the responder/"effector."

⁴¹ **Use of Tele-intensivists to Cover Calls**

Hospitals that use telemedicine to cover 'call' for the on-site intensivist are able to answer "yes" to question #7 if: (1) the telemedicine service meets all ten of the requirements outlined in endnote #38; and (2) the hospital has an 'effector' (physician/PA/NP/FCCS certified nurse or intern) on-site during that time period to carry out the tele-intensivist's orders and can reach the ICU patient within 5 minutes, 95% of the time.

⁴² **Physician/PA/NP serving as the Responder/"Effector"**

Physicians/PAs/NPs (includes Clinical nurse Specialists, Nurse Anesthetists, or NPs) serving as the responder in the ICU must meet the following criteria:

1. Be a graduate with a training license from an ACGME accredited training program or have an active state license to practice as a physician, nurse practitioner, or physician assistant in the state in which the patient is located.
2. Have privileges to provide medical services in the unit (i.e., ICU) and for patients of the age range approved in advance by the hospital's governing body (e.g., medical staff committee, chief

medical officer, chief nursing officer, etc.), as specified by the institutions internal policies (bylaws).

3. Carry out the intensivist's orders and instructions, under the intensivist's guidance, when they are serving in a responder role.

If the effector is dedicated 24/7 to the ICU (as defined as being within a 5 min walk to the ICU), then hospitals can indicate "yes" to meeting the response time requirement (5 min response; 95% of the time) in question #8, in lieu of conducting a response time audit.

⁴³ **Modified Intensivist Presence via Telemedicine**

To earn reduced credit on the Leapfrog ICU standard for intensivist presence in the ICU via telemonitoring, a hospital must affirm that its telemonitoring intensivist presence fulfills the following nine key features based on a modification of the approach reported in Critical Care Medicine (Rosenfeld, B. et al. "Intensive care unit telemedicine: Alternate paradigm for providing continuous intensivist care," *Critical Care Medicine*, Vol. 28, No. 1, pp. 3925-3931). Note that, as with other Leapfrog specifications, these features must be met under ordinary circumstances.

1. When an intensivist is not on-site in the ICU managing or co-managing all ICU patients, a tele-intensivist is continuously monitoring and able to manage all ICU patients for the remaining 24 hours per day, 7 days per week. "Continuously monitoring" means the tele-intensivist has no other concurrent responsibilities, is immediately available to communicate with ICU staff, and is continuously in the physical presence of the tele-ICU's patient monitoring and communications equipment. "Manage" means authorized to diagnose, treat, and write orders for a patient in the ICU on the intensivist's own authority.
2. The tele-intensivist's care is proactive, with routine visualization and physiological review of all patients at a frequency appropriate to their severity of illness.
3. The tele-intensivist has immediate access to key patient data, including:
 - a) physiologic bedside monitor data (in real-time);
 - b) laboratory orders and results;
 - c) medications ordered and administered; and,
 - d) notes, radiographs, ECGs, etc. on demand.
4. Bedside cameras are physically available in each ICU. If cameras are not mounted in each patient room within the unit, then at least one dedicated bedside camera must be available for every five beds in the ICU, plus a dedicated back-up camera in each ICU. If ICUs are located on different floors of the hospital, each ICU on each floor must have its own set of dedicated cameras if they are not mounted in every room. "Dedicated" means that the cameras are on the unit for the sole purpose of patient care. Personal devices (e.g., personal phones, tablets, etc.) would not meet this requirement.
5. The tele-intensivist must be able to turn on each bedside camera to visualize patients, with sufficient clarity to assess breathing pattern and communicate with on-site personnel at the bedside in real time.
6. Within five minutes of a request for assistance being initiated by hospital staff, the tele-intensivist's patient workload ordinarily permits the tele-intensivist to complete a comprehensive visual and physiological assessment of any patient.
7. Data links between the ICU and the tele-intensivist are reliable (>98% up-time) and secure (HIPAA compliant).
8. Written standards for remote care are established and include, at a minimum:

- a) tele-intensivists are certified by a national medical specialty board in critical care medicine;
- b) tele-intensivists are licensed to practice in the legal jurisdiction in which the ICU is located;
- c) tele-intensivists are credentialed in each hospital to which he/she provides remote care (can be special telemedicine credentialing);
- d) activities of the tele-intensivist are reviewed within the hospital's quality assurance committee structure;
- e) there are explicit written policies regarding roles and responsibilities of both the on-site intensivist and the tele-intensivist;
- f) ICU staff are educated regarding the function, roles, and responsibilities of the tele-intensivist; and
- g) there is an established written process to ensure effective communication between the ICU staff and the tele-intensivist.

9. The tele-intensivist documents patient care activities and this documentation is incorporated into the patient record.

⁴⁴ ***Individuals who touch patients or who touch items that will be used by patients***

This would include individuals who are formally engaged by the hospital to help support the patient care process. This would include both direct and indirect care providers that are likely to have contact with patients in a patient care unit, enter a patient care unit, touch items that will be used by patients in a patient care unit, or interact with patient fluids (e.g., blood, specimens) in a patient care unit, such as doctors, mid-levels, nurses, pharmacists, environmental services staff, phlebotomists, laboratory techs, etc. This would also include students and volunteers. These individuals must be trained to identify and perform proper hand hygiene for the specific indications/moments (see [WHO's 5 Moments for Hand Hygiene](#), [CDC's Guideline for Hand Hygiene](#)) that are relevant to their work.

Administrative workers that only perform office duties and do not touch patients or touch items that will be used by patients in a patient care unit would not be included in this definition. Patients and their visitors would also not be included in this definition. While patients and their loved ones are important parts of the patient care process, they are not formally engaged by the hospital for this work. Vendors would also not be included.

⁴⁵ ***Professional with Appropriate Training and Skills***

This would include staff formally trained in Infection Control or Infectious Diseases, whose tasks include dedicated time for staff training. In some settings, this could also be medical or nursing staff involved in clinical work, with dedicated time to acquire thorough knowledge of the evidence for and correct practice of hand hygiene.

At a minimum, the trainer must have an understanding of the information and concepts presented in the [WHO Guidelines on Hand Hygiene in Health Care](#) and the [Hand Hygiene Technical Reference Manual](#).

⁴⁶ ***Diagnostic Process***

A process that starts with the patient's first engagement with the health care system and ends with clinicians either communicating a timely and correct diagnosis or learning from a diagnostic error or near miss that contributed to the patient's clinical outcomes. In that timeframe, clinicians and others involved in caring for the patient gather information, integrate and interpret that information, formulate a diagnosis, communicate the diagnosis to the patient, and develop a plan of care based on the diagnosis (adapted from the National Academy of Medicine's Improving Diagnosis in Health Care, 2015).

⁴⁷ Dedicated Emergency Department

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

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

For the purposes of reporting on the Survey, only include emergency departments that are located in your hospital. Exclude free-standing emergency departments.

⁴⁸ Never Event

In 2011, the National Quality Forum released a list of 29 events that they termed “serious reportable events,” extremely rare medical errors that should never happen to a patient. Often termed “never events,” these include errors such as surgery performed on the wrong body part or on the wrong patient, leaving a foreign object inside a patient after surgery, or discharging an infant to the wrong person. This is an update of NQF’s original 2002 and 2006 reports. Please see NQF’s “Never Events” list at <https://digitalassets.jointcommission.org/api/public/content/4534bbaeee4f4bd280c2054765f37f4b?v=a60f8f9a>. Hospitals may not earn credit for this question if they have only implemented a policy that includes the Center for Medicare and Medicaid (CMS) Never Events.

⁴⁹ Apology to the Patient

While Leapfrog recognizes that on very rare occasions “never events” can occur that are not the fault of care systems or clinical care staff, given the high level of trust patients place in health care providers, Leapfrog feels it is appropriate for caregivers to apologize when a patient within their care setting suffers a serious event.

As the National Quality Forum identified in their 2002, 2006, and 2011 Serious Reportable Events Report, given the serious nature of these events, it is reasonable for hospitals to initially assume that the adverse event was due to the referenced course of care. And while further investigation and/or root cause analysis of the unplanned event may be needed to confirm or refute the presumed relationship, delaying an apology to the patient is not treating the patient with compassion and sympathy.

⁵⁰ Reporting Never Events to External Agencies

If your hospital is not accredited by The Joint Commission or DNV GL Healthcare, is located in a state without a state-wide reporting program for medical errors, AND there is no available Patient Safety Organization to which your hospital can report medical errors, the hospital should report the event to the Board of Trustees. Full implementation of the Never Events policy still requires the hospital to conduct a root cause analysis of the event.

⁵¹ Root Cause Analysis

The National Patient Safety Foundation published a set of best practices and guidelines in its report “RCA² Improving Root Cause Analysis and Action to Prevent Harm.” The report can be found at <http://www.ihf.org/resources/Pages/Tools/RCA2-Improving-Root-Cause-Analyses-and-Actions-to-Prevent-Harm.aspx>.

⁵² Top Box Score

The percent of survey respondents who chose the most positive score for a given item. Looking at the **top box** is an approach to understand the number of responses with a strong sentiment.

For the CAHPS Child Hospital Survey “Global Rating – Recommend hospital” domain, responses of 9 and 10 are included in the top box score. For the “Global Rating – Recommend hospital” domain,

responses of “Definitely yes” are included in the top box score. For all other domains included in Section 8A, the top box score is the percent of survey respondents choosing “Always.”

For the OAS CAHPS Survey “Patients’ Rating of the Facility” domain, responses of 9 or 10 are included in the top box score. For the “Patients Recommending the Facility” domain, responses of “Definitely yes” are included in the top box score. For all other domains included in Section 9F, the top box score is the percent of survey respondents choosing “Yes, definitely.”

⁵³ **Operating Rooms**

If your state designates and licenses operating rooms, enter the number of operating rooms licensed by your state that are used to perform the outpatient procedures listed in Section 9C. If your state does not designate and license operating rooms, enter the number of operating rooms used to perform the outpatient procedures listed in Section 9C that meet the following definition from the 2018 FGI Guidelines: a room that meets the requirements of a restricted area, is designated and equipped for performing surgical or other invasive procedures, and has the environmental controls for an OR as indicated in ASHRAE 170. An aseptic field is required for all procedures performed in an OR.

More information about the 2018 FGI Guidelines can be found at https://www.fgiguideelines.org/wp-content/uploads/2017/08/SLS17_FGI_ExamProcedureOperatingImaging_170721.pdf.

Hospitals must include the total number of operating rooms that are used to perform the outpatient procedures listed in Section 9C, including operating rooms that are used for both inpatient and outpatient procedures.

⁵⁴ **Endoscopic Procedure Rooms**

If your state designates and licenses procedure rooms, enter the number of procedure rooms licensed by your state that are used for endoscopies listed in Section 9C. If your state does not designate and license procedure rooms, enter the number of procedure rooms that are used for endoscopies listed in Section 9C that meet the following definition from the 2018 FGI Guidelines: a room designated for the performance of patient care that requires high-level disinfection or sterile instruments and some environmental controls but is not required to be performed with the environmental controls of an operating room.

More information about the 2018 FGI Guidelines can be found at https://www.fgiguideelines.org/wp-content/uploads/2017/08/SLS17_FGI_ExamProcedureOperatingImaging_170721.pdf.

Hospitals must include the total number of procedure rooms that are used to perform the endoscopies listed in Section 9C, including procedure rooms that are used for both inpatient and outpatient procedures.

⁵⁵ **Clinician**

A clinician refers to a physician, physician assistant (PA), nurse practitioner (NP), certified registered nurse anesthetist (CRNA), nurse (RN or MSN), or respiratory therapist.

⁵⁶ **Eligible Discharges**

Discharged adult patients (ages 18 years and older) who had both medically and non-medically necessary outpatient surgeries and/or procedures are eligible to complete the OAS CAHPS Survey. A detailed description of patient sampling criteria, including a list of OAS CAHPS-eligible surgeries and procedures is available in the Protocols and Guidelines Manual, version 9.0 at <https://oascahps.org/Survey-Materials>.

The 2025 Leapfrog Hospital Survey is a publication of The Leapfrog Group. The Survey cannot be copied, distributed, or used without the written permission of The Leapfrog Group for any purpose other than an individual hospital's participation in the Survey.

EXHIBIT 10



Frequently Asked Questions from Hospitals

How is the Leapfrog Hospital Safety Grade different from the Leapfrog Hospital Survey?

The Leapfrog Hospital Survey is an annual voluntary survey in which Leapfrog asks hospitals to report quality and safety data and then publicly reports that information by hospital. The Leapfrog Hospital Safety Grade is a letter grade Leapfrog bi-annually assigns to all general hospitals in the United States, whether they report to the Survey or not. If a hospital does not report to the Survey, the Safety Grade uses publicly available data from numerous secondary sources. The majority of data used to calculate the Safety Grade comes from the Centers for Medicare and Medicaid Services.

The infographic at right and the guide below are meant to help you understand the differences between the two, the timeline for each, and who to contact if you have any questions.

Scroll down or click the links below to learn more.



(click to expand)

I. What is the Leapfrog Hospital Safety Grade?

II. What is the Leapfrog Hospital Survey?

What is the Leapfrog Hospital Safety Grade?

Web address:

www.hospitalsafetygrade.org

What it is: The Leapfrog Hospital Safety Grade is a composite score made up of up to 22 evidence-based measures of patient safety, including CMS Medicare PSI 90 Patient Safety and Adverse Events composite which includes 10 component measures. The Leapfrog Group calculated a numerical score for all eligible hospitals in the U.S. These national performance measures of patient safety indicate how well hospitals protect patients from preventable errors, injuries and infections. Grades are assigned to U.S. general hospitals twice annually, using a scoring algorithm to determine each hospital's score as an A, B, C, D, or F letter grade.

How many hospitals? Nearly 3,000 general hospitals are assigned a grade twice per year.

What kind of hospitals are included/eligible? Any general, acute-care hospital in the U.S. for which there is enough publicly available data. Submission of a Leapfrog Hospital Survey is strongly encouraged but not required to receive a Grade, as long as the hospital has enough data available from other sources. Because of limitations and exclusions in publicly available data, the Leapfrog Hospital Safety Grade does not assess hospitals such as:

- critical access hospitals
- specialty hospitals such as children's hospitals or cancer hospitals
- hospitals in U.S. Territories such as Puerto Rico and Guam

What does it measure? The Leapfrog Hospital Safety Grade looks at publicly available measures of safety – inpatient injuries, infections, and medical and medication errors.

- Outcome Measures include, among other measures:

- infections, including:
 - central line-associated bloodstream infections,
 - catheter-associated urinary tract infections,
 - surgical site infections for colon surgery,
 - MRSA and C. diff.
- falls and trauma, very severe pressure ulcers
- preventable complications from surgery such as foreign objects retained in the body and accidental punctures or lacerations
- Process/Structural Measures include, among other measures:
 - strong nursing leadership and engagement
 - computerized physician order entry systems to prevent medication errors
 - safe medication administration
 - hand hygiene policies
 - the right staffing for the ICU

- The Leapfrog Hospital Safety Grade does NOT measure:
 - Issues commonly considered quality measures, such as death rates for certain procedures
 - Measures of hospital quality, such as ratings by specialty or procedure
 - Readmission rates

Where does the data come from?

The Leapfrog Hospital Safety Grade primarily consists of measures collected and publicly reported by the Centers for Medicare & Medicaid Services (CMS), and also includes some measures from the Leapfrog Hospital Survey for hospitals that report to Leapfrog. Beginning with the spring 2021 Safety Grade, the Leapfrog Group will use an expert-developed New Link to calculate scores for three measures: Computerized Prescriber Order Entry (CPOE), Bar Code Medication Administration (BCMA), and/or ICU Physician Staffing (IPS).

How is the data assessed? The scoring algorithm was developed by an Expert Panel of patient

safety experts from across the country. The panel carefully considered the evidence base and opportunity for impact behind each of the measures, and weight the importance of each of the measures based in part on the strength of that evidence. The Panel regularly reconvenes to reevaluate the merits of each measure. Leapfrog's transparent methodology involves computing data for these measures through a scoring algorithm and then assigning each hospital an A, B, C, D, or F letter grade.

Is it true that hospitals can “game” the Hospital Safety Grade, as reported in *Medical Care*? While it's theoretically possible to “game” any ratings system, we find that hospitals attempting this with the Leapfrog Hospital Safety Grade are generally frustrated by the result for two reasons. First, the grade is composed of more than 30 measures, meaning that there are thousands of potential statistical outcomes that cannot be predicted with certainty. Second, the grade is calculated on a curve, so even by using data from one point in time, hospitals cannot know how they will

compare until the full range of hospitals are scored.

How long has Leapfrog been doing this? Since 2012

How often are results made available? The Leapfrog Hospital Safety Grade is issued twice a year, in the fall and spring. Results are publicly available and presented in an easy-to-use format for consumers and other interested parties.

How do I communicate with patients who have questions about our grade? Health care consumers are increasingly becoming concerned with the quality and safety of care they receive at hospitals and are using this information to make a decision on where to seek care. To help patients interpret your Safety Grade, refer them to the detailed information on the measures that make up your grade. The colored gas gauge images show areas where your hospital has demonstrated strong performance and where there is room for improvement. For areas in which your hospital scores poorly, assure your patients that you recognize this is an area of concern and illustrate what steps you are actively taking to improve

the safety of care you provide. No hospital is perfectly safe, so even if your hospital has received an A Safety Grade, it is likely that there are still some areas where you score poorly. If your hospital has received a low grade and scores below average on many measures, explain to your patients how your hospital leadership has recognized these shortcomings and hopefully is instituting a facility-wide commitment to improving safety. Finally, you can also encourage patients who have additional questions to contact Leapfrog directly at info@leapfroggroup.org.

Where can I find more information? You can find more information and the full methodology at www.HospitalSafetyGrade.org.

Who can I contact for help with this? For the Leapfrog Hospital Safety Grade, please contact HelpDesk@Leapfrog-Group.org.

How can my hospital promote our "A" grade? Hospitals that are interested in promoting their "A" or "Straight A's" Safety Grade are encouraged to issue a [press release](#) about their achievement.

For hospitals interested in using their Safety Grade in paid advertising or other promotional and marketing materials, a licensure agreement is required. Please visit our licensure agent's website, www.leapfroglicensing.org.

For more information about the timeline for hospitals, [click here](#).

What is the Leapfrog Hospital Survey?

Web address:

www.LeapfrogGroup.org/Hospital

What it is: The Leapfrog Hospital Survey is a voluntary, annual patient safety and quality survey that is free to all hospitals in the U.S. It was created to encourage hospitals to publicly report their progress in meeting quality and safety objectives, and it focuses on hospital structures, processes of care and outcomes.

How many hospitals are included? Over 2,300 hospitals voluntarily report to the Leapfrog Hospital Survey.

What kind of hospitals are eligible? All hospitals are eligible and encouraged to submit data.

What does it measure? The Survey includes a variety of nationally standardized and endorsed measures pertaining to the safety and quality of inpatient care, including maternity care, high-risk surgical procedures, Computerized Physician Order Entry (CPOE) system implementation, ICU physician staffing, and more.

Where does the data come from? Hospitals provide all data for the Leapfrog Hospital Survey directly.

How is the data assessed? All measures on the Leapfrog Hospital Survey are reviewed and approved by a voluntary panel of experts in that subject area. Where possible, measures are harmonized with other reporting entities such as the Joint Commission or the Centers for Medicare & Medicaid Services (CMS) to minimize the reporting burden on hospitals. The Leapfrog Hospital Survey does not have an overall composite score; each measure included on the survey is scored individually.

How long has Leapfrog been doing this? Since 2001

How often are results made

available? Leapfrog publishes findings from the Leapfrog Hospital Survey starting in July each year, and monthly through February. From time to time, Leapfrog also releases topical reports on the results of the Survey, offering trends and insights on areas such as [maternity care](#). All results are publicly available on the website.

How do I communicate with patients who have questions

about our Survey results? Health care consumers are increasingly becoming concerned with the quality and safety of care they receive at hospitals and are using this information to make a decision on where to seek care. To help patients interpret your Leapfrog Hospital Survey results, refer them to your hospital's detail page that can be accessed from ratings.leapfroggroup.org. This will allow patients to see where your hospital has demonstrated strong performance and where there is room for improvement. For areas in which your hospital scores poorly, assure your patients that you recognize this is an area of concern and illustrate what steps you are actively taking to improve

the care you provide. Patients deserve full transparency from the hospitals in which they trust their lives and will likely be skeptical if they see your hospital has Declined to Respond to some or all of the Leapfrog Hospital Survey. We hope that you will respond to requests from patients to participate in the voluntary Survey, and escalate this request to your hospital leadership if appropriate. Finally, you can also encourage patients who have additional questions to contact Leapfrog directly at info@leapfroggroup.org.

Where can I find more information? You can find more information about the survey at www.LeapfrogGroup.org/Hospital, which also contains the link to the online survey tool that your hospital would use to complete the annual survey. Leapfrog Hospital Survey Results are publicly reported at ratings.leapfroggroup.org.

Who can I contact for help with this? For the Leapfrog Hospital Survey, please contact the [Help Desk](#).



independent nonprofit organization committed to driving quality, safety, and transparency in the U.S. health system.

The Leapfrog Hospital Safety Grade

The Leapfrog Hospital Safety Grade is a public service provided by The Leapfrog Group, an

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EXHIBIT 11

Welcome to the 2025 Leapfrog Hospital Survey

This section of the website is designed for hospitals that are submitting a Hospital Survey.

The 2025 Leapfrog Hospital Survey is free and open to hospitals from April 1 to November 30. The annual survey assesses hospital safety, quality, and efficiency based on national performance measures that are of specific interest to health care purchasers and consumers. Survey Results are publicly reported, and provide hospitals with information to benchmark their progress in improving the care they deliver. For general, acute-care hospitals only, some Survey Results are also used to calculate the Leapfrog Hospital Safety Grade.

2026 Recognized Leaders in Diabetes Care

The 2026 Recognized Leaders in Ca...

[Download the Application Materials](#)

November 30 Deadline

The 2025 Leapfrog Hospital Surve...

[Review Survey Deadlines](#)

Prepare to Submit a Survey

Annually, over 2,400 hospitals submit a Leapfrog Hospital Survey. Please review the information on these webpages before you begin. These resources will help you to successfully complete the submission process.



Get Started

Request a security code, learn about our multi-campus reporting policy, and join our NHSN group.

[Learn More](#) >



Deadlines

View important deadlines related to the Survey, Leapfrog's NHSN Group, Top Hospitals, and more.

[Learn more](#) >



Survey Materials

Download a hard copy of the Survey and supporting materials that you will need to complete the Online Hospital Survey Tool.

[Learn more](#) >

Alignment with Other National Programs

Many of the measures included in the Leapfrog Hospital Survey are in use by other national agencies and organizations including the Centers for Medicare & Medicaid Services (CMS), the CDC's National Healthcare Safety Network (NHSN), and The Joint Commission. For general hospitals, some of the measures are used to calculate the Hospital Safety Grade.



[View the Survey Overview](#)



Looking for Extra Help?

The Leapfrog Hospital Survey Webinar Series is designed for Survey coordinators, hospital leaders, and others who would benefit from a more interactive presentation of Survey materials and information. The Webinar Series is held monthly from March to December and includes monthly office hours in addition to monthly webinars.

[Join Now](#)

[Contact the Help Desk](#)



Leapfrog's Rating Programs

Leapfrog administers two different ratings programs for hospitals: the Leapfrog Hospital Survey and the Leapfrog Hospital Safety Grade. Most every hospital is targeted to submit an annual Hospital Survey, but only general hospitals are eligible for a Hospital Safety Grade.

**Learn About the Differences
Between the Survey and Safety
Grade**

Find more information about the Safety Grade

Innovators for Leapfrog

Innovators for Leapfrog (IFL) support Leapfrog's mission to make "giant leaps for patient safety." While The Leapfrog Group does not endorse the products, services, and/or technology showcased in the IFL, we encourage you to explore these offerings that support Leapfrog's work.

**Learn more about Innovators for
Leapfrog**



EXHIBIT 12

11/12/25, 12:48 AM

The Leapfrog Hospital Survey



12:48 PM (ET)



Welcome to the 2025 Leapfrog Hospital Survey login page.

Before beginning a Survey, review measure specifications, endnotes, and FAQs in the hard copy of the Survey [here](#).

Before beginning a CPOE Test, review information on preparing for the CPOE Tool [here](#).

Contact the Help Desk with any questions.

Oops! Are you an ASC?

To log in to the Hospital Survey, please provide your hospital's 16-digit security code.

Security Code

[Need a security code?](#)

Your Email Address

For ID purposes, in case others attempt to log in to the survey while you are logged in.

Login

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EXHIBIT 13

Hospital Details Page

Data Accuracy

Updating Your
Hospital Survey

How Results Are
Used

Custom
Benchmarking

Scoring and Results



[2025 Leapfrog Hospital Survey Scoring Algorithms](#)

The scoring algorithms document contains important information about how your responses to each section of the Survey are scored and publicly reported. The document includes cut-points for process and outcome measures, as well as scoring details and criteria for each of Leapfrog's performance categories (e.g., Achieved the Standard, Considerable Achievement, Some Achievement, Limited Achievement, etc.).

Any changes to the 2024 Leapfrog Hospital Survey Scoring Algorithms that are published after April 1 will be listed here.

Hospital Details Page

On July 12, the Hospital Details Page will be updated to display 2025 Leapfrog Hospital Survey Results for hospitals that submitted a 2025 Survey by the [June 30 Submission Deadline](#). See [Hospital Details page](#) for more information.

Leapfrog Hospital Survey Results

2025 Leapfrog Hospital Survey Results will be [published](#) on July 25 for hospitals that submit a Survey by the [June 30 Submission Deadline](#). After July, Survey Results will be refreshed within the first seven business days of each month to reflect Surveys submitted or re-submitted between July 1 and November 30, and previously submitted Surveys that are corrected by January 31. Survey Results are then frozen from February to July 25.

2024 Hospital Survey Results

[View Results](#)

2024 Leapfrog Hospital Survey Results are available on Leapfrog's public reporting website until July 25, 2025.

EXHIBIT 14

The Leapfrog Hospital Survey Scoring Algorithms

Scoring Details for Sections 1 – 9 of the 2025 Leapfrog Hospital Survey



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Scoring Algorithms

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2025 Leapfrog Hospital Survey Scoring Algorithms

<http://leapfroggroup.org/hospital>

This document includes the scoring algorithms for the 2025 Leapfrog Hospital Survey. The scoring algorithms are organized by section:

- [What's New in 2025](#)
- [Change Summary Since Release](#)
- [Section 1 Patient Rights and Ethics](#)
- [Section 2 Medication Safety](#)
- [Section 3 Adult and Pediatric Complex Surgery](#)
- [Section 4 Maternity Care](#)
- [Section 5 Physician and Nurse Staffing](#)
- [Section 6 Patient Safety Practices](#)
- [Section 7 Managing Serious Errors](#)
- [Section 8 Pediatric Care](#)
- [Section 9 Outpatient Procedures](#)

For a hard copy of the Leapfrog Hospital Survey, which includes measure specifications, endnotes, and FAQs, please visit the [Survey and CPOE Materials webpage](#).

Leapfrog is committed to data accuracy. Please carefully review Leapfrog's data accuracy protocols on the [Data Accuracy webpage](#).

Scoring and Public Reporting Overview

Once a hospital submits a Leapfrog Hospital Survey via the [Online Hospital Survey Tool](#), the submitted responses will be scored using the algorithms detailed in this document. Only those responses that have been submitted will be scored and publicly reported; saved responses will not be scored or publicly reported.

Hospitals that submit by the [June 30 Submission Deadline](#) will be able to view their Survey Results on Leapfrog's [public reporting website](#) on **July 25**. In addition, these hospitals will be able to preview their Survey Results, including their VON data for Section 4E High-Risk Deliveries (if applicable), NHSN data for Section 7B Healthcare-Associated Infections, and CMS outpatient data for Section 9D Safety of Procedures (if applicable) on the [Hospital Details Page](#) on **July 12**, about two weeks prior to the public release.

After July 25, the Hospital Details Page and public reporting website will be refreshed monthly within the first seven (7) business days of each month to reflect Surveys submitted or re-submitted between July 1 and November 30, and previously submitted Surveys that were corrected by January 31. Survey Results are frozen from February to July 25 of the following year. More information about Survey submission deadlines is available on our [website](#).

Hospitals should review their Survey Results following their submission to ensure accuracy and completeness.

For the purposes of public reporting, performance on each measure on the Leapfrog Hospital Survey is placed into one of four performance categories:

- **Achieved the Standard** (displayed as four filled bars)
- **Considerable Achievement** (displayed as three filled bars)
- **Some Achievement** (displayed as two filled bars)
- **Limited Achievement** (displayed as one filled bar)

Additional scoring terms include:

- **Does Not Apply:** This term is used for hospitals that report not performing a particular procedure (e.g., SSI Colon), not having a particular unit (e.g., ICU), or are not applicable for a particular measure (e.g., hospital does not deliver newborns).
- **Did Not Measure:** This term is used for hospitals that report not measuring certain measures on the Leapfrog Hospital Survey (e.g. Medication Reconciliation, DVT Prophylaxis, Bilirubin Screening, Nurse Staffing and Skill Mix, etc.)
- **Unable to Calculate Score:** This term is used for hospitals that report a sample size that does not meet Leapfrog's minimum reporting requirements. For the healthcare-associated infections, this term is used if the hospital reported too small of a sample size to calculate their results reliably (i.e., the number of predicted infections across all locations is <1) or the number of observed MRSA or CDI infections present on admission (community-onset prevalence) was above a pre-determined cut-point. For the CMS outpatient measure (OP-32), the term is used for hospitals that do not participate with CMS or do not have a measure score published by CMS.
- **Declined to Respond:** This term is used for hospitals that do not submit a Survey or a section of the Survey.
- **Pending Leapfrog Verification:** This term is used for hospitals that have Survey responses that are undergoing Leapfrog's standard verification process.

Additionally, for hospitals that have obtained approval from Leapfrog to participate in the 2025 Leapfrog Hospital Survey using limited data due to a cybersecurity event or natural disaster, the following footnote will be included alongside impacted Survey Results: "Results are based on limited data due to a reported cybersecurity event or natural disaster." For more information, please visit our [webpage](#).

Figure 1: Legend from Leapfrog's public reporting [website](#).**Progress towards meeting Leapfrog standards:**

	Achieved the Standard
	Considerable Achievement
	Some Achievement
	Limited Achievement
	Did not report to the Survey on this measure
DOES NOT APPLY	This measure is not applicable to this facility
DID NOT MEASURE	Facility reported not collecting data on this measure
UNABLE TO CALCULATE	Sample size too small to calculate score
PENDING LEAPFROG VERIFICATION	This facility's responses are undergoing Leapfrog's standard data verification process

2025 Leapfrog Hospital Survey**Scoring Algorithms**

For the purposes of [public reporting](#), measures are organized into twelve groups. The following measures are included in each group:

Group Name	Section/ Subsection	Measure Name	Shown on public reporting website as:
Patient Rights and Ethics	Subsection 1B	Billing Ethics	<i>Billing Ethics</i>
	Subsection 1C	Health Care Equity	<i>Health Care Equity</i>
	Subsection 1D	Informed Consent	<i>Informed Consent</i>
	Subsection 7A	Never Events	<i>Responding to Never Events</i>
Preventing Patient Harm	Subsection 5C	Total Nursing Care Hours per Patient Day	<i>Nursing and Bedside Care for Patients</i>
	Subsection 5C	RN Hours per Patient Day	<i>Nursing for Patients</i>
	Subsection 5C	Nursing Skill Mix	<i>Percentage of Nursing Staff who are Registered Nurses (RNs)</i>
	Subsection 5C	Percentage of RNs who are BSN-Prepared	<i>Percentage of Registered Nurses (RNs) who have a Bachelor's Degree in Nursing</i>
	Subsection 6A	NQF Safe Practice #1 – Culture of Safety Leadership Structures and Systems	<i>Effective Leadership to Prevent Errors</i>
	Subsection 6B	NQF Safe Practice #2 – Culture Measurement, Feedback, and Intervention	<i>Staff Work Together to Prevent Errors</i>
	Subsection 6C	Hand Hygiene	<i>Handwashing</i>
Critical Care	Section 5A	Adult ICU Physician Staffing	<i>Specially Trained Doctors Care for Adult Critical Care Patients</i>
	Section 5B	Pediatric ICU Physician Staffing	<i>Specially Trained Doctors Care for Pediatric Critical Care Patients</i>
Healthcare-Associated Infections	Subsection 7B	Facility-wide inpatient <i>C. diff.</i> Laboratory-identified Events	<i>C. difficile Infection</i>
	Subsection 7B	Central Line-Associated Blood Stream Infections (CLABSI) in ICUs and Select Wards	<i>Infection in the Blood</i>
	Subsection 7B	Catheter-Associated Urinary Tract Infections (CAUTI) in ICUs and Select Wards	<i>Infection in the Urinary Tract</i>
	Subsection 7B	Facility-wide inpatient MRSA Blood Laboratory-identified Events	<i>MRSA Infection</i>
	Subsection 7B	Surgical Site Infection: Colon	<i>Surgical Site Infection after Colon Surgery</i>
Maternity Care	Subsection 4E	High-Risk Deliveries	<i>High-Risk Deliveries</i>
	Subsection 4B	Cesarean Birth	<i>Cesarean Sections</i>
	Subsection 4C	Episiotomy	<i>Episiotomies</i>

2025 Leapfrog Hospital Survey

Scoring Algorithms

Group Name	Section/ Subsection	Measure Name	Shown on public reporting website as:
	Subsection 4D	Newborn Bilirubin Screening Prior to Discharge	<i>Screening Newborns for Jaundice before Discharge</i>
	Subsection 4D	Appropriate DVT Prophylaxis in Women Undergoing Cesarean Delivery	<i>Preventing Blood Clots in Women Undergoing Cesarean Section</i>
	Subsection 4A*	Maternity Care Volume	<i>Number of Live Births</i>
	Subsection 4A*	Maternity Care Services	<i>Maternity Care Services</i>
Medication Safety	Subsection 2A	Computerized Physician Order Entry (CPOE)	<i>Safe Medication Ordering</i>
	Subsection 2D	Medication Reconciliation	<i>Medication Reconciliation</i>
	Subsection 2C	Bar Code Medication Administration (BMCA)	<i>Safe Medication Administration</i>
	Subsection 9E	Medication Safety for Outpatient Procedures	<i>Medication Documentation for Elective Outpatient Surgery Patients</i>
Pediatric Care	Subsection 8A	Patient Experience (CAHPS Child Hospital Survey)	<i>Experience of Children and Their Parents</i>
	Subsection 8B	Pediatric Computed Tomography (CT) Radiation Dose – Abdomen/Pelvis Scans	<i>Radiation Dose for Abdomen/Pelvis Scans</i>
	Subsection 8B	Pediatric Computed Tomography (CT) Radiation Dose – Head Scans	<i>Radiation Dose for Head Scans</i>
Complex Adult and Pediatric Surgery	Subsection 3A	Carotid Endarterectomy	<i>Carotid Endarterectomy</i>
	Subsection 3A	Mitral Valve Repair and Replacement	<i>Mitral Valve Repair and Replacement</i>
	Subsection 3A	Open Aortic Procedures	<i>Open Aortic Procedures</i>
	Subsection 3A	Bariatric Surgery for Weight Loss	<i>Bariatric Surgery for Weight Loss</i>
	Subsection 3A	Esophageal Resection for Cancer	<i>Esophageal Resection for Cancer</i>
	Subsection 3A	Lung Resection for Cancer	<i>Lung Resection for Cancer</i>
	Subsection 3A	Pancreatic Resection for Cancer	<i>Pancreatic Resection for Cancer</i>
	Subsection 3A	Rectal Cancer Surgery	<i>Rectal Cancer Surgery</i>
	Subsection 3A	Norwood Procedure	<i>Congenital Heart Surgery for Infants (Norwood Procedure)</i>
	Subsection 3B	Safe Surgery Checklist for Adult and Pediatric Complex Surgery	<i>Safe Surgery Checklist – Complex Surgery</i>
Total Joint Replacement	Subsection 3A	Total Knee Replacement	<i>Total Knee Replacement Surgery</i>
	Subsection 3A	Total Hip Replacement	<i>Total Hip Replacement Surgery</i>

2025 Leapfrog Hospital Survey**Scoring Algorithms**

Group Name	Section/ Subsection	Measure Name	Shown on public reporting website as:
Elective Outpatient Surgery – Adult*	Subsection 9C*	Ophthalmology	<i>Ophthalmology (Eyes)</i>
	Subsection 9C*	Orthopedic	<i>Orthopedic (Bones and Joints)</i>
	Subsection 9C*	Otolaryngology	<i>Otolaryngology (Ear, Nose, Mouth, and Throat)</i>
	Subsection 9C*	Gastroenterology	<i>Gastroenterology (Stomach and Digestive)</i>
	Subsection 9C*	General Surgery	<i>General Surgery</i>
	Subsection 9C*	Urology	<i>Urology (Urinary Tract, Male Reproductive)</i>
	Subsection 9C*	Neurological Surgery	<i>Neurosurgery</i>
	Subsection 9C*	Obstetrics and Gynecology	<i>Obstetrics and Gynecology</i>
	Subsection 9C*	Plastic and Reconstructive Surgery	<i>Plastic and Reconstructive Surgery</i>
Elective Outpatient Surgery – Pediatric*	Subsection 9C*	Ophthalmology	<i>Ophthalmology (Eyes)</i>
	Subsection 9C*	Orthopedic	<i>Orthopedic (Bones and Joints)</i>
	Subsection 9C*	Otolaryngology	<i>Otolaryngology (Ear, Nose, Mouth, and Throat)</i>
Care for Elective Outpatient Surgery Patients	Subsection 9B	Clinicians Present While Adult Patients are Recovering	<i>Elective Outpatient Surgery Recovery Staffing – Adult</i>
	Subsection 9B	Clinicians Present While Pediatric Patients are Recovering	<i>Elective Outpatient Surgery Recovery Staffing – Pediatric</i>
	Subsection 9D	Safe Surgery Checklist for Adult and Pediatric Outpatient Procedures	<i>Safe Surgery Checklist – Elective Outpatient Surgery</i>
	Subsection 9F	Patient Experience (OAS CAHPS)	<i>Experience of Patients Undergoing Elective Outpatient Surgery</i>
	Subsection 9D	Rate of Unplanned Hospital Visits After an Outpatient Colonoscopy	<i>Unplanned Hospital Visits After Colonoscopy</i>

*Note: These data will not be scored but are displayed on Leapfrog's public reporting website.

Summary of Changes to the 2025 Leapfrog Hospital Survey
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For details on all changes to the 2025 Leapfrog Hospital Survey, visit the [Survey and CPOE Materials webpage](#). Changes to scoring and public reporting for the 2025 Leapfrog Hospital Survey are highlighted below:

- **General:**
 - Leapfrog added a new performance category of “Did Not Measure” for hospitals reporting that they did not measure and therefore cannot report on select measures on the Leapfrog Hospital Survey. These measures include:
 - Section 2D: Medication Reconciliation
 - Section 4D: Newborn Bilirubin Screening Prior to Discharge
 - Section 4D: Appropriate DVT Prophylaxis in Women Undergoing Cesarean Delivery
 - Section 5C: Total Nursing Care Hours per Patient Day
 - Section 5C: RN Hours per Patient Day
 - Section 5C: Nursing Skill Mix
 - Section 5C: Percentage of RNs who are BSN-Prepared
 - Section 8A: Patient Experience (CAHPS Child Hospital Survey)
 - Section 8B: Pediatric CT Radiation Dose for Head Scans
 - Section 8B: Pediatric CT Radiation Dose for Abdomen/Pelvis Scans
 - Section 9E: Medication Safety for Outpatient Procedures
 - Section 9F: Patient Experience (OAS CAHPS)
- **[Section 1A – Basic Hospital Information](#)**
 - Leapfrog updated and added new questions so hospitals can report on beds used to care for ICU patients in mixed acuity units.
- **[Section 1C - Health Care Equity](#)**
 - Leapfrog added a new response option of “ability status” to question #1. Additionally, a new optional question was added asking hospitals to provide a link to where they publicly share their efforts to identify and reduce health care disparities. This question, and the provided URL, will not be used in scoring or public reporting.
- **[Section 2C - Bar Code Medication Administration \(BCMA\)](#)**
 - Leapfrog added new questions to assess the utilization of step-down/progressive units separate from medical and/or surgical units and updated one of the questions for hospitals reporting on their mechanisms to reduce and understand potential BCMA system “workarounds” to ask about “back-up equipment” instead of “back-up systems.”
- **[Section 2D – Medication Reconciliation](#)**
 - Leapfrog updated the performance category for hospitals that report using a nationally endorsed protocol to collect data on the accuracy of its medication reconciliation process, but did not sample at least 30 patients from “Some Achievement” to “Limited Achievement.”
- **[Section 3A Hospital and Surgeon Volume](#)**
 - For mitral valve repair and replacement, Leapfrog updated the questions to clarify that hospitals can only report on their Mitral Valve Repair/Replacement Composite Score if the score is publicly reported on the STS website.
- **[Section 3B Safe Surgery Checklist for Adult and Pediatric Complex Surgery](#)**
 - Leapfrog added a new response option to question #6 for hospitals that perform fewer than 30 inpatient procedures under general anesthesia. Hospitals selecting this response option will be scored and publicly reported as “Unable to Calculate Score.”
- **[Section 4A - Maternity Care Volume and Services](#)**
 - Leapfrog updated the policy question regarding the prevention of nonmedically indicated early elective deliveries to specify that the written protocols must be approved by the medical director or other designated physician.

2025 Leapfrog Hospital Survey

Scoring Algorithms

- **Section 5A/5B – Adult and Pediatric ICU Physician Staffing**
 - Leapfrog split Section 5: ICU Physician Staffing into two subsections: Section 5A: Adult ICU Physician Staffing and Section 5B: Pediatric ICU Physician Staffing. The questions were updated to reference adult or pediatric units.
- **Section 5C - Nursing Workforce**
 - Leapfrog has updated question #2 to clarify that hospitals should only respond to the questions about mixed acuity units if the hospital does not operate any of the applicable single acuity units. Further clarification on single acuity medical, surgical and med-surg units to include or exclude, as well as additional clarification on the definition of acuity (i.e., level of care), was added. Critical Access Units, defined as units where more than 10% of beds are for skilled nursing (swing beds), was added as an exclusion for both single acuity and mixed acuity units. The Midnight Census method for calculating the total number of patient days for each unit was clarified so that observation patients must be included and short stay patients (who are in and out of the unit before the census is taken) must be included.
- **Section 6C – Hand Hygiene**
 - Leapfrog updated the hospital units included in the Hand Hygiene measure to add further clarification and alignment with reporting in other sections of the Survey.
- **Section 9B – Medical, Surgical, and Clinical Staff**
 - Leapfrog updated question #2 asking about clinicians trained in Pediatric Advanced Life Support (PALS), to include a new response option of “Not applicable; pediatric patients are all aged 13-17” to clarify that all pediatric procedures reported on in Section 9C during the reporting period were performed on patients 13 years and older.

2025 Leapfrog Hospital Survey

Scoring Algorithms

Change Summary Since Release

This section will be updated if changes are made to scoring after this document's initial release on April 1, 2025.

2025 Leapfrog Hospital Survey Sect. 1 – Patient Rights and Ethics Scoring Algorithms**Section 1: 2025 Patient Rights and Ethics Scoring Algorithms****1A: Basic Hospital Information**

This section will not be scored in 2025. However, the responses will be shown on Leapfrog's public reporting [website](#). For example, Leapfrog will display the number of ICU beds.

1B: Billing Ethics

Hospitals are scored on three aspects of their billing practices, including the quality and timeliness of the billing statement or master itemized bill, the availability of a billing representative to negotiate a patient's bill within 10 business days, and whether or not the facility takes legal action against patients for late or insufficient payment of a medical bill in cases where the facility did not have a written agreement in place specifying a good faith estimate for a medical service.

Billing Ethics Score (Performance Category)	Meaning that...
Achieved the Standard	- The hospital provides every patient with a billing statement and/or master itemized bill within 30 days of final claims adjudication that includes all 10 required elements listed in question #1, - Gives patients instructions for contacting a billing representative who has access to an interpretation service and has the authority to do all three required elements in question #2 within 10 business days, and - Does not take legal action against patients for late or insufficient payment of a medical bill in cases where the facility did not have a written agreement in place specifying a good faith estimate for a medical service. OR (applies to Military Treatment Facilities only) - The hospital provides every patient with a billing statement and/or master itemized bill within 30 days of final claims adjudication that includes all 10 required elements listed in question #1, - Gives patients instructions for contacting a billing representative who has access to an interpretation service and has the authority to do all three required elements in question #2 within 10 business days, and - Does not take legal action against patients but is required by federal law to transfer delinquent payments to the Department of Treasury for action.
Considerable Achievement	Upon request, the hospital provides patients with a billing statement and/or master itemized bill within 30 days of final claims adjudication that includes all 10 required elements listed in question #1, - Gives patients instructions for contacting a billing representative who has access to an interpretation service and has the authority to do all three required elements in question #2 within 10 business days, and - Does not take legal action against patients for late or insufficient payment of a medical bill in cases where the facility did not have a written agreement in place specifying a good faith estimate for a medical service, or the hospital does not take legal action against

2025 Leapfrog Hospital Survey Sect. 1 – Patient Rights and Ethics Scoring Algorithms

	patients but is required by federal law to transfer delinquent payments to the Department of Treasury for action.
Some Achievement	- The hospital does not provide patients with a billing statement and/or master itemized bill within 30 days of final claims adjudication that includes all 10 required elements listed in question #1, but - Gives patients instructions for contacting a billing representative who has access to an interpretation service and has the authority to do all three required elements in question #2 within 10 business days, and - Does not take legal action against patients for late or insufficient payment of a medical bill in cases where the facility did not have a written agreement in place specifying a good faith estimate for a medical service, or the hospital does not take legal action against patients but is required by federal law to transfer delinquent payments to the Department of Treasury for action.
Limited Achievement	The hospital responded to all the questions in this section, but it does not yet meet the criteria for Some Achievement.
Declined to Respond	The hospital did not submit a Survey.
Pending Leapfrog Verification	The hospital's responses are undergoing Leapfrog's standard verification process.

1C: Health Care Equity

Hospitals are scored on whether they meet the requirements for collecting patient self-reported demographic data, training staff responsible for collecting demographic data, stratifying at least one quality measure, and additional steps the hospital takes once this data is collected and analyzed.

Health Equity Score (Performance Category)	Meaning that...
Achieved the Standard	- The hospital collects, at a minimum, patient self-identified race, ethnicity, and preferred written and/or spoken language data as described in question #1, - Trains staff responsible for collecting the self-identified demographic data from patients as described in question #2, - Uses the patient self-identified demographic data to stratify at least one quality measure as described in question #3, - If disparities were identified in question #4, has updated or revised a policy or procedure to address the disparity or developed a written action plan as described in question #5, - Shares information about efforts to identify and reduce health care disparities on its public website as described in question #6, and - Reports out and discusses efforts to identify and address health care disparities with the board as described in question #8. <i>Question #5 is not used in scoring for hospitals that responded "No, disparities were not identified" or "Inadequate data available to determine if disparities exist" to question #4.</i>

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Considerable Achievement	• The hospital collects, at a minimum, patient self-identified race, ethnicity, and preferred written or spoken language data as described in question #1, • Trains staff responsible for collecting the self-identified demographic data from patients as described in question #2, • Uses the patient self-identified demographic data to stratify at least one quality measure as described in question #3, • If disparities were identified in question #4, has updated or revised a policy or procedure to address the disparity or developed a written action plan as described in question #5, • And either: ○ Shares information about efforts to identify and reduce health care disparities on its public website as described in question #6, - OR ○ Reports out and discusses efforts to identify and address health care disparities with the board as described in question #8. <i>Question #5 is not used in scoring for hospitals that responded “No, disparities were not identified” or “Inadequate data available to determine if disparities exist” to question #4.</i>
Some Achievement	• The hospital collects, at a minimum, patient self-identified race, ethnicity, and preferred written or spoken language data as described in question #1, • Trains staff responsible for collecting the self-identified demographic data from patients as described in question #2, • Uses the patient self-identified demographic data to stratify at least one quality measure as described in question #3, • And either: ○ Has updated or revised a policy or procedure to address the disparity or developed a written action plan as described in question #5 (if disparities were identified in question #4). - OR ○ Shares information about efforts to identify and reduce health care disparities on its public website as described in question #6, - OR ○ Reports out and discusses efforts to identify and address health care disparities with the board as described in question #8. <i>Question #5 is not used in scoring for hospitals that responded “No, disparities were not identified” or “Inadequate data available to determine if disparities exist” to question #4.</i>
Limited Achievement	The hospital responded to all the questions in this section, but it does not yet meet the criteria for Some Achievement.
Declined to Respond	The hospital did not submit a Survey.
Pending Leapfrog Verification	The hospital's responses are undergoing Leapfrog's standard verification process.

2025 Leapfrog Hospital Survey Sect. 1 – Patient Rights and Ethics Scoring Algorithms**1D: Informed Consent**

Hospitals are scored on whether they meet the requirements for their informed consent policies and training, the content of their informed consent forms, and their processes for gaining informed consent for all procedures where general and regional anesthesia are used, or where monitored anesthesia care is administered.

Informed Consent Score (Performance Category)	Meaning that...
Achieved the Standard	• The hospital responded “yes, <u>all</u> applicable forms are written at a 6th grade reading level or lower” to question #5, <u>and</u> • The hospital responded “yes” to the remaining <u>five</u> questions in ○ Policies and Training (question #1), ○ Content of Informed Consent Forms (questions #3-4), and ○ Process for Gaining Informed Consent (questions #6-7).
Considerable Achievement	• The hospital responded “yes, <u>all</u> applicable forms are written at a 6th grade reading level or lower” to question #5, <u>and</u> • The hospital responded “yes” to at least <u>four</u> additional questions in ○ Policies and Training (question #1), ○ Content of Informed Consent Forms (questions #3-4), and ○ Process for Gaining Informed Consent (questions #6-7). <u>OR</u> • The hospital responded “no, but at least <u>one</u> form is written at a 6th grade reading level or lower” OR “no, all applicable forms are written at a 9th grade reading level or lower” to question #5, <u>and</u> • The hospital responded “yes” to the <u>five</u> remaining questions in ○ Policies and Training (question #1), ○ Content of Informed Consent Forms (questions #3-4), and ○ Process for Gaining Informed Consent (questions #6-7).
Some Achievement	• The hospital responded “yes, <u>all</u> applicable forms are written at a 6th grade reading level or lower” <u>OR</u> “no, but at least <u>one</u> form is written at a 6th grade reading level or lower” <u>OR</u> “no, all applicable forms are written at a 9th grade reading level or lower” to question #5 <u>and</u> • The hospital responded “yes” to at least <u>three</u> additional questions in ○ Policies and Training (question #1), ○ Content of Informed Consent Forms (questions #3-4), and ○ Process for Gaining Informed Consent (questions #6-7). <u>OR</u> • The hospital responded “no forms are written at a 6th grade reading level or lower” to question #5, <u>and</u> • The hospital responded “yes” to at least <u>four</u> additional questions in ○ Policies and Training (question #1), ○ Content of Informed Consent Forms (questions #3-4), and ○ Process for Gaining Informed Consent (questions #6-7).

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Limited Achievement	The hospital responded to all the questions in this section, but it does not yet meet the criteria for Some Achievement.
Declined to Respond	The hospital did not submit a Survey.
Pending Leapfrog Verification	The hospital's responses are undergoing Leapfrog's standard verification process.

Section 2: 2025 Medication Safety Scoring Algorithms

2A: CPOE Scoring Algorithm for Adult/General Hospitals

Adult and general hospitals are scored on both their implementation and the efficacy of an inpatient CPOE system.

CPOE Test results are available within the CPOE Evaluation Tool from April 1 to November 30. See “Step 7 of 7: View Results” in the [CPOE Tool Instructions](#) for more information.

Score on Adult Inpatient Test via the CPOE Evaluation Tool (see Appendix I for details on the CPOE Evaluation Tool Scoring Algorithm)						
Implementation Status (from Leapfrog Hospital Survey Questions #3-4)	<i>Full Demonstration of National Safety Standard for Decision Support</i> (60% or greater of test orders correct)	<i>Substantial Demonstration of National Safety Standard for Decision Support</i> (50-59% of test orders correct)	<i>Some Demonstration of National Safety Standard for Decision Support</i> (40-49% of test orders correct)	<i>Completed the Evaluation</i> (Less than 40% of test orders correct)	<i>Insufficient Evaluation</i> (Hospital was not able to test at least 50% of test orders)	<i>Incomplete Evaluation</i> (Potentially inaccurate test results or timed out) -or- <i>Did not complete an evaluation</i>
85% or greater of all inpatient medication orders entered through CPOE System	Achieved the Standard	Considerable Achievement	Considerable Achievement	Some Achievement	Unable to Calculate Score	Limited Achievement
75-84% of all inpatient medication orders entered through CPOE System	Achieved the Standard	Considerable Achievement	Some Achievement	Some Achievement	Unable to Calculate Score	Limited Achievement
50-74% of all inpatient medication orders entered through CPOE System	Considerable Achievement	Considerable Achievement	Some Achievement	Limited Achievement	Unable to Calculate Score	Limited Achievement
CPOE implemented in at least one inpatient unit but <50% of all inpatient medication orders entered through CPOE System	Considerable Achievement	Some Achievement	Some Achievement	Limited Achievement	Unable to Calculate Score	Limited Achievement
CPOE not implemented in at least one inpatient unit	Cannot take CPOE Evaluation Tool; hospital will be scored as “Limited Achievement”					

Declined to respond:

The hospital did not submit a Survey.

Pending Leapfrog Verification:

The hospital's responses are undergoing Leapfrog's standard verification process.

2A: CPOE Scoring Algorithm for Pediatric Hospitals

Pediatric hospitals are scored on their implementation of an inpatient CPOE system.

CPOE Score (Performance category)	Implementation Status (from Leapfrog Hospital Survey Questions #3-4)
Achieved the Standard	85% or greater of all inpatient medication orders entered through CPOE System.
Considerable Achievement	75-84% of all inpatient medication orders entered through CPOE System.
Some Achievement	50-74% of all inpatient medication orders entered through CPOE System.
Limited Achievement	CPOE implemented in at least one inpatient unit but <50% of all inpatient medication orders entered through CPOE System OR CPOE not implemented in at least one inpatient unit.
Declined to Respond	The hospital did not submit a Survey.
Pending Leapfrog Verification	The hospital's reported responses are undergoing Leapfrog's standard verification process.

2C: Bar Code Medication Administration (BCMA)

Hospitals are scored on their performance on four components of BCMA use:

- **% Units:** A hospital's implementation of BCMA throughout the hospital, as measured by the percentage of adult and/or pediatric units with a focus on general medical, surgical, medical/surgical, neuro, neonatal, or specialty ICUs, medical, surgical, or medical/surgical units (including telemetry units), step-down/progressive units, labor and delivery units, and pre-operative and post-anesthesia care units.
- **% Compliance:** A hospital's compliance with scanning the patient and medication during the administration in applicable units where BCMA is implemented.
- **Decision Support:** The types of decision support that the hospital's BCMA system offers, including:
 1. Wrong patient
 2. Wrong medication
 3. Wrong dose
 4. Wrong time (e.g., early/late warning; warning that medication cannot be administered twice within a given window of time)
 5. Second nurse check needed
- **Workarounds:** A hospital's structures to monitor and reduce workarounds, including:
 1. Having a formal committee that meets routinely to review data reports on BCMA system use
 2. Having back-up equipment for hardware failures
 3. Having a help desk that provides timely responses to urgent BCMA issues in real-time
 4. Conducting real-time observations of users at the unit level using the BCMA system
 5. Engaging nursing leadership at the unit level on BCMA use
 6. In the past 12 months, used the data and information obtained through items 1-5 to implement quality improvement projects that have focused on improving the hospital's BCMA performance

OR

In the past 12 months, used the data and information obtained through items 1-5 to monitor a previously implemented quality improvement project focused on improving the hospital's BCMA performance

 7. In the past 12 months, evaluated the results of the quality improvement projects (from 6) and demonstrated that these projects have resulted in higher adherence to the hospital's standard medication administration process

OR

In the past 12 months, evaluated the results of the quality improvement projects (from 6) and demonstrated continued adherence to the hospital's standard medication administration process

 8. Communicated to end users the resolution of any system deficiencies and/or problems that may have contributed to the workarounds

BCMA Score (Performance Category)	% Units	% Compliance	Decision Support	Processes & Structures to Prevent Workarounds
Achieved the Standard	100%	95%	5 out of 5	6 out of 8
Considerable Achievement	The hospital meets three of the four standards.			
Some Achievement	The hospital meets two of the four standards.			
Limited Achievement	The hospital meets one or zero of the four standards.			
Declined to Respond	The hospital did not submit a Survey.			
Pending Leapfrog Verification	The hospital's responses are undergoing Leapfrog's standard verification process.			

2D: Medication Reconciliation

Hospitals are scored on their use of a nationally endorsed protocol to collect data on the accuracy of their medication reconciliation process and the rate of unintentional medication discrepancies per medication based on a sample of at least 30 patients. The rate of unintentional medication discrepancies per medication is calculated by dividing the total number of discrepancies by the total number of medications, using the following formula:

$$= \frac{\text{Unintent. discrepancies among GSMs§ (Q6) + Discrepancies due to unintent. ordered meds (Q8)}}{\text{Meds from the GSM§ history (Q5) + Unintent. ordered additional meds (Q7)}}$$

§ GSM = gold standard medication(s)

The 50th and 75th percentiles are based on the distribution of hospital performance from 2021 Leapfrog Hospital Surveys submitted as of July 31, 2021. These cut-points will remain in place for the entire Survey Cycle, unless it is determined that there are compelling reasons to make revisions.

	2021 Survey Results for Rate of Unintentional Medication Discrepancies per Medication
Minimum	0
50th percentile	0.119
75th percentile	0.213
Maximum	1.065

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Sect. 2 – Medication Safety Scoring Algorithms

Medication Reconciliation Score (Performance Category)	Meaning that...
Achieved the Standard	- The hospital uses a nationally endorsed protocol to collect data on the accuracy of its medication reconciliation process, - Sampled at least 30 patients, and - Based on the sample, the rate of unintentional medication discrepancies per medication is <u>lower than or equal to the 50th percentile</u> (where lower performance is better).
Considerable Achievement	- The hospital uses a nationally endorsed protocol to collect data on the accuracy of its medication reconciliation process, - Sampled at least 30 patients, and - Based on the sample, the rate of unintentional medication discrepancies per medication is <u>higher than the 50th percentile, but lower than or equal to the 75th percentile</u> (where lower performance is better).
Some Achievement	- The hospital uses a nationally endorsed protocol to collect data on the accuracy of its medication reconciliation process, - Sampled at least 30 patients, but - Based on the sample, the rate of unintentional medication discrepancies per medication is <u>higher than the 75th percentile</u> (where lower performance is better).
Limited Achievement	- The hospital uses a nationally endorsed protocol to collect data on the accuracy of its medication reconciliation process, but - Did not sample at least 30 patients.
Did Not Measure	The hospital reported not collecting data on this measure.
Unable to Calculate Score	More than 10 out of 30 patients (or one-third) included in the sample had zero Gold Standard Medications.
Does Not Apply	The hospital is a pediatric facility or had too few adult admissions to medical or medical/surgical units.
Declined to Respond	The hospital did not submit a Survey.
Pending Leapfrog Verification	The hospital's responses are undergoing Leapfrog's standard verification process.

2025 Leapfrog Hospital Survey

Sect. 3 – Adult and Pediatric Complex Surgery
Scoring Algorithms

Section 3: 2025 Adult and Pediatric Complex Surgery Scoring Algorithms

3A: Hospital and Surgeon Volume

Leapfrog's minimum hospital and surgeon volume standards:

Procedure	Hospital Volume	Surgeon Volume
Carotid endarterectomy	20	10
Mitral valve repair and replacement	40	20
Open aortic procedures	10	7
Lung resection for cancer	40	15
Esophageal resection for cancer	20	7
Pancreatic resection for cancer	20	10
Rectal cancer surgery	16	6
Bariatric surgery for weight loss	50	20
Total knee replacement surgery	50	25
Total hip replacement surgery	50	25
Norwood Procedure	8	5

For the procedures listed above, other than mitral valve repair and replacement and Norwood procedures, hospitals are scored on whether they met the minimum hospital volume standards and whether the hospital's process for privileging its surgeons includes meeting or exceeding the minimum annual surgeon volume standards in the table above.

Hospital and Surgeon Volume Score (Performance Category)	Meaning that for each of the procedures performed...
Achieved the Standard	- The hospital met the minimum hospital volume standard for the procedure, and - The hospital's process for privileging surgeons does include meeting or exceeding the minimum annual surgeon volume standard.
Considerable Achievement	- The hospital met the minimum hospital volume standard for the procedure, but - The hospital's process for privileging surgeons does not include meeting or exceeding the minimum annual surgeon volume standard.
Some Achievement	- The hospital did not meet the minimum hospital volume standard for the procedure, but - The hospital's process for privileging surgeons does include meeting or exceeding the minimum annual surgeon volume standard.
Limited Achievement	- The hospital did not meet the minimum hospital volume standard for the procedure, and - The hospital does not include the minimum annual surgeon volume standard in its privileging process.
Does Not Apply	The hospital does not perform the procedure or is a pediatric facility.
Declined to Respond	The hospital did not respond to the questions in this section of the Survey or did not Submit a Survey.
Pending Leapfrog Verification	The hospital's responses are undergoing Leapfrog's standard verification process.

2025 Leapfrog Hospital Survey**Sect. 3 – Adult and Pediatric Complex Surgery
Scoring Algorithms****For mitral valve repair and replacement:**

Hospitals that perform mitral valve repair and replacements and have a Mitral Valve Repair/Replacement Composite Score publicly reported on the STS website will be scored using four criteria: total hospital volume, whether their surgeon privileging process incorporates Leapfrog's minimum annual surgeon volume standards, participation in The Society of Thoracic Surgeons' (STS) Adult Cardiac Surgery Database (ACSD), and outcomes from the STS ACSD.

First, hospitals are assigned points based on whether they meet each of the four criteria:

Mitral Valve Repair and Replacement Criteria	Leapfrog's Standard	Points Assigned
The hospital met the minimum hospital volume standard	Hospital has experience with 40 cases per year.	• 50 points, if met • 0 points, if not met
The hospital's process for privileging surgeons includes meeting or exceeding the minimum annual surgeon volume standard	Hospital's privileging process requires a surgeon to have experience with at least 20 cases per year.	• 25 points, if met • 0 points, if not met
The hospital participates in the Society of Thoracic Surgeons (STS) Adult Cardiac Surgery Database (ACSD)	Hospital participates in STS ACSD.	• 25 points, if participates • 0 points, if does not participate
The hospital's Mitral Valve Repair/Replacement Composite Score	The hospital's performance on the publicly reported STS mitral valve repair/replacement composite score that looks at both mortality and absence of mortality.	• 75 points for 3 Stars • 25 points for 2 Stars OR did not meet the data completeness requirement • 0 points for 1 star OR did not publicly report performance

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

Mitral Valve Repair and Replacement Score (Performance Category)	Meaning that the hospital earned...
Achieved the Standard	100 or more points
Considerable Achievement	75 points
Some Achievement	50 points
Limited Achievement	25 or fewer points
Does Not Apply	The hospital does not perform the procedure or is a pediatric facility.
Declined to Respond	The hospital did not respond to the questions in this section of the Survey or did not submit a Survey.
Pending Leapfrog Verification	The hospital's responses are undergoing Leapfrog's standard verification process.

2025 Leapfrog Hospital Survey**Sect. 3 – Adult and Pediatric Complex Surgery
Scoring Algorithms****For the Norwood procedure:**

Hospitals that perform the Norwood procedure will be scored using three criteria: total hospital volume, whether their surgeon privileging process incorporates Leapfrog's minimum annual surgeon volume standards, and participation in The Society of Thoracic Surgeons' (STS) Congenital Heart Surgery Database (CHSD).

First, hospitals are assigned points based on whether they meet each of the three criteria:

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

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

Norwood Procedure Score (Performance Category)	Meaning that the hospital earned...
Achieved the Standard	100 or more points
Considerable Achievement	75 points
Some Achievement	50 points
Limited Achievement	25 or fewer points
Does Not Apply	The hospital does not perform the procedure.
Declined to Respond	The hospital did not respond to the questions in this section of the Survey or did not submit a Survey.
Pending Leapfrog Verification	The hospital's responses are undergoing Leapfrog's standard verification process.

3B: Safe Surgery Checklist for Adult and Pediatric Complex Surgery

Hospitals are scored on their use of a safe surgery checklist and whether all elements of the checklist are verbalized in the presence of the appropriate personnel for every patient undergoing an applicable procedure based on an audit of a sample of patients.

Safe Surgery Checklist Score (Performance Category)	Meaning that...
Achieved the Standard	- The hospital uses a safe surgery checklist on <u>all</u> patients undergoing an applicable procedure, - The checklist includes <u>all</u> safe surgery checklist elements, and these elements were verbalized in the presence of the appropriate personnel (i.e., hospital responded “yes” to questions #3, #4, and #5), - The hospital completed an audit of 15 or 30 patients, as applicable, and documented adherence to the checklist, and - Based on the audit, has documented adherence to the checklist for <u>at least 90%</u> of the patients included in the audit.
Considerable Achievement	- The hospital uses a safe surgery checklist on <u>all</u> patients undergoing an applicable procedure, - The checklist includes <u>all</u> safe surgery checklist elements, and these elements were verbalized in the presence of the appropriate personnel (i.e., hospital responded “yes” to questions #3, #4, and #5), - The hospital completed an audit of 15 or 30 patients, as applicable, and documented adherence to the checklist, and - Based on the audit, has documented adherence to the checklist for <u>at least 75%</u> of the patients included in the audit.
Some Achievement	- The hospital uses a safe surgery checklist on <u>all</u> patients undergoing an applicable procedure, - The checklist includes <u>all</u> safe surgery checklist elements, and these elements were verbalized in the presence of the appropriate personnel (i.e., hospital responded “yes” to questions #3, #4, and #5), - The hospital completed an audit of 15 or 30 patients, as applicable, and documented adherence to the checklist, and - Based on the audit, has documented adherence to the checklist for <u>at least 50%</u> of the patients included in the audit.
Limited Achievement	The hospital responded to the questions in this section, but it does not yet meet the criteria for Some Achievement.
Unable to Calculate Score	The hospital performs fewer than 30 total inpatient procedures under general anesthesia.
Does Not Apply	The hospital does not perform any of the adult or pediatric complex procedures.
Declined to Respond	The hospital did not respond to the questions in this section of the Survey or did not submit a Survey.

2025 Leapfrog Hospital Survey

**Sect. 3 – Adult and Pediatric Complex Surgery
Scoring Algorithms**

Pending Leapfrog Verification	The hospital's responses are undergoing Leapfrog's standard verification process.
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Section 4: 2025 Maternity Care Scoring Algorithms

4A: Maternity Care Volume and Services

Responses to this subsection are not scored but are publicly reported. Leapfrog will report on volume of deliveries, as well as the availability of midwives and doulas, breastfeeding support, vaginal delivery after cesarean section, postpartum tubal ligation, and whether the hospital has a policy in place to limit early elective deliveries.

4B: Cesarean Birth

Hospitals are scored on their nulliparous, term, singleton, vertex (NTSV) cesarean section rate.

NTSV Cesarean Section Score (Performance Category)	Meaning that the hospital's NTSV Cesarean Section Rate is...
Achieved the Standard	$\leq 23.6\%$
Considerable Achievement	$> 23.6\%$ and $\leq 25.2\%$
Some Achievement	$> 25.2\%$ and $\leq 29.5\%$
Limited Achievement	$> 29.5\%$
Unable to Calculate Score	The hospital did not meet the minimum reporting size ($n < 10$).
Does Not Apply	The hospital did not deliver newborns during the reporting period, or the labor and delivery unit is now closed.
Declined to Respond	The hospital did not submit a Survey.
Pending Leapfrog Verification	The hospital's responses are undergoing Leapfrog's standard verification process.

4C: Episiotomy

Hospitals are scored on their rate of episiotomy.

Episiotomy Score (Performance Category)	Meaning that the hospital's Episiotomy Rate is...
Achieved the Standard	$\leq 5\%$
Considerable Achievement	$> 5\%$ and $\leq 10\%$
Some Achievement	$> 10\%$ and $\leq 15\%$
Limited Achievement	$> 15\%$
Unable to Calculate Score	The hospital did not meet the minimum reporting size ($n < 10$).
Does Not Apply	The hospital did not deliver newborns during the reporting period, or the labor and delivery unit is now closed.
Declined to Respond	The hospital did not submit a Survey.
Pending Leapfrog Verification	The hospital's responses are undergoing Leapfrog's standard verification process.

4D: Newborn Bilirubin Screening Prior to Discharge

Hospitals are scored on their adherence to the newborn bilirubin screening prior to discharge clinical guideline.

Newborn Bilirubin Screening Score (Performance Category)	Meaning that...
Achieved the Standard	The hospital met the 90% target for Newborn Bilirubin Screening Prior to Discharge.
Limited Achievement	The hospital did not meet the 90% target for Newborn Bilirubin Screening Prior to Discharge.
Did Not Measure	The hospital reported not collecting data on this measure.
Unable to Calculate Score	The hospital did not meet the minimum reporting size ($n < 10$).
Does Not Apply	The hospital did not deliver newborns during the reporting period, or the labor and delivery unit is now closed.
Declined to Respond	The hospital did not submit a Survey.
Pending Leapfrog Verification	The hospital's responses are undergoing Leapfrog's standard verification process.

4D: Appropriate DVT Prophylaxis in Women Undergoing Cesarean Delivery

Hospitals are scored on their adherence to the appropriate deep vein thrombosis (DVT) prophylaxis in women undergoing cesarean delivery clinical guideline.

DVT Prophylaxis Score (Performance Category)	Meaning that...
Achieved the Standard	The hospital met the 90% target for Appropriate DVT Prophylaxis in Women Undergoing Cesarean Delivery.
Limited Achievement	The hospital did not meet the 90% target for Appropriate DVT Prophylaxis in Women Undergoing Cesarean Delivery.
Did Not Measure	The hospital reported not collecting data on this measure.
Unable to Calculate Score	The hospital did not meet the minimum reporting size (n < 10).
Does Not Apply	The hospital did not deliver newborns during the reporting period, or the labor and delivery unit is now closed.
Declined to Respond	The hospital did not submit a Survey.
Pending Leapfrog Verification	The hospital's responses are undergoing Leapfrog's standard verification process.

4E: High-Risk Deliveries

Hospitals are scored on either (a) their annual volume of very-low birth weight (VLBW) infants **or** (b) their performance on the VON's Death or Morbidity outcome measure.

For hospitals reporting on Volume:

High-Risk Deliveries Score (Performance Category)	Meaning that the hospital's annual volume of very-low birth weight infants is...
Achieved the Standard	>= 50 VLBW infants
Considerable Achievement	25-49 VLBW infants
Some Achievement	10-24 VLBW infants
Limited Achievement	< 10 VLBW infants OR The hospital does not operate a NICU.
Does Not Apply	The hospital does not electively admit high-risk deliveries.
Declined to Respond	The hospital did not report on volume and did not elect to share their VON data with Leapfrog, did not provide a valid VON Transfer Code, or did not submit a Survey.
Pending Leapfrog Verification	The hospital's responses are undergoing Leapfrog's standard verification process.

2025 Leapfrog Hospital Survey**Sect. 4 – Maternity Care Scoring Algorithms****For hospitals reporting on VON's Death or Morbidity Outcome Measure:**

If the **upper bound** of the shrunken standardized mortality ratios (SMR) is less than 1, the center is performing **better than expected**. (e.g., SMR: 0.7; lower bound: 0.3; upper bound: 0.9)

If the **lower bound** of the shrunken SMR is greater than 1, the center is performing **worse than expected**. (e.g., SMR: 1.6; lower bound: 1.2; upper bound: 2.1)

If the **lower and upper bounds include 1**, then the center is performing **as expected**. (e.g., SMR: 1.0; lower bound: 0.8; upper bound: 1.2)

High-Risk Deliveries Score (Performance Category)	Meaning that the hospital's Death or Morbidity standardized ratio is...
Achieved the Standard	Hospital's outcomes are better than expected.
Considerable Achievement	Hospital's outcomes are equal to what is expected.
Limited Achievement	Hospital's outcomes are worse than expected OR The hospital does not operate a NICU.
Does Not Apply	The hospital does not electively admit high-risk deliveries.
Declined to Respond	The hospital did not report on volume and did not elect to share their VON data with Leapfrog, or did not provide a valid VON Transfer Code, or did not submit a Survey.
Pending Leapfrog Verification	The hospital's responses are undergoing Leapfrog's standard verification process.

Section 5: 2025 Physician and Nurse Staffing Scoring Algorithm

5A: Adult ICU Physician Staffing

Hospitals are scored on the staffing structures they have in place to care for adult intensive care patients in adult general medical, surgical, medical/surgical, neuro intensive care units, and in mixed acuity units.

Hospitals with more than one applicable adult ICU, are asked to respond to all questions within the section based on the adult ICU that has the least intensive staffing structure (refer to endnote #14 in the hard copy of the [2025 Leapfrog Hospital Survey](#)).

The term “intensivist” is used to describe physicians who are certified in critical care medicine or who meet Leapfrog’s expanded definition for certified in critical care medicine (refer to endnote #36 in the hard copy of the [2025 Leapfrog Hospital Survey](#)).

Adult ICU Physician Staffing Score (Performance Category)	Meaning that...
Achieved the Standard	The hospital responded “yes” or “not applicable, intensivists are present on-site 24/7” to all the following questions: Question #3: The adult ICU is staffed with physicians either present on-site or via telemedicine who are either certified in critical care medicine or who meet Leapfrog’s expanded definition for certification in critical care medicine. Question #4: All critical care patients in the adult ICU are managed or co-managed by physicians certified in critical care medicine (when present on-site or via telemedicine). Question #5 or #6: One or more intensivists are: - Ordinarily present on-site in the adult ICU during daytime hours for at least eight hours per day, seven days per week, providing clinical care exclusively in the ICU during these hours. - Present via telemedicine, in combination with on-site intensivist coverage, for a total of 24 hours per day, 7 days per week; meet all of Leapfrog’s ICU requirements for intensivist presence in the ICU via telemedicine; and supported by an on-site intensivist who establishes and revises the daily care plan for each ICU patient. Question #7: When physicians (from question #3) are not present (on-site or via telemedicine) in the adult ICU, one of them returns more than 95% of calls/pages/texts from these units within five minutes. Question #8: When physicians (from question #3) are not present (on-site or via telemedicine) in the adult ICU or not able to physically reach an ICU patient within five minutes, another physician, physician assistant, nurse practitioner, or FCCS-certified nurse “effector” is on-site at the hospital and able to reach ICU patients within five minutes in more than 95% of the cases.

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Adult ICU Physician Staffing Score (Performance Category)	Meaning that...
	Note: When telemedicine is employed as a substitute for on-site intensivist coverage, it must meet all 10 requirements detailed in endnote #38 (in the hard copy of the Survey), which includes some on-site intensivist time to manage the ICU patients' admissions, discharges, and care planning.
Considerable Achievement	The hospital responded "yes" or "clinical pharmacist rounds seven days per week" to all the following questions: • Question #3: The adult ICU is staffed with physicians either present on-site or via telemedicine who are either certified in critical care medicine or meet Leapfrog's expanded definition for certification in critical care medicine. • Question #4: All critical care patients in the adult ICU are managed or co-managed by physicians certified in critical care medicine (when present on-site or via telemedicine). • Question #9 or #13: ○ One or more intensivists are ordinarily present in the adult ICU during daytime hours for at least eight hours per day, four days per week, OR four hours per day, seven days per week; providing clinical care exclusively in the adult ICU during these hours. ○ An on-site clinical pharmacist makes daily rounds on all critical care patients in the adult ICU at least five days/week, and on the other two days/week, a clinical pharmacist returns more than 95% of calls/pages/texts from the unit within five minutes; OR the on-site clinical pharmacist rounds on all critical care patients in the adult ICU seven days per week. • Question #14 or #15: ○ An intensivist leads daily, interprofessional rounds on-site on all critical care patients in the adult ICU seven days per week. ○ When intensivists are on-site in the adult ICU, for at least eight hours per day, four days per week OR four hours per day, seven days a week, they make all admission and discharge decisions.
Considerable Achievement (alternative)	The hospital responded "yes" to all the following questions: • Question #3: The adult ICU is staffed with physicians either present on-site or via telemedicine who are either certified in critical care medicine or meet Leapfrog's expanded definition for certification in critical care medicine. • Question #4: All critical care patients in the adult ICU are managed or co-managed by physicians certified in critical care medicine (when present on-site or via telemedicine). • Question #10: One or more intensivists are present via telemedicine 24 hours per day, 7 days per week, meet all of Leapfrog's modified adult ICU requirements, with on-site care planning done by an intensivist, hospitalist, anesthesiologist, or a physician trained in emergency medicine.

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Adult ICU Physician Staffing Score (Performance Category)	Meaning that...
	Note: When telemedicine is employed as a substitute for on-site intensivist coverage, it must meet all 9 requirements detailed in endnote #43 (in the hard copy of the Survey).
Some Achievement	The hospital responded “yes” to <u>all</u> the following questions: • Question #3: The adult ICU is staffed with physicians either present on-site or via telemedicine who are either certified in critical care medicine or meet Leapfrog’s expanded definition for certification in critical care medicine. • Question #4: All critical care patients in the adult ICU are managed or co-managed by physicians certified in critical care medicine (when present on-site or via telemedicine). • Question #11: One or more intensivists are present on-site at least four days per week to establish or revise daily care plans for all critical care patients. • Question #14 or #15: ○ An intensivist leads daily, interprofessional rounds on-site on all critical care patients in the adult ICU seven days per week. ○ When intensivists are on-site in the adult ICU, at least eight hours per day, four days per week OR four hours per day, seven days a week, they make all admission and discharge decisions. Or the hospital responded “yes” to <u>all</u> the following questions: • Question #12: If not all, at least <u>some</u> critical care patients are managed or co-managed by physicians who are certified in critical care medicine, either on-site or via telemedicine for at least eight hours per day, four days per week OR four hours per day, seven days per week. • Question #14 or #15: ○ An intensivist leads daily, interprofessional rounds on-site on all critical care patients in the adult ICU seven days per week. ○ When intensivist are on-site in the adult ICU, at least eight hours per day, four days per week OR four hours per day, seven days a week, they make all admissions and discharge decisions. Note: When telemedicine is employed as a substitute for on-site intensivist coverage, it must meet all 10 requirements detailed in endnote #38 (in the hard copy of the Survey).
Limited Achievement	The hospital responded to all the questions in this section, but it does not yet meet the criteria for Some Achievement.
Does Not Apply	The hospital does not operate an adult general medical, surgical, medical/surgical, or neuro intensive care unit or does not regularly admit adult critical care patients to mixed acuity units.

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Adult ICU Physician Staffing Score (Performance Category)	Meaning that...
Declined to Respond	The hospital did not submit a Survey.
Pending Leapfrog Verification	The hospital’s responses are undergoing Leapfrog’s standard verification process.

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Hospitals are scored on the staffing structures they have in place to care for pediatric intensive care patients in pediatric general medical, surgical, medical/surgical, neuro intensive care units, and in mixed acuity units.

Hospitals with more than one applicable pediatric ICU, are asked to respond to all questions within the section based on the pediatric ICU that has the least intensive staffing structure (refer to endnote #14 in the hard copy of the [2025 Leapfrog Hospital Survey](#)).

The term “intensivist” is used to describe physicians who are certified in critical care medicine or who meet Leapfrog’s expanded definition for certified in critical care medicine (refer to endnote #36 in the hard copy of the [2025 Leapfrog Hospital Survey](#)).

Pediatric ICU Physician Staffing Score (Performance Category)	Meaning that...
Achieved the Standard	The hospital responded “yes” or “not applicable, intensivists are present on-site 24/7” to <u>all</u> the following questions: • Question #3: The pediatric ICU is staffed with physicians either present on-site or via telemedicine who are either certified in critical care medicine or who meet Leapfrog’s expanded definition for certification in critical care medicine. • Question #4: All critical care patients in the pediatric ICU are managed or co-managed by physicians certified in critical care medicine (when present on-site or via telemedicine). • Question #5 or #6: One or more intensivists are: ○ Ordinarily present on-site in the pediatric ICU during daytime hours for at least eight hours per day, seven days per week, providing clinical care exclusively in the ICU during these hours. ○ Present via telemedicine, in combination with on-site intensivist coverage, for a total of 24 hours per day, 7 days per week; meet all of Leapfrog’s ICU requirements for intensivist presence in the ICU via telemedicine; and supported by an on-site intensivist who establishes and revises the daily care plan for each ICU patient. • Question #7: When physicians (from question #3) are not present (on-site or via telemedicine) in the pediatric ICU, one of them returns more than 95% of calls/pages/texts from these units within five minutes. • Question #8: When physicians (from question #3) are not present (on-site or via telemedicine) in the pediatric ICU or not able to physically reach an ICU patient within five minutes, another physician, physician assistant, nurse practitioner, or FCCS-certified nurse “effector” is on-site at the hospital and able to reach ICU patients within five minutes in more than 95% of the cases. Note: When telemedicine is employed as a substitute for on-site intensivist coverage, it must meet all 10 requirements detailed in endnote #38 (in the hard

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Pediatric ICU Physician Staffing Score (Performance Category)	Meaning that...
	copy of the Survey), which includes some on-site intensivist time to manage the ICU patients' admissions, discharges, and care planning.
Considerable Achievement	The hospital responded "yes" or "clinical pharmacist rounds seven days per week" to <u>all</u> the following questions: • Question #3: The pediatric ICU is staffed with physicians either present on-site or via telemedicine who are either certified in critical care medicine or meet Leapfrog's expanded definition for certification in critical care medicine. • Question #4: All critical care patients in the pediatric ICU are managed or co-managed by physicians certified in critical care medicine (when present on-site or via telemedicine). • Question #9 or #13: ○ One or more intensivists are ordinarily present in the pediatric ICU during daytime hours for at least eight hours per day, four days per week, OR four hours per day, seven days per week; providing clinical care exclusively in the pediatric ICU during these hours. ○ An on-site clinical pharmacist makes daily rounds on all critical care patients in the pediatric ICU at least five days/week, and on the other two days/week, a clinical pharmacist returns more than 95% of calls/pages/texts from the unit within five minutes; OR the on-site clinical pharmacist rounds on all critical care patients in the pediatric ICU seven days per week. • Question #14 or #15: ○ An intensivist leads daily, interprofessional rounds on-site on all critical care patients in the pediatric ICU seven days per week. ○ When intensivists are on-site in the pediatric ICU, for at least eight hours per day, four days per week OR four hours per day, seven days a week, they make all admission and discharge decisions.
Considerable Achievement (alternative)	The hospital responded "yes" to <u>all</u> the following questions: • Question #3: The pediatric ICU is staffed with physicians either present on-site or via telemedicine who are either certified in critical care medicine or meet Leapfrog's expanded definition for certification in critical care medicine. • Question #4: All critical care patients in the pediatric ICU are managed or co-managed by physicians certified in critical care medicine (when present on-site or via telemedicine). • Question #10: One or more intensivists are present via telemedicine 24 hours per day, 7 days per week, meet all of Leapfrog's modified pediatric ICU requirements, with on-site care planning done by an intensivist, hospitalist, anesthesiologist, or a physician trained in emergency medicine.

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Pediatric ICU Physician Staffing Score (Performance Category)	Meaning that...
	Note: When telemedicine is employed as a substitute for on-site intensivist coverage, it must meet all 9 requirements detailed in endnote #43 (in the hard copy of the Survey).
Some Achievement	The hospital responded “yes” to all the following questions: • Question #3: The pediatric ICU is staffed with physicians either present on-site or via telemedicine who are either certified in critical care medicine or meet Leapfrog’s expanded definition for certification in critical care medicine. • Question #4: All critical care patients in the pediatric ICU are managed or co-managed by physicians certified in critical care medicine (when present on-site or via telemedicine). • Question #11: One or more intensivists are present on-site at least four days per week to establish or revise daily care plans for all critical care patients. • Question #14 or #15: ○ An intensivist leads daily, interprofessional rounds on-site on all critical care patients in the pediatric ICU seven days per week. ○ When intensivists are on-site in the pediatric ICU, at least eight hours per day, four days per week OR four hours per day, seven days a week, they make all admission and discharge decisions. Or the hospital responded “yes” to all the following questions: • Question #12: If not all, at least <u>some</u> critical care patients are managed or co-managed by physicians who are certified in critical care medicine, either on-site or via telemedicine for at least eight hours per day, four days per week OR four hours per day, seven days per week. • Question #14 or #15: ○ An intensivist leads daily, interprofessional rounds on-site on all critical care patients in the pediatric ICU seven days per week. ○ When intensivist are on-site in the pediatric ICU, at least eight hours per day, four days per week OR four hours per day, seven days a week, they make all admissions and discharge decisions. Note: When telemedicine is employed as a substitute for on-site intensivist coverage, it must meet all 10 requirements detailed in endnote #38 (in the hard copy of the Survey).
Limited Achievement	The hospital responded to all the questions in this section, but it does not yet meet the criteria for Some Achievement.
Does Not Apply	The hospital does not operate an adult general medical, surgical, medical/surgical, or neuro intensive care unit or does not regularly admit adult critical care patients to mixed acuity units.
Declined to Respond	The hospital did not submit a Survey.

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Pediatric ICU Physician Staffing Score (Performance Category)	Meaning that...
Pending Leapfrog Verification	The hospital’s responses are undergoing Leapfrog’s standard verification process.

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5C: Nursing Workforce

Total Nursing Care Hours per Patient Day

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

ONLY hospitals that do not operate any single acuity adult or pediatric medical, surgical, or med-surg units are asked to report on their mixed acuity units.

See [Appendix II](#) for an example of these calculations.

To calculate the 50th, 25th, and 10th percentiles used in scoring, hospitals reporting on single acuity units are placed into one of five cohorts based on the teaching designation reported on their 2024 Patient Safety Component - Annual Hospital Survey in NHSN, the number of staffed beds reported in Section 1A Basic Hospital Information of the 2025 Leapfrog Hospital Survey, and the hospital type (pediatric or CAH).

Cohorts for hospitals that operate at least one adult or pediatric single acuity medical, surgical, or med-surg unit:

1. Small Teaching (< 500 staffed beds)
2. Large Teaching (>= 500 staffed beds)
3. Non-teaching (includes hospitals that do not join Leapfrog's NHSN Group)
4. Pediatric
5. Critical access hospital

Hospitals reporting on mixed acuity units are placed into a single cohort.

Cohort for hospitals that only operate adult or pediatric mixed acuity medical, surgical, or med-surg unit(s):

6. Mixed acuity units

For the purposes of scoring, hospitals are only compared to other hospitals within the same cohort.

The percentiles for cohorts 1-5 were calculated based on the responses from 2023 Leapfrog Hospital Surveys submitted as of June 30, 2023. Percentiles for cohort 6 were calculated based on the responses from submitted 2024 Leapfrog Hospital Surveys as of June 30, 2024. These cut-points will remain in place for the entire Survey Cycle, unless it is determined that there are compelling reasons to make revisions.

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Total Nursing Care Hours per Patient Day	Single Acuity Units					Mixed Acuity Units
	Small Teaching Hospitals	Large Teaching Hospitals	Non-Teaching Hospitals	Pediatric Hospitals	CAH Hospitals	
50 th percentile	9.04	9.14	9.56	10.38	10.38	9.94
25 th percentile	7.88	8.18	8.13	9.42	8.68	8.63
10 th percentile	6.86	7.57	6.93	8.52	6.48	6.78

Total Nursing Care Hours per Patient Day Score (Performance Category)	Meaning that...
Achieved the Standard	The hospital's total nursing care hours per patient day is <u>greater than or equal to the 50th percentile</u> (where higher is better) for that hospital's cohort (small teaching, large teaching, non-teaching, pediatric, critical access hospital, or mixed acuity units).
Considerable Achievement	The hospital's total nursing care hours per patient day <u>is less than the 50th percentile but greater than or equal to the 25th percentile</u> (where higher is better) for that hospital's cohort (small teaching, large teaching, non-teaching, pediatric, critical access hospital, or mixed acuity units).
Some Achievement	The hospital's total nursing care hours per patient day is <u>less than the 25th percentile but greater than or equal to the 10th percentile</u> (where higher is better) for that hospital's cohort (small teaching, large teaching, non-teaching, pediatric, critical access hospital, or mixed acuity units).
Some Achievement (alternative)	The hospital's total nursing care hours per patient day is <u>less than the 10th percentile</u> (where higher is better) for that hospital's cohort (small teaching, large teaching, non-teaching, pediatric, critical access hospital, or mixed acuity units). AND The hospital responded "yes" to all five elements of the National Quality Forum (NQF) Safe Practice #9 – Nursing Workforce, or the hospital is currently recognized as an American Nurses Credentialing Center (ANCC) Magnet® organization, or the hospital is currently recognized as a 2020 or 2024 Pathway to Excellence® organization.

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Limited Achievement	The hospital's total nursing care hours per patient day is less than the 10th percentile (where higher is better) for that hospital's cohort (small teaching, large teaching, non-teaching, pediatric, critical access hospital, or mixed acuity units).
Did Not Measure	The hospital reported not collecting data on this measure.
Unable to Calculate Score	The hospital operates single or mixed acuity Medical, Surgical, or Med-Surg units, but all applicable units had fewer than 15 patient days per month for all 3 months of any quarter of the reporting period.
Does Not Apply	The hospital does not operate any single or mixed acuity Medical, Surgical, or Med-Surg Units.
Declined to Respond	The hospital did not submit a Survey.
Pending Leapfrog Verification	The hospital's responses are undergoing Leapfrog's standard verification process.

RN Hours per Patient Day

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

ONLY hospitals that do not operate any single acuity adult or pediatric medical, surgical, or med-surg units are asked to report on their mixed acuity units.

See [Appendix II](#) for an example of these calculations.

To calculate the 50th, 25th, and 10th percentiles used in scoring, hospitals reporting on single acuity units are placed into one of five cohorts based on the teaching designation reported on their 2024 Patient Safety Component - Annual Hospital Survey in NHSN, the number of staffed beds reported in Section 1A Basic Hospital Information of the 2025 Leapfrog Hospital Survey, and the hospital type (pediatric or CAH).

Cohorts for hospitals that operate at least one adult or pediatric single acuity medical, surgical, or med-surg unit:

1. Small Teaching (< 500 staffed beds)
2. Large Teaching (>= 500 staffed beds)
3. Non-teaching (includes hospitals that do not join Leapfrog's NHSN Group)
4. Pediatric
5. Critical access hospital

Hospitals reporting on mixed acuity units are placed into a single cohort.

Cohort for hospitals that only operate adult or pediatric mixed acuity medical, surgical, or med-surg unit(s):

6. Mixed acuity units

For the purposes of scoring, hospitals are only compared to other hospitals within the same cohort.

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The percentiles for cohorts 1-5 were calculated based on the responses from 2023 Leapfrog Hospital Surveys submitted as of June 30, 2023. Percentiles for cohort 6 were calculated based on the responses from submitted 2024 Leapfrog Hospital Surveys as of June 30, 2024. These cut-points will remain in place for the entire Survey Cycle, unless it is determined that there are compelling reasons to make revisions.

RN Hours per Patient Day	Single Acuity Units					Mixed Acuity Units
	Small Teaching Hospitals	Large Teaching Hospitals	Non-Teaching Hospitals	Pediatric Hospitals	CAH Hospitals	
50th percentile	6.03	6.16	6.30	8.84	6.63	6.62
25th percentile	5.10	5.47	5.25	8.05	4.89	5.26
10th percentile	4.26	4.85	3.77	6.54	4.30	4.01

RN Hours per Patient Day Score (Performance Category)	Meaning that...
Achieved the Standard	The hospital's RN hours per patient day is <u>greater than or equal to the 50th percentile</u> (where higher is better) for that hospital's cohort (small teaching, large teaching, non-teaching, pediatric, critical access hospital, or mixed acuity units).
Considerable Achievement	The hospital's RN hours per patient day is <u>less than the 50th percentile but greater than or equal to the 25th percentile</u> (where higher is better) for that hospital's cohort (small teaching, large teaching, non-teaching, pediatric, critical access hospital, or mixed acuity units).
Some Achievement	The hospital's RN hours per patient day is <u>is less than the 25th percentile but greater than or equal to the 10th percentile</u> (where higher is better) for that hospital's cohort (small teaching, large teaching, non-teaching, pediatric, critical access hospital, or mixed acuity units).

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Some Achievement (alternative)	The hospital's RN hours per patient day is <u>less than the 10th percentile</u> (where higher is better) for that hospital's cohort (small teaching, large teaching, non-teaching, pediatric, critical access hospital, or mixed acuity units). AND The hospital responded “yes” to all five elements of the National Quality Forum (NQF) Safe Practice #9 – Nursing Workforce, or the hospital is currently recognized as an American Nurses Credentialing Center (ANCC) Magnet® organization, or the hospital is currently recognized as a 2020 or 2024 Pathway to Excellence® organization.
Limited Achievement	The hospital's RN hours per patient day is <u>less than the 10th percentile</u> (where higher is better) for that hospital's cohort (small teaching, large teaching, non-teaching, pediatric, critical access hospital, or mixed acuity units).
Did Not Measure	The hospital reported not collecting data on this measure.
Unable to Calculate Score	The hospital operates single or mixed acuity Medical, Surgical, or Med-Surg units, but all applicable units had fewer than 15 patient days per month for all 3 months of any quarter of the reporting period.
Does Not Apply	The hospital does not operate any single or mixed acuity Medical, Surgical, or Med-Surg Units.
Declined to Respond	The hospital did not submit a Survey.
Pending Leapfrog Verification	The hospital's responses are undergoing Leapfrog's standard verification process.

Nursing Skill Mix

A hospital's performance on the **Nursing Skill Mix** measure is calculated by adding together the “Total number of productive hours worked by RN nursing staff with direct patient care responsibilities” across all unit types (either single or mixed acuity medical, surgical, and med-surg) and all four quarters, and then dividing by the sum of the “Total number of productive hours worked by employed and contracted nursing staff with direct patient care responsibilities” across all unit types (either single or mixed acuity medical, surgical, and med-surg) and all four quarters. The result is the percentage of total productive nursing hours worked by RN (employed and contracted) nursing staff with direct patient care responsibilities in all applicable units.

ONLY hospitals that do not operate any single acuity adult or pediatric medical, surgical, or med-surg units are asked to report on their mixed acuity units.

To calculate the 50th, 25th, and 10th percentiles used in scoring, hospitals reporting on single acuity units are placed into one of five cohorts based on the teaching designation reported on their 2024 Patient Safety Component - Annual Hospital Survey in NHSN, the number of staffed beds reported in Section 1A Basic Hospital Information of the 2025 Leapfrog Hospital Survey, and the hospital type (pediatric or CAH).

Cohorts for hospitals that operate at least one adult or pediatric single acuity medical, surgical, or med-surg unit:

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1. Small Teaching (< 500 staffed beds)
2. Large Teaching (>= 500 staffed beds)
3. Non-teaching (includes hospitals that do not join Leapfrog's NHSN Group)
4. Pediatric
5. Critical access hospital

Hospitals reporting on mixed acuity units are placed into a single cohort.

Cohort for hospitals that only operate adult or pediatric mixed acuity medical, surgical, or med-surg unit(s):

6. Mixed acuity units

For the purposes of scoring, hospitals are only compared to other hospitals within the same cohort.

The percentiles for cohorts 1-5 were calculated based on the responses from 2023 Leapfrog Hospital Surveys submitted as of June 30, 2023. Percentiles for cohort 6 were calculated based on the responses from 2024 Leapfrog Hospital Surveys as of June 30, 2024. These cut-points will remain in place for the entire Survey Cycle, unless it is determined that there are compelling reasons to make revisions.

Nursing Skill Mix	Single Acuity Units					Mixed Acuity Units
	Small Teaching Hospitals	Large Teaching Hospitals	Non-Teaching Hospitals	Pediatric Hospitals	CAH Hospitals	
50th percentile	67.75%	69.10%	67.64%	80.53%	66.36%	68.17%
25th percentile	62.23%	63.00%	60.31%	73.38%	55.94%	59.07%
10th percentile	54.73%	58.26%	52.74%	62.38%	52.89%	47.84%

Nursing Staffing and Skill Mix Score (Performance Category)	Meaning that...
Achieved the Standard	The hospital's percentage of total productive nursing hours worked by RN nursing staff is greater than or equal to the 50th percentile (where higher is better) for that hospital's cohort (small teaching, large teaching, non-teaching, pediatric, critical access hospital, or mixed acuity units).
Considerable Achievement	The hospital's percentage of total productive nursing hours worked by RN nursing staff is less than the 50th percentile but greater than or equal to the 25th percentile (where higher is better) for that hospital's cohort (small teaching, large teaching, non-teaching, pediatric, critical access hospital, or mixed acuity units).
Some Achievement	The hospital's percentage of total productive nursing hours worked by RN nursing staff is less than the 25th percentile but greater than or equal to the 10th percentile (where higher is better) for that hospital's cohort (small teaching, large teaching, non-teaching, pediatric, critical access hospital, or mixed acuity units).

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Some Achievement (alternative)	The hospital's percentage of total productive nursing hours worked by RN nursing staff is less than the 10th percentile (where higher is better) for that hospital's cohort (small teaching, large teaching, non-teaching, pediatric, critical access hospital, or mixed acuity units). AND The hospital responded "yes" to all five elements of the National Quality Forum (NQF) Safe Practice #9 – Nursing Workforce, or the hospital is currently recognized as an American Nurses Credentialing Center (ANCC) Magnet® organization, or the hospital is currently recognized as a 2020 or 2024 Pathway to Excellence® organization.
Limited Achievement	The hospital's percentage of total productive nursing hours worked by RN nursing staff is less than the 10th percentile (where higher is better) for that hospital's cohort (small teaching, large teaching, non-teaching, pediatric, critical access hospital, or mixed acuity units).
Did Not Measure	The hospital reported not collecting data on this measure.
Unable to Calculate Score	The hospital operates single or mixed acuity Medical, Surgical, or Med-Surg units, but all applicable units had fewer than 15 patient days per month for all 3 months of any quarter of the reporting period.
Does Not Apply	The hospital does not operate any single or mixed acuity Medical, Surgical, or Med-Surg Units.
Declined to Respond	The hospital did not submit a Survey.
Pending Leapfrog Verification	The hospital's responses are undergoing Leapfrog's standard verification process.

Percentage of RNs who are BSN-Prepared

Hospitals are scored on the percentage of RNs who are BSN-prepared.

Percentage of RNs who are BSN-prepared Score (Performance Category)	Meaning that the hospital's percentage of BSN-prepared RNs is...
Achieved the Standard	$\geq 80\%$
Considerable Achievement	$\geq 50\%$ and $< 80\%$
Some Achievement	$\geq 20\%$ and $< 50\%$
Limited Achievement	$< 20\%$
Did Not Measure	The hospital reported not collecting data on this measure.
Declined to Respond	The hospital did not submit a Survey.

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Pending Leapfrog Verification	The hospital's responses are undergoing Leapfrog's standard verification process.
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Section 6: 2025 Patient Safety Practices Scoring Algorithms

6A: NQF Safe Practice #1 – Culture of Safety Leadership Structures and Systems

Hospitals are scored on their progress in implementing elements of the National Quality Forum's (NQF) Safe Practice #1 – Culture of Safety Leadership Structures and Systems.

NQF Safe Practice #1 Score (Performance Category)	Meaning the hospital earned...
Achieved the Standard	100% of Points
Considerable Achievement	80% to 99% of Points
Some Achievement	50% to 79% of Points
Limited Achievement	0% to 49% of Points
Declined to Respond	The hospital did not submit a Survey.
Pending Leapfrog Verification	The hospital's responses are undergoing Leapfrog's standard verification process.

Scoring details are described below.

- 1. Maximum Points:** NQF Safe Practice #1 – Culture of Safety Leadership Structures and Systems has a maximum number of points of 120.
- 2. Point Values per Safe Practice Element:** Each question has an equal point value, computed as the Maximum Points for this NQF Safe Practice divided by the number of elements within this NQF Safe Practice (n=13).
- 3. Points Earned:** Total points earned for this NQF Safe Practice is the sum of the elements for which the hospital responded “yes” for this NQF Safe Practice.
- 4. Performance Category Cut Points** are based on a percentage of the Maximum Points achievable for this NQF Safe Practice. The distribution of scores, including new or updated Survey Results, will be reviewed periodically to determine if there are compelling reasons to revise these performance categories cut points further. However, there are no current plans or commitments to change the cut-points during the 2025 Survey Cycle.
- 5. Updated Submissions:** Hospitals may update and resubmit their Surveys as often as needed to reflect actual progress achieved or additional commitments undertaken in these patient safety areas up until **November 30**. Updates made to reflect a change in performance after November 30 will not be scored or publicly reported.

6B: NQF Safe Practice #2 – Culture Measurement, Feedback, and Intervention

Hospitals are scored on their progress in implementing elements of the National Quality Forum's (NQF) Safe Practice #2 – Culture Measurement, Feedback, and Intervention.

NQF Safe Practice #2 Score (Performance Category)	Meaning the hospital earned...
Achieved the Standard	100% of Points
Considerable Achievement	80% to 99% of Points
Some Achievement	50% to 79% of Points
Limited Achievement	0% to 49% of Points
Declined to Respond	The hospital did not submit a Survey.
Pending Leapfrog Verification	The hospital's responses are undergoing Leapfrog's standard verification process.

Scoring details are described below.

- 1. Maximum Points:** NQF Safe Practice #2 - Culture Measurement, Feedback, and Intervention has a maximum number of points of 120.
- 2. Point Values per Safe Practice Element:** Each question has an equal point value, computed as the Maximum Points for this NQF Safe Practice divided by the number of elements within this NQF Safe Practice (n=12).
- 3. Points Earned:** Total points earned for this NQF Safe Practice is the sum of the elements for which the hospital responded "yes" for this NQF Safe Practice.
- 4. Performance Category Cut Points** are based on a percentage of the Maximum Points achievable for this NQF Safe Practice. The distribution of scores, including new or updated Survey Results, will be reviewed periodically to determine if there are compelling reasons to revise these performance categories cut points further. However, there are no current plans or commitments to change the cut-points during the 2025 Survey Cycle.
- 6. Updated Submissions:** Hospitals may update and resubmit their Surveys as often as needed to reflect actual progress achieved or additional commitments undertaken in these patient safety areas up until **November 30**. Updates made to reflect a change in performance after November 30 will not be scored or publicly reported.

6C: Hand Hygiene

Hospitals are scored on their performance in five domains of hand hygiene. To meet the requirements of each domain, the hospital must respond in the affirmative to all applicable questions.

1. Monitoring: questions #8-11
 - a. Electronic: questions #12-13
 - b. Direct Observation: questions #14-15
2. Feedback*: questions #16-19
3. Training and Education: questions #1-3
4. Infrastructure: questions #4-7
5. Culture: questions #20-21

*Hospitals must respond “yes” to question #8, #9, or #10 in the Monitoring Domain to access the questions in the Feedback Domain.

Hand Hygiene Score (Performance Category)	Meaning that...
Achieved the Standard	The hospital responded “yes” to all applicable questions in the Monitoring and Feedback Domains and meets the monthly sample size of 200 hand hygiene opportunities, or at least the number of hand hygiene opportunities outlined based on the unit type in Tables 1-3 of the 2025 Hospital Survey (measure specifications, Section 6), for monitoring hand hygiene opportunities, each month in each patient care unit: • Monitoring Domain: ○ Question #8: Hospital collects hand hygiene compliance data on at least 200 hand hygiene opportunities, or at least the number of hand hygiene opportunities outlined based on the unit type in Tables 1-3 of the 2025 Hospital Survey (measure specifications, Section 6), each month in each patient care unit. ○ Question #11: Hospital uses hand hygiene coaches or compliance observers to provide individuals who touch patients or who touch items that will be used by patients with feedback on both when they are and are not compliant with performing hand hygiene. ○ The hospital responded “yes” to all questions pertaining to the monitoring method used (as indicated in question #8): ▪ <i>Electronic Compliance Monitoring</i>: questions #12-13 ▪ <i>Direct Observation</i>: questions #14-15 • Feedback Domain: questions #16-19 <u>AND</u> The hospital responded “yes” to all questions in any two of the following domains: • Training and Education Domain: questions #1-3 • Infrastructure Domain: questions #4-7 • Culture Domain: questions #20-21

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Hand Hygiene Score (Performance Category)	Meaning that...
Achieved the Standard (alternative)	Hospitals that collect hand hygiene compliance data on a monthly sample size of 100 hand hygiene opportunities per unit per month, or at least the number of hand hygiene opportunities outlined based on the unit type in Tables 4-6 of the 2025 Hospital Survey (measure specifications, Section 6), can achieve the standard if they meet the following: • Monitoring Domain: ○ Question #9: Hospital collects hand hygiene compliance data on at least 100 hand hygiene opportunities, or at least the number of hand hygiene opportunities outlined based on the unit type in Tables 4-6 of the 2025 Hospital Survey (measure specifications, Section 6), each month in each patient care unit. ○ Question #11: Hospital uses hand hygiene coaches or compliance observers to provide individuals who touch patients or who touch items that will be used by patients with feedback on both when they are and are not compliant with performing hand hygiene. ○ The hospital responded “yes” to all questions pertaining to the monitoring method used (as indicated in question #9): ▪ <i>Electronic Compliance Monitoring:</i> questions #12-13 ▪ <i>Direct Observation:</i> questions #14-15 <u>AND</u> The hospital responded “yes” to all questions in the other four domains: • Feedback Domain: questions #16-19 • Training and Education Domain: questions #1-3 • Infrastructure Domain: questions #4-7 • Culture Domain: questions #20-21
Considerable Achievement	The hospital responded “yes” to all applicable questions in the Monitoring and Feedback Domains and meets the monthly or quarterly sample size of 100 for monitoring hand hygiene opportunities, each month or quarter in each patient care unit: • Monitoring Domain: ○ Question #9 or #10: ▪ Hospital collects hand hygiene compliance data on at least 100 hand hygiene opportunities, or at least the number of hand hygiene opportunities outlined based on the unit type in Tables 4-6 of the 2025 Hospital Survey (measure specifications, Section 6), each month in each patient care unit. ▪ Hospital collects hand hygiene compliance data on at least 100 hand hygiene opportunities each quarter in each patient care unit. ○ Question #11: Hospital uses hand hygiene coaches or compliance observers to provide individuals who touch patients or who touch items that will be used by patients with feedback on both when they are and are not compliant with performing hand hygiene. ○ The hospital responded “yes” to all questions pertaining to the monitoring method used (as indicated in question #10):

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Hand Hygiene Score (Performance Category)	Meaning that...
	▪ <i>Electronic Compliance Monitoring</i>: questions #12-13 ▪ <i>Direct Observation</i>: questions #14-15 • Feedback Domain: questions #16-19 <u>AND</u> The hospital responded “yes” to <u>all</u> questions in any two of the following domains: • Training and Education Domain: questions #1-3 • Infrastructure Domain: questions #4-7 • Culture Domain: questions #20-21
Some Achievement	The hospital responded “yes” to <u>all</u> applicable questions in any two of the following domains: • Monitoring Domain: ○ Question #8, #9, or #10: ▪ Hospital collects hand hygiene compliance data on at least 200 hand hygiene opportunities, or at least the number of hand hygiene opportunities outlined based on the unit type in Tables 1-3 of the 2025 Hospital Survey (measure specifications, Section 6), each month in each patient care unit. ▪ Hospital collects hand hygiene compliance data on at least 100 hand hygiene opportunities, or at least the number of hand hygiene opportunities outlined based on the unit type in Tables 4-6 of the 2025 Hospital Survey (measure specifications, Section 6), each month in each patient care unit. ▪ Hospital collects hand hygiene compliance data on at least 100 hand hygiene opportunities each quarter in each patient care unit. ○ Question #11: Hospital uses hand hygiene coaches or compliance observers to provide individuals who touch patients or who touch items that will be used by patients with feedback on both when they are and are not compliant with performing hand hygiene. ○ The hospital responded “yes” to all questions pertaining to the monitoring method used (as indicated in question #8, #9, or #10): ▪ <i>Electronic Compliance Monitoring</i>: questions #12-13 ▪ <i>Direct Observation</i>: questions #14-15 • Feedback Domain: questions #16-19 • Training and Education Domain: questions #1-3 • Infrastructure Domain: questions #4-7 • Culture Domain: questions #20-21
Limited Achievement	The hospital responded “yes” to <u>all</u> applicable questions in any one of the following domains: • Monitoring Domain: ○ Question #8, #9, or #10: ▪ Hospital collects hand hygiene compliance data on at least 200 hand hygiene opportunities, or at least the number of hand hygiene opportunities outlined based on

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Hand Hygiene Score (Performance Category)	Meaning that...
	the unit type in Tables 1-3 of the 2025 Hospital Survey (measure specifications, Section 6), each month in each patient care unit. ▪ Hospital collects hand hygiene compliance data on at least 100 hand hygiene opportunities, or at least the number of hand hygiene opportunities outlined based on the unit type in Tables 4-6 of the 2025 Hospital Survey (measure specifications, Section 6), each month in each patient care unit. ▪ Hospital collects hand hygiene compliance data on at least 100 hand hygiene opportunities each quarter in each patient care unit. ○ Question #11: Hospital uses hand hygiene coaches or compliance observers to provide individuals who touch patients or who touch items that will be used by patients with feedback on both when they are and are not compliant with performing hand hygiene. ○ The hospital responded “yes” to all questions pertaining to the monitoring method used (as indicated in question #8, #9, or #10): ▪ <i>Electronic Compliance Monitoring</i>: questions #12-13 ▪ <i>Direct Observation</i>: questions #14-15 • Feedback Domain: questions #16-19 • Training and Education Domain: questions #1-3 • Infrastructure Domain: questions #4-7 • Culture Domain: questions #20-21 <u>OR</u> The hospital met 0 domains.
Declined to Respond	The hospital did not submit a Survey.
Pending Leapfrog Verification	The hospital's responses are undergoing Leapfrog's standard verification process.

Section 7: 2025 Managing Serious Errors Scoring Algorithms

7A: Never Events

Hospitals are scored on their adoption of the nine principles of The Leapfrog Group's Never Events Policy.

Never Events Score (Performance Category)	Meaning that...
Achieved the Standard	The hospital has implemented a policy that adheres to <u>all nine principles</u> of The Leapfrog Group's Never Events Policy.
Considerable Achievement	The hospital has implemented a policy that adheres to all the <u>original five principles</u> * of The Leapfrog Group's Never Events Policy, as well as <u>at least two additional principles</u> .
Some Achievement	The hospital has implemented a policy that adheres to all the <u>original five principles</u> * of The Leapfrog Group's Never Events Policy.
Limited Achievement	The hospital responded to all the questions in this section, but it does not yet meet the criteria for Some Achievement.
Declined to Respond	The hospital did not submit a Survey.
Pending Leapfrog Verification	The hospital's responses are undergoing Leapfrog's standard verification process.

*The Leapfrog Group's original five principles include: apologizing to the patient, performing a root cause analysis, reporting to an external agency within 15 days, waiving all associated costs, and making a copy of the policy available to patients and payors upon request. More information is available at <https://ratings.leapfroggroup.org/measure/hospital/2025/responding-never-events>.

7B: Healthcare-Associated Infections (HAIs)

The **standardized infection ratios (SIRs)** for CLABSI, CAUTI, MRSA, *C. diff.*, and SSI: Colon are calculated by [NHSN](#), and will be scored and publicly reported for each hospital that joins Leapfrog's NHSN group, provides a valid NHSN ID in their Leapfrog Survey Profile, and submits a 2025 Leapfrog Hospital Survey. Hospitals that submit a Survey by the June 30 [Submission Deadline](#) are able to review these data on the [Hospital Details Page](#) as of July 12, 2025.

As described in the hard copy of the [Survey](#), all hospitals in Leapfrog's NHSN Group are required to (a) generate datasets within NHSN, (b) download CMS IPPS reports, and (c) and download a copy of your 2024 Patient Safety Component - Annual Hospital Survey from NHSN on the **same day** that Leapfrog will be downloading the data from NHSN for all current group members.

By generating datasets and downloading reports within NHSN on the same day as Leapfrog, hospitals can ensure that the data matches what Leapfrog has obtained. If hospitals do not generate datasets and download reports on the same day as Leapfrog, the Help Desk will not review any discrepancies. Leapfrog provides hospitals with step-by-step instructions on how to download the same reports that Leapfrog uses in our "[NHSN Guidance: Join the Group, Review/Accept Data Rights Template, and Download Reports](#)" document. Hospitals are scored on their standardized infection ratios for each of the applicable healthcare-associated infection measures.

HAI Score (Performance Category)	CLABSI SIR	CAUTI SIR	MRSA SIR	CDI SIR	SSI Colon SIR
Achieved the Standard	<= 0.413	<= 0.427	<= 0.496	<= 0.621	<= 0.349
Considerable Achievement	> 0.413 and <=0.788	> 0.427 and <=0.823	> 0.496 and <=0.901	> 0.621 and <=0.885	> 0.349 and <=0.783
Some Achievement	> 0.788 and <=1.184	> 0.823 and <=1.281	> 0.901 and <=1.516	> 0.885 and <=1.161	> 0.783 and <=1.302
Limited Achievement	> 1.184	> 1.281	> 1.516	> 1.161	> 1.302
Unable to Calculate Score	The hospital reported too small of a sample size to calculate their results reliably (i.e., the number of predicted infections across all locations is <1) or the number of observed MRSA or CDI infections present on admission (community-onset prevalence) was above a pre-determined cut point.				
Does Not Apply	The measure did not apply to the hospital during the reporting period (e.g., zero device days or procedures, no applicable locations, etc.) or the hospital is a PPS-Exempt Cancer Hospital as classified by CMS (only applies to CLABSI and CAUTI).				
Declined to Respond	The hospital did not join Leapfrog's NHSN group, did not provide a valid NHSN ID, did not complete the 2024 Patient Safety Component - Annual Hospital Survey in NHSN, or did not submit a Leapfrog Hospital Survey.				
Pending Leapfrog Verification	The hospital's responses are undergoing Leapfrog's standard verification process.				

Note: Cut points are based on the distribution of results from 2017 Leapfrog Hospital Surveys submitted as of July 31, 2017, which included data downloaded from NHSN on July 25, 2017 and reflects the last time NHSN data was rebaselined. These cut-points will remain in place for the entire Survey Cycle, unless it is determined that there are compelling reasons to make revisions. Cut points will be updated when rebaselined NHSN data is available, likely in 2026.

Section 8: 2025 Pediatric Care Scoring Algorithms

8A: Patient Experience (CAHPS Child Hospital Survey)

Hospitals are scored on their Top Box Scores from a subset of the domains (5 out of 13) included on the CAHPS Child Hospital Survey. These domains were selected for use in scoring due to having the lowest median performance and the largest variation in performance across hospitals:

- Communication with Parent – Communication about your child's medicines
- Communication with Parent – Keeping you informed about your child's care
- Communication with Child – How well nurses communicate with your child
- Communication with Child – How well doctors communicate with your child
- Attention to Safety and Comfort – Preventing mistakes and helping you report concerns

Hospitals are scored based on the number of domains where the hospital is performing in the top quartile.

Top Quartile for CAHPS Child Hospital Survey Domains (Quartiles [Q])	Communication about child's medicines (%)	Keeping you informed about child's care (%)	Child Communication with nurses (%)	Child Communication with doctors (%)	Preventing mistakes and reporting concerns (%)
Top Quartile (>= Q3)	>= 83	>= 80	>= 82	>= 78	>= 66

Patient Experience (CAHPS Child Hospital Survey) Score (Performance Category)	Meaning that...
Achieved the Standard	The hospital scored in top quartile of hospitals on at least four out of five Child CAHPS domains.
Considerable Achievement	The hospital scored in top quartile of hospitals on three out of five Child CAHPS domains.
Some Achievement	The hospital scored in top quartile of hospitals on two out of five Child CAHPS domains.
Limited Achievement	The hospital scored in top quartile of hospitals on one or fewer Child CAHPS domains.
Did Not Measure	The hospital reported not collecting data on this measure.
Unable to Calculate Score	The hospital did not meet the minimum reporting requirements for the measure (<100 returned CAHPS Child Hospital Surveys).
Does Not Apply	The hospital had too few pediatric inpatient admissions (n < 500) to administer the CAHPS Child Hospital Survey or had fewer than 100 non-NICU pediatric inpatient admissions.
Declined to Respond	The hospital did not respond to the questions in this section of the Survey or did not submit a Survey.
Pending Leapfrog Verification	The hospital's responses are undergoing Leapfrog's standard verification process.

Note: The top quartiles are based on the distribution of performance reported from 2019 Leapfrog Hospital Surveys and 2020 Leapfrog Hospital Surveys submitted by August 31, 2020. These cut-points will remain in place for the entire Survey Cycle, unless it is determined that there are compelling reasons to make revisions.

8B: Pediatric Computed Tomography (CT) Radiation Dose

Hospitals are scored on their performance for head scans and abdomen/pelvis scans separately, by comparing the median radiation dose length product (DLP) for each anatomic region and age stratum by phantom dose to two benchmarks. The first benchmark is the Median Benchmark, which is the median of the median doses reported across all Leapfrog-reporting hospitals. The second benchmark is the 75th Percentile Benchmark, which is the median of the 75th percentile doses reported across all Leapfrog-reporting hospitals.

Hospitals receive points based on their reported median dose (50th percentile) compared to the benchmarks. If the hospital's reported median dose is less than the Median Benchmark, then it receives two points. If the hospital's reported median dose is greater than or equal to the Median Benchmark and less than the 75th Percentile Benchmark, then it receives one point. Otherwise, if the hospital's reported median dose is greater than or equal to the 75th Percentile Benchmark, it receives no points for that category.

Therefore, for each anatomic region, there are at most 10 possible points. If a hospital had less than 10 CT scans for an age stratum, then the age stratum is not included in scoring.

HEAD SCANS					
Point Assignment (Benchmarks)	< 1 year	1 - 4	5 - 9	10-14	15-17
2 Points (Median Dose < Median Benchmark)	< 265	< 338	< 479	< 615	< 736
1 Point (Median Dose >= Median Benchmark and < 75 th Percentile Benchmark)	>= 265 and < 318	>= 338 and < 441	>= 479 and < 602	>= 615 and < 758	>= 736 and < 862
0 Points (Median Dose >= 75 th Percentile Benchmark)	>= 318	>= 441	>= 602	>= 758	>= 862

ABDOMEN/PELVIS SCANS					
Point Assignment (Benchmarks)	< 1 year	1 - 4	5 - 9	10-14	15-17
2 Points (Median Dose < Median Benchmark)	< 48	< 82	< 127	< 274	< 388
1 Point (Median Dose >= Median Benchmark and < 75 th Percentile Benchmark)	>= 48 and < 73	>= 82 and < 110	>= 127 and < 176	>= 274 and < 394	>= 388 and < 565
0 Points (Median Dose >= 75 th Percentile Benchmark)	>= 73	>= 110	>= 176	>= 394	>= 565

*Note: Cut points are based on the distribution of median doses from 2020 Leapfrog Hospital Surveys submitted by January 31, 2021. These cut-points will remain in place for the entire Survey Cycle, unless it is determined that there are compelling reasons to make revisions.

For each anatomic region, the percentage of points awarded is calculated by summing the points earned and dividing by the total number of possible points (i.e., two times the number of age strata with at least

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10 CT scans). This percentage of points earned is used to assign a performance category according to the table below:

Pediatric CT Dose Score (Performance Category)	Meaning that for Head Scans, the hospital earned...	Meaning that for Abdomen/Pelvis Scans, the hospital earned...
Achieved the Standard	>= 75% of total possible points.	>= 75% of total possible points.
Considerable Achievement	>= 50% and < 75% of total possible points.	>= 50% and < 75% of total possible points.
Some Achievement	>=25% and < 50% of total possible points.	>=25% and < 50% of total possible points.
Limited Achievement	< 25% of total possible points.	< 25% of total possible points.
Did Not Measure	The hospital did not measure.	The hospital did not measure.
Unable to Calculate Score	Fewer than 10 CT scans for all age ranges.	Fewer than 10 CT scans for all age ranges.
Does Not Apply	The hospital does not perform CT scans on pediatric patients.	
Declined to Respond	The hospital did not respond to the questions in this section of the Survey or did not submit a Survey.	
Pending Leapfrog Verification	The hospital's responses are undergoing Leapfrog's standard verification process.	

Section 9: 2025 Outpatient Procedures Scoring Algorithms

9A: Basic Outpatient Department Information

This section will not be scored in 2025. However, responses will be shown on Leapfrog's public reporting [website](#). For example, Leapfrog will display the number of operating and/or procedure rooms.

9B: Medical, Surgical, and Clinical Staff***Certified Clinicians Present While Patients Are Recovering***

Hospitals are scored on whether an Advanced Cardiac Life Support (ACLS) trained clinician, plus a second clinician, are always present and immediately available while adult patients are recovering and whether a Pediatric Advanced Life Support (PALS) trained clinician, plus a second clinician, are always present and immediately available while pediatric patients are recovering.

Clinicians Present While Patients are Recovering Score (Performance Category)	Meaning that...	Meaning that...
Achieved the Standard	While adult patients are recovering from an outpatient procedure, the hospital ensures an ACLS trained clinician, as well as a second clinician (regardless of ACLS training), are present at all times and immediately available in the building while an adult patient (13 years and older) is present in the hospital outpatient department.	While pediatric patients are recovering from an outpatient procedure, the hospital ensures a PALS trained clinician, as well as a second clinician (regardless of PALS training), are present at all times and immediately available in the building while a pediatric patient (infant through 12 years) is present in the hospital outpatient department.
Limited Achievement	While adult patients are recovering from an outpatient procedure, an ACLS trained clinician, as well as a second clinician (regardless of ACLS training), are NOT present at all times and immediately available in the building while an adult patient (13 years and older) is present in the hospital outpatient department.	While pediatric patients are recovering from an outpatient procedure, a PALS trained clinician, as well as a second clinician (regardless of PALS training), are NOT present at all times and immediately available in the building while a pediatric patient (infant through 12 years) is present in the hospital outpatient department.
Does Not Apply	The hospital does not perform outpatient procedures on adult patients.	The hospital does not perform outpatient procedures on pediatric patients.
Declined to Respond	The hospital did not respond to the questions in this section of the Survey or did not submit a Survey.	
Pending Leapfrog Verification	The hospital's responses are undergoing Leapfrog's standard verification process.	

9C: Volume of Procedures

Responses to the annual volume of each procedure performed are not scored. However, responses are used to facilitate the search functionality on Leapfrog's public reporting [website](#) (e.g., allowing users to search for facilities that perform the procedure they need) and the information will be publicly reported to inform purchasers and consumers about the facility's experience with the procedure.

9D: Safety of Procedures***Patient Follow-up***

Hospitals are scored based on their performance on an outcome measure collected and published by the Centers for Medicare and Medicaid Services (CMS): OP-32 Rate of Unplanned Hospital Visits After an Outpatient Colonoscopy.

Leapfrog will download the CMS data on the dates indicated in the Section 9D measure specifications in the hard copy of the Survey and match it with the CMS Certification Number (CCN) provided in the Hospital Profile. The CMS data will only be scored and publicly reported for hospitals that have provided an accurate CCN in the Hospital Profile, reported volume for colonoscopy procedures in Section 9C, and submitted Section 9 Outpatient Procedures of the Leapfrog Hospital Survey. Hospitals that submit a Survey by the [June 30 Submission Deadline](#) can review these data on the [Hospital Details Page](#) as of July 12, 2025.

Hospitals' performance is divided into quartiles. The quartiles are based on the distribution of hospital and ambulatory surgery center (ASC) performance from 2022 Leapfrog Hospital Surveys and 2022 Leapfrog ASC Surveys submitted as of June 30, 2022. These cut-points will remain in place for the entire 2025 Survey Cycle, unless it is determined that there are compelling reasons to make revisions.

	2022 Cut-points for Rate of Unplanned Hospital Visits After an Outpatient Colonoscopy
Minimum	9.2
Top Quartile	13.0
Second Quartile	13.7
Third Quartile	14.6
Maximum	18.5

Scoring Algorithm for OP-32: Rate of Unplanned Hospital Visits After Colonoscopy

Rate of Unplanned Hospital Visits After Colonoscopy Score (Performance Category)	Meaning that...
Achieved the Standard	• The hospital provided an accurate CCN in the Hospital Profile, • Reported volume for adult lower GI endoscopy in Section 9C, and • Is in the top quartile of performance (where lower scores are better).
Considerable Achievement	• The hospital provided an accurate CCN in the Hospital Profile, • Reported volume for adult lower GI endoscopy in Section 9C, and • Is in the second quartile of performance.
Some Achievement	• The hospital provided an accurate CCN in the Hospital Profile, • Reported volume for adult lower GI endoscopy in Section 9C, and • Is in the third quartile of performance.
Limited Achievement	• The hospital provided an accurate CCN in the Hospital Profile, • Reported volume for adult lower GI endoscopy in Section 9C, and • Is in the bottom quartile of performance.
Does Not Apply	The hospital does not perform adult lower GI endoscopy or the hospital is a pediatric facility.
Unable to Calculate Score	The hospital is not participating with CMS, is scored as “Not Available” by CMS or did not provide an accurate CCN in the Hospital Profile.
Declined to Respond	The hospital did not respond to the questions in this section of the Survey or did not submit a Survey.
Pending Leapfrog Verification	The hospital's responses are undergoing Leapfrog's standard verification process.

Safe Surgery Checklist for Adult and Pediatric Outpatient Procedures

Hospitals are scored on their use of a safe surgery checklist and whether elements of the checklist are verbalized in the presence of the appropriate personnel for every patient undergoing an applicable procedure based on an audit of a sample of patients.

Safe Surgery Checklist Score (Performance Category)	Meaning that...
Achieved the Standard	- The hospital uses a safe surgery checklist on all patients undergoing an applicable procedure, - The checklist includes all safe surgery checklist elements, and these elements were verbalized in the presence of the appropriate personnel (i.e., hospital responded “yes” to questions #3, #4, and #5), - The hospital completed an audit of 15 or 30 patients, as applicable, and documented adherence to the checklist, and - Based on the audit, has documented adherence to the checklist for at least 90% of the patients included in the audit.
Considerable Achievement	- The hospital uses a safe surgery checklist on all patients undergoing an applicable procedure, - The checklist includes all safe surgery checklist elements, and these elements were verbalized in the presence of the appropriate personnel (i.e., hospital responded “yes” to questions #3, #4, and #5), - The hospital completed an audit of 15 or 30 patients, as applicable, and documented adherence to the checklist, and - Based on the audit, has documented adherence to the checklist for at least 75% of the patients included in the audit.
Some Achievement	- The hospital uses a safe surgery checklist on all patients undergoing an applicable procedure, - The checklist includes all safe surgery checklist elements, and these elements were verbalized in the presence of the appropriate personnel (i.e., hospital responded “yes” to questions #3, #4, and #5), - The hospital completed an audit of 15 or 30 patients, as applicable, and documented adherence to the checklist, and - Based on the audit, has documented adherence to the checklist for at least 50% of the patients included in the audit.
Limited Achievement	The hospital responded to this section but does not yet meet the criteria for Some Achievement.
Does Not Apply	The hospital does not perform outpatient procedures on adult or pediatric patients.
Declined to Respond	The hospital did not respond to the questions in this section of the Survey or did not submit a Survey.
Pending Leapfrog Verification	The hospital's responses are undergoing Leapfrog's standard verification process.

9E: Medication Safety for Outpatient Procedures

Hospitals are scored based on their rates of documentation for home medications, visit medications, and allergies/adverse reaction(s).

Medication and Allergy Documentation Score (Performance Category)	Meaning that ...
Achieved the Standard	The hospital met the 90% target for documenting <u>all three components</u> : home medications, visit medications, and medication allergies/adverse reaction(s) in the clinical record.
Considerable Achievement	The hospital met the 90% target for documenting <u>two of the three</u> components.
Some Achievement	The hospital met the 90% target for documenting <u>one of the three</u> components.
Limited Achievement	The hospital <u>did not meet</u> the 90% target for documenting any of the three components.
Did Not Measure	The hospital reported not collecting data on this measure.
Unable to Calculate Score	The hospital did not meet the minimum reporting requirements for clinical record documentation (n < 30).
Does Not Apply	The hospital does not perform outpatient procedures on adult or pediatric patients.
Declined to Respond	The hospital did not respond to the questions in this section of the Survey or did not submit a Survey.
Pending Leapfrog Verification	The hospital's responses are undergoing Leapfrog's standard verification process.

9F: Patient Experience (OAS CAHPS)

Hospitals are scored on their Top Box Scores from four domains included on the Outpatient and Ambulatory Surgery (OAS) CAHPS Survey:

- Facilities and Staff
- Communication About Your Procedure
- Patients' Rating of the Facility
- Patients Recommending the Facility

Hospitals are scored based on the number of domains where the hospital is performing in the top quartile.

Top Quartile for OAS CAHPS Domains (Quartiles [Q])	Facilities and Staff (%)	Communication About Your Procedure (%)	Patients' Rating of the Facility (%)	Patients Recommending the Facility (%)
Top Quartile (>= Q3)	>= 97	>= 93	>= 88	>= 87

Patient Experience (OAS CAHPS) Score (Performance Category)	Meaning that the hospital...
Achieved the Standard	Scored in top quartile of facilities on 4 out of 4 OAS CAHPS domains.
Considerable Achievement	Scored in top quartile of facilities on 3 out of 4 OAS CAHPS domains.
Some Achievement	Scored in top quartile of facilities on 2 out of 4 OAS CAHPS domains.
Limited Achievement	Scored in top quartile of facilities on 1 or fewer OAS CAHPS domains.
Did Not Measure	The hospital did not measure.
Unable to Calculate Score	The hospital did not meet the minimum reporting requirements for the measure (<100 returned OAS CAHPS Surveys).
Does Not Apply	The hospital had too few eligible discharges (n < 300) to administer the OAS CAHPS Survey OR the hospital does not perform outpatient procedures on adult patients.
Declined to Respond	The hospital did not respond to the questions in this section of the Survey or did not submit a Survey.
Pending Leapfrog Verification	The hospital's responses are undergoing Leapfrog's standard verification process.

Note: The top quartiles are based on the distribution of hospital and ASC performance from 2020 Leapfrog Hospital Surveys and 2020 Leapfrog ASC Surveys submitted by August 31, 2020. These cut-points will remain in place for the entire Survey Cycle, unless it is determined that there are compelling reasons to make revisions.

Appendix I: CPOE Evaluation Tool Scoring Algorithm

CPOE Evaluation Tool Scoring**(For Adult and General Hospitals Only)**

To achieve Leapfrog's CPOE Standard, each adult and general hospital must (1) ensure that licensed prescribers enter at least 85% of inpatient medication orders via a computer system that includes decision support software to reduce prescribing errors, and (2) demonstrate, via a test, that its inpatient CPOE system can alert physicians to at least 60% of frequent serious medication errors known to cause harm to patients.

Hospitals are asked to use Leapfrog's CPOE Evaluation Tool to complete an Adult Inpatient Test to fulfill the second requirement of our standard. Upon successful completion of an Adult Inpatient Test, a hospital's responses are immediately scored and available to be viewed and printed. These CPOE Test results are available within the CPOE Evaluation Tool from April 1 to November 30. Hospitals are urged to print and save a copy of the results for their records. Results from prior year's tests are also archived and can be accessed until November 30 by logging back into the CPOE Evaluation Tool from the Hospital Survey Dashboard. See "Step 7 of 7: View Results" in the [CPOE Tool Instructions](#) for more information.

See [Section 2A: CPOE Scoring Algorithm for Adult/General Hospitals](#) for more information.

Results from the Adult Inpatient Test

The CPOE Evaluation Tool calculates the results from the Adult Inpatient Test and displays the results that includes eight individual category scores and an overall score using the criteria described below. As described above, the results are only available within the CPOE Evaluation Tool from April 1 to November 30. Hospitals are urged to print and save a copy of the results for their records.

Category Scores

- Seven of the eight Order Checking Categories included in the CPOE Evaluation Tool represent an area where a serious adverse drug event (ADE) could occur if the CPOE system's clinical decision support fails to alert the prescriber. The eighth order checking category includes Test Orders that, if presented interruptedly, could contribute to alert fatigue and physician burnout.
- Results are calculated for each category and are displayed as a percent correct (e.g., 80% in the Drug Age category means that the hospital responded to 80% of the test orders in this category correctly).
- Test Orders that include medications that could not be electronically entered in any formulation are excluded from the overall score calculation.
- For any category for which too few orders were entered to reliably calculate a category score, "insufficient responses to evaluate performance in this category" appears instead of a percentage score. Individual orders that were able to be tested within a category are included in the overall score.

2025 Leapfrog Hospital Survey Appendix I – CPOE Evaluation Tool Scoring Algorithm

Order Checking Category	Description	Example	Type of Clinical Decision Support
Inappropriate Medication Combinations	Medication combinations to avoid ordering together or ones to use with caution	Using clonazepam and lorazepam together	Medication-specific advice/information
Excessive Dosing	Specified dose of medication or frequency of administration exceeds safe range for single or daily dose	Tenfold overdose of digoxin	Medication-specific advice/information
Drug Route	Specified route of administration is inappropriate and potentially harmful	Use of hydroxyzine intravenously	Medication-specific advice/information
Drug Diagnosis	Medication dose inappropriate/contraindicated based on documented problem/diagnosis	Non-selective beta-blocker in patient with asthma	Scenario-specific advice/information
Drug Age	Medication dose inappropriate/contraindicated based on patient age	Prescribing diazepam for a patient over 65 years old	Scenario-specific advice/information
Drug Laboratory	Medication dose inappropriate/contraindicated based on documented laboratory test results (includes renal status)	Use of nitrofurantoin in patient with severe renal failure or ordering digoxin for a patient with hypokalemia	Scenario-specific advice/information
Drug Monitoring	Medication for which the standard of care includes subsequent monitoring of the drug level or lab value to avoid harm	Prompt to monitor drug levels when ordering aminoglycosides or INR/PT when ordering warfarin or checking baseline LFTs when starting a statin	Medication-specific advice/information
Excessive Alerts	Low-priority medication combinations, such as drug interactions or therapeutic duplications, that should not trigger decision support warnings.	Concurrent use of hydrochlorothiazide and captopril	Medication-specific advice/information

The Adult Inpatient Test also includes a “Potentially Inaccurate Test Results” test category, which checks for “false positives” (e.g., hospitals reporting advice/information for Test Orders that should not generate any warning in the hospital’s CPOE system). Hospitals that score “Potentially Inaccurate Test Results” are scored and publicly reported as “Incomplete Evaluation” and will not be able to retake an Adult Inpatient Test for 120 days.

2025 Leapfrog Hospital Survey Appendix I – CPOE Evaluation Tool Scoring Algorithm**Overall Score**

In addition to individual category scores for each of the eight categories for which hospitals were able to test a sufficient number of orders, the results also include an overall score based on all scored orders across all categories. The overall score is used as part of [Leapfrog's CPOE Standard Scoring Algorithm](#).

The overall score is based on the performance of the hospital's CPOE clinical decision support to alert prescribers to frequent serious medication errors known to cause harm to patients. The test includes a number of orders that could result in a fatal adverse drug event. Any of these potentially fatal orders not flagged by the clinical decision support are listed on the results page of the CPOE Evaluation Tool. In addition, the test includes a number of orders that, if alerted on, could contribute to over-alerting. Any Excessive Alerts orders for which advice or information was reported are also listed on the results page of the CPOE Evaluation Tool.

Overall Score (Combined with the hospital's % of inpatient medication orders entered via CPOE and publicly reported)	Description
Full Demonstration of National Safety Standard for Decision Support	This hospital's CPOE system alerts prescribers to most common serious prescribing errors. Meaning that: • The hospital responded to ≥ 20 test orders • The hospital responded correctly to $\geq 60\%$ of test orders across all categories
Substantial Demonstration of National Safety Standard for Decision Support	This hospital's CPOE system alerts prescribers to many common serious prescribing errors. Meaning that: • The hospital responded to ≥ 20 test orders • The hospital responded correctly to $\geq 50\%$, but less than 60% of test orders across all categories
Some Demonstration of National Safety Standard for Decision Support	This hospital's CPOE system alerts prescribers to some common serious prescribing errors. Meaning that: • The hospital responded to ≥ 20 test orders • The hospital responded correctly to $\geq 40\%$, but less than 50% of test orders across all categories
Completed the Evaluation	This hospital's CPOE system alerts prescribers to few common serious prescribing errors. Meaning that: • The hospital responded to ≥ 20 test orders • The hospital responded correctly to less than 40% of test orders across all categories
Insufficient Evaluation	This hospital was not able to test a sufficient number of orders (< 20) to receive an overall score. However, the hospital may use the category scores for local hospital quality improvement efforts. The hospital is eligible to retake the test in 120 days.
Incomplete Evaluation	This hospital did not complete the CPOE Evaluation Tool within the allotted time. The hospital is eligible to retake the test in 120 days. Note: Hospital will not be able to view results within the CPOE Evaluation Tool. The test is not scored.
Potentially Inaccurate Test Results (Publicly reported as Incomplete Evaluation)	This hospital submitted responses that included potentially inaccurate results. The hospital is eligible to retake the test in 120 days.

Appendix II: Nursing Workforce Calculation Examples
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Details on how the “Total Nursing Hours per Patient Day” and “RN Nursing Hours per Patient Day” measures are calculated are available below for hospitals that operate at least one adult or pediatric single acuity unit (**Medical**, **Surgical**, or **Med-surg** units).

Example 1: Calculating Total Nursing Care Hours per Patient Day and RN Hours per Patient Day for hospitals with at least one adult or pediatric SINGLE acuity unit (medical, surgical, or med-surg)

Step 1: Sum the number of patient days, total number of productive hours worked by employed or contracted nursing staff with direct patient care responsibilities, and total number of productive hours worked by RN nursing staff with direct patient care responsibilities from all four quarters for all applicable medical units, surgical units, and med-surg units.

Question #7: Enter your hospital's responses for each quarter for all adult and pediatric single acuity Medical Units for the reporting period selected in question #1:			
	(a) Total number of patient days:	(b) Total number of productive hours worked by employed and contracted nursing staff (RN, LPN/LVN, and UAP) with direct patient care responsibilities:	(c) Total number of productive hours worked by RN nursing staff with direct patient care responsibilities:
Quarter 1	7,000	58,000	45,000
Quarter 2	5,000	60,000	45,000
Quarter 3	8,000	58,000	45,000
Quarter 4	7,000	60,000	45,000
TOTAL	27,000	236,000	180,000

Question #9: Enter your hospital's responses for each quarter for all adult and pediatric single acuity Surgical Units for the reporting period selected in question #1:			
	(a) Total number of patient days:	(b) Total number of productive hours worked by employed and contracted nursing staff (RN, LPN/LVN, and UAP) with direct patient care responsibilities:	(c) Total number of productive hours worked by RN nursing staff with direct patient care responsibilities:
Quarter 1	5,000	58,000	45,000
Quarter 2	6,000	60,000	45,000
Quarter 3	6,000	58,000	45,000
Quarter 4	6,000	60,000	45,000
TOTAL	23,000	236,000	180,000

2025 Leapfrog Hospital Survey**Scoring Algorithms**

Question #11: Enter your hospital's responses for each quarter for all adult and pediatric single acuity Med-Surg Units for the reporting period selected in question #1:			
	(a) Total number of patient days:	(b) Total number of productive hours worked by employed and contracted nursing staff (RN, LPN/LVN, and UAP) with direct patient care responsibilities:	(c) Total number of productive hours worked by RN nursing staff with direct patient care responsibilities:
Quarter 1	6,300	80,000	60,000
Quarter 2	6,700	80,000	65,000
Quarter 3	7,000	78,000	60,000
Quarter 4	6,400	80,000	64,000
TOTAL	26,400	318,000	249,000

Step 2: Then sum the total number of patient days, total number of productive hours worked by employed or contracted nursing staff with direct patient care responsibilities, and total number of productive hours worked by RN nursing staff with direct patient care responsibilities across all units.

	(a) Total number of patient days:	(b) Total number of productive hours worked by employed and contracted nursing staff (RN, LPN/LVN, and UAP) with direct patient care responsibilities:	(c) Total number of productive hours worked by RN nursing staff with direct patient care responsibilities:
Medical Units	27,000	236,000	180,000
Surgical Units	23,000	236,000	180,000
Med-Surg Units	26,400	318,000	249,000
TOTAL	76,400	790,000	609,000

Step 3: Next divide the total number of productive hours worked by employed or contracted nursing staff with direct patient care responsibilities by the total number of patient days from Step 2 to calculate the total nursing care hours per patient day.

Total number of patient days:	Total number of productive hours worked by employed and contracted nursing staff (RN, LPN/LVN, and UAP) with direct patient care responsibilities:	Total Nursing Care Hours per Patient Day:
76,400	790,000	$790,000 / 76,400 =$ 10.34

Step 4: Lastly, divide the total number of productive hours worked by RN nursing staff with direct patient care responsibilities by the total number of patient days from Step 2 to calculate the RN hours per patient day.

Total number of patient days:	Total number of productive hours worked by RN nursing staff with direct patient care responsibilities:	RN Hours per Patient Day:
76,400	609,000	$609,000 / 76,400 =$ 7.97

2025 Leapfrog Hospital Survey

Scoring Algorithms

Example 2: Calculating Total Nursing Care Hours per Patient Day and RN Hours per Patient Day for hospitals the only operate adult or pediatric MIXED acuity medical, surgical, or med-surg units

*Step 1: Sum the number of patient days, total number of productive hours worked by employed and contracted nursing staff with direct patient care responsibilities, and total number of productive hours worked by RN nursing staff with direct patient care responsibilities from all four quarters for all **mixed acuity** medical units, surgical units, or med-surg units.*

Question #14: Enter your hospital's responses for each quarter for all adult and pediatric mixed acuity Medical, Surgical, and Med-Surg Units for the reporting period selected in question #1:			
	(a) Total number of patient days:	(b) Total number of productive hours worked by employed and contracted nursing staff (RN, LPN/LVN, and UAP) with direct patient care responsibilities:	(c) Total number of productive hours worked by RN nursing staff with direct patient care responsibilities:
Quarter 1	18,000	151,000	83,000
Quarter 2	21,000	158,500	90,000
Quarter 3	16,000	143,000	86,000
Quarter 4	22,000	150,000	92,000
TOTAL	77,000	602,500	351,000

Step 2: Next divide the total number of productive hours worked by employed and contracted nursing staff with direct patient care responsibilities by the total number of patient days from Step 1 to calculate the total nursing care hours per patient day.

Total number of patient days:	Total number of productive hours worked by employed and contracted nursing staff (RN, LPN/LVN, and UAP) with direct patient care responsibilities:	Total Nursing Care Hours per Patient Day:
77,000	602,500	$602,500 / 77,000 = 7.82$

Step 3: Lastly, divide the total number of productive hours worked by RN nursing staff with direct patient care responsibilities by the total number of patient days from Step 1 to calculate the RN hours per patient day.

Total number of patient days:	Total number of productive hours worked by RN nursing staff with direct patient care responsibilities:	RN Hours per Patient Day:
77,000	351,000	$351,000 / 77,000 = 4.56$

Results from the 2025 Leapfrog Hospital Survey will be available at <http://ratings.leapfroggroup.org/> on July 25, 2025.

Beginning in August, results are updated within the first seven (7) business days of each month to reflect new Survey submissions and resubmissions.

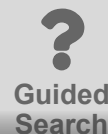
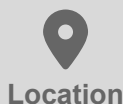
Find more information about the 2025 Leapfrog Hospital Survey at: <http://leapfroggroup.org/hospital>.

EXHIBIT 15

LEAPFROG RATINGS

Search Leapfrog's Hospital and Surgery Center Ratings

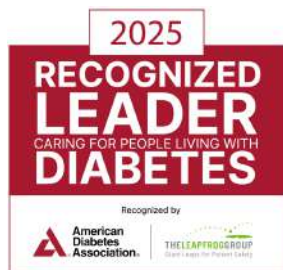
Search by:



Facility name

Start typing the name of the facility here

Search



The first ever group of Recognized Leaders in Caring for People Living with Diabetes designated by the American Diabetes Association and The Leapfrog Group.

View List



The highest-performing hospitals on the Leapfrog Hospital Survey are recognized annually with the prestigious Leapfrog Top Hospital award.

[View List](#)



The highest-performing surgery centers on the Leapfrog ASC Survey are recognized annually with the prestigious Leapfrog Top ASC award.

[View List](#)



Looking for the Leapfrog Hospital Safety Grade website?

How safe is your hospital? [The Hospital Safety Grade](#) is a single letter grade representing a hospital's overall performance in keeping patients safe from errors, injuries, accidents, and infections.

About The Leapfrog Group

The Leapfrog Group is a nonprofit watchdog organization that serves as a voice for health care consumers and purchasers, using their collective influence to foster positive change in U.S. health care. Leapfrog is the nation's premier advocate of transparency in health care—collecting, analyzing and disseminating data to inform value-based purchasing and improved decision-making.

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EXHIBIT 16

From: [Alexandra Campione](#) on behalf of [Alexandra Campione <ACampione@leapfrog-group.org>](#)
To: [Missy Danforth](#)
Subject: FW: Final Fall 2024 Methodology Changes- public comments draft
Date: Monday, June 24, 2024 12:07:40 PM
Attachments: [image001.png](#)
[Fall 2024 Proposed Changes Public Comments.docx](#)
[Fall2024HospitalSafetyGrade_FinalMethodologyChanges - v1.docx](#)

Hi Missy,

Just wanted to remind you about this. I think you were going to take the first pass then send to Matt and maybe Leah? We said we would publish by this Friday.

Thanks,
Alex

From: Alexandra Campione
Sent: Monday, June 17, 2024 5:11 PM
To: Missy Danforth <mdanforth@leapfrog-group.org>
Subject: Final Fall 2024 Methodology Changes- public comments draft

Hi Missy,

Please find the first draft of responses to public comments attached for review. I also included the public comments with the themes highlighted.

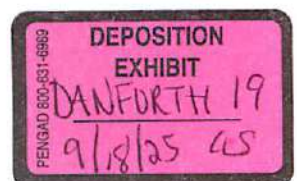
Best,
Alex

Alexandra Campione, MPH (*she/her/hers*)
Program Analyst, Health Care Ratings
The Leapfrog Group
1775 K St. NW, Suite 400
Washington, DC 20009



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Fall 2024 Proposed Changes Public Comments

Proponents

Cleveland Clinic-David Orr

I think the imputation change makes a lot of sense. It is painful to see folks who don't submit get more points than those who are transparently submitting. I think this takes care of that issue.

Providence St. Jude Medical Center- Lisa Michelle DuPree

Positive feedback for the proposed changes - the new method will encourage participation & cease to allow lesser performing hospitals from absorbing the positive performance of surrounding hospitals (or vice versa) from previous imputation model.

FHN Memorial Hospital- Doreen Timm

I agree with the new calculations for BCMA and hand hygiene if a hospital does not choose to submit a hospital survey. I believe this change would better reflect a hospital's commitment to an overall patient safety program

CommonSpirit Health- Tamra O'Bryan

The proposed changes to the imputation method for CPOE, BCMA, IPS and Hand Hygiene seem logical and appropriate. Thank you for the opportunity to comment. Tamra

Against Themes and Color Coding

- Misrepresents performance
- More time
- Do not penalize hospitals for not completing a resource intensive survey (keep them separate or allow hospitals to opt out)
- Hospital Performance does not change that much in 2 years (addressed in response to theme above)

Allina Health- Becky Wenthold

These changes will penalize hospitals that do not submit a Leapfrog Survey. The public will not understand nor dig into the methodology of these grades and hospitals will be falsely represented with a lower grade because they chose to not complete a survey. The survey is extremely time intensive and, in a time, when hospitals are barely breaking even financially, they do not have the resources to commit to this survey. Additionally, there is no option to submit a survey for a health system, where process measures apply to several hospitals in that system. A hospital with excellent outcomes, will no longer be able to receive an A grade because limited achievement is assigned to process measures that actually may be in place.

Cedars-Sinai Medical Center- Gail Grant

The timing of your proposed changes to the Hospital Safety Grade seems unduly short with implementation proposed for Fall 2024. That short time to implementation leaves little time for hospitals who had not planned on participating in the Leapfrog Annual Hospital Survey to complete and submit the survey. Could the implementation be pushed to the Spring 2025 Safety Grade? That way, hospitals will have until the November 2024 deadline to complete the survey. If not, is there a specific reason why implementation is planned to occur so soon?

Mount Sinai Health System- Alana Noble

We strongly disagree with the proposed Fall 2024 Step 2 Imputation. If Leapfrog is going to implement this change, they need to offer hospitals an option to opt out of being graded rather than penalize a hospital for not submitting the resource-intensive survey. The survey is very resource intensive outside of existing regulatory, quality operations and quality improvement efforts. Hospitals who do not have the resources to do the survey annually should not be so adversely punished especially in the post-Covid era where resources are increasingly hard to come by and retain.

Piedmont Healthcare- Zubin Momin

Leapfrog should consider moving towards one CPOE test for large hospital systems that utilize the same EMR. It is a large administrative burden to get all tests scheduled and completed in a short amount of time from April 1st to June 30th. The time commitment to complete the test for each hospital is extensive and requires numerous hours of high-salaried FTEs. The frequency requirement should also be re-evaluated as it is unlikely hospitals are changing their EMR significantly each year or every other year.

Imputation Step 1 Model:

Is Leapfrog willing to re-evaluate the decision on the point assignment for the BCMA measure? 25 points out of the 100 points seems very low for hospitals that chose to not submit a survey to save on the time and resource commitment required to complete a survey this year if they have just submitted one last year. The impact of adding a few units to the BCMA measure is unlikely to drop performance from 100 to 25 for hospitals. Even if compliance was low, pre-op and PACU areas do not typically administer a volume of medications that would yield a drop from 100 to 25 points. Leapfrog should consider using N/A or a higher point assignment for this measure. The current proposal is causing hospitals to allocate unplanned hours and resources to complete the annual survey to avoid a negative impact to their Safety Grades.

Leapfrog should also consider announcing changes to imputation models at least one year in advance. The last-minute notice of changes that negatively impact hospitals that do not submit requires rapid shifting of priorities for the FTEs heavily involved in survey submission. The completion of the survey requires a great deal of coordination between various departments across the hospital including Informatics, Physicians, Pharmacy, Women's Services, Quality & Safety, and Nursing. The brief time period does not allow us to have all required sections completed without the addition of unplanned supplementary resources.

Imputation Step 2 Model:

We feel like this model is unnecessarily punitive. We often skip survey submission because the responses provided for IPS, Hand Hygiene, BCMA, and CPOE are largely unchanged in the 2-year period that was allotted before negatively impacting grades. The FTE resource commitment to complete the survey is already significant. There is no value added by completing a survey every year or every other year when practices in our hospitals have not changed.

Ascension- Peter M. Leibold (Executive Vice President and Chief Advocacy Officer)

Ascension cannot support Leapfrog's proposed update and strongly encourages Leapfrog to refrain from implementing it. We fundamentally believe that the Hospital Safety Grade and the Hospital Survey should remain separate; the Survey should not affect the grades. We believe this is not in the best interest of public policy, as not all hospitals have the information and/or capabilities to complete the Hospital Survey. Further, we believe it is unreasonable for an optional Survey to have such a significant impact.

Providence System- Susan Boardman

The proposed changes to the Imputation Method would result in an inaccurate portrayal of the actual status of the patient safety structures and processes in place for the Leapfrog grade measures CPOE, BCMA, IPS, and Hand Hygiene at hospitals that choose not to expend the resources to submit a 2024 Leapfrog Hospital Survey and had not submitted a 2023 Leapfrog Hospital Survey. Under "Step 2" of the proposed new imputation method, the points assigned for these measures would be the same that earned for "Limited Achievement" if the 2024 Survey were submitted. This is not a like to like comparison between hospitals. Rather, if 2023 or 2024 were not submitted, more accurate options include: 1) Not assigning a Grade for hospitals that did not submit either a 2023 or a 2024 survey, or at least allowing these hospitals to opt out of the Fall 2024 Leapfrog Hospital Safety Grade; 2) Publishing two versions of the Fall 2024 Leapfrog Hospital Safety Grade: one for hospitals completing the 2023 or 2024 Survey, and one just based on CMS measures, not including the survey based measures so there is no penalty for not submitting a survey. For the proposed new Imputation Method, if a hospital has completed a survey in the past where the measure section has not substantially changed, allowing the hospital to attest that there has not been changes to reduce the number of Medication Alerts for the CPOE measure, to save the resources required for retaking the CPOE evaluation test. And for the BCMA, IPS and Hand Hygiene measures, allow hospitals to just submit any of these sections if there have been changes on the Leapfrog questions, or if the hospital cannot attest that there have not been changes to their previous response.



Final Updates to the Leapfrog Hospital Safety Grade Methodology for Fall 2024

On May 21, 2024, Leapfrog published planned updates to the Hospital Safety Grade methodology and held a public comment period through June 7, 2024. We thank commenters for their insightful feedback and suggestions that helped us finalize the methodology.

This document includes responses to the comments received and summarizes the final updates that will be made to the scoring methodology. Additionally, Table 2 on pages 5-6 includes a summary of data sources and anticipated reporting periods for the fall 2024 Hospital Safety Grades.

Summary of Changes

Starting in fall 2024, Leapfrog will update the Imputation Methodology for CPOE, BCMA, IPS, and Hand Hygiene measures for hospitals that do not submit a 2024 Leapfrog Hospital Survey by August 31, 2024. The changes come under the guidance of Leapfrog's national expert panel, the research team at Johns Hopkins Medicine, and in response to stakeholder feedback.

More information can be found on the Hospital Safety Grade website at <https://www.hospitalsafetygrade.org/for-hospitals/key-dates-and-information>.

RESPONSES TO PUBLIC COMMENTS

Four commenters supported the change to the imputation methodology.

We appreciate the feedback and agree that participating hospitals committed to transparency should be acknowledged for the resources and time they devote to completing the Leapfrog Hospital Survey. Hospitals that choose not to complete the Survey should not inadvertently benefit from hospitals that continuously strive to make improvements and maintain Leapfrog standards.

Two commenters expressed concerns about Step 2 Imputation misrepresenting the current procedures or infrastructure of the hospital to the public.

We recognize that hospitals eligible for Step 2 Imputation may score higher if they complete a Leapfrog Hospital Survey. However, we cannot ensure this is the case if we do not have the data, and our analyses have shown that performance among hospitals that intermittently complete the annual Survey is lower than those hospitals that completed the most recent Survey. The expert panel recognized that hospitals with a drop in performance may be incentivized to not report via the Leapfrog Hospital Survey and scores calculated using participating hospitals would misrepresent their true performance. We encourage hospitals to complete the Leapfrog Hospital Survey so they can receive credit for implementing processes that protect patients and save lives.

We do acknowledge the commentor's point that the public may misinterpret the assigned measure scores. In response, we will add a new denotation to the Hospital Safety Grade website (<https://www.hospitalsafetygrade.org/>) for scores that have been imputed.

Two commenters requested that the proposed changes be delayed until spring 2025 to allow hospitals time to complete the Leapfrog Hospital Survey.

While we do strongly encourage hospitals to submit their Survey by the Submission Deadline of June 30, 2024, hospitals that wish to have 2024 Leapfrog Hospital Survey data used in their fall 2024 Safety Grade will have until August 31 to submit or resubmit their Survey. Hospitals that completed a 2023 Leapfrog Hospital Survey will be eligible for Step 1 Imputation. Hospitals eligible for Step 2 imputation have opted not to complete 2 consecutive years of the Leapfrog Hospital Survey and will be scored accordingly.

Four commenters opposed penalizing hospitals that choose not to devote resources to completing a voluntary Survey each year and be allowed to opt out of the Hospital Safety Grade.

The Leapfrog Hospital Survey is designed to help hospitals benchmark their progress in quality and safety. To ensure that these standards are consistently met, hospitals must continuously measure. While our Survey, is not required or linked to federal funding, we think it is just as important. Patients, employers, and purchasers benefit from having access to current and accurate information.

Our expert panel recognized that awareness and participation in the Leapfrog Hospital Survey has grown exponentially in recent years. As such, the choice of hospitals to not complete the Leapfrog Hospital Survey is one that could not be ignored as patient safety must remain a priority. A key element of the Hospital Safety Grade is that all eligible hospitals are compared to hospitals nationwide. The choice to not participate should not excuse a hospital from being graded, nor should they be given a score that unfairly awards them points.

FINAL UPDATE TO IMPUTATION METHOD FOR CPOE, BCMA, IPS, AND HAND HYGIENE

BACKGROUND

The Leapfrog Group and other national organizations have ongoing concerns with the trajectory of patient safety in US hospitals. Leapfrog wants to ensure that the public has timely, transparent, and trustworthy information about a hospital's patient safety performance. Leapfrog's longstanding commitment is to use the best and most recent data publicly available to calculate Hospital Safety Grades.

To ensure the Hospital Safety Grade methodology continues to support these goals, Leapfrog's blue-ribbon Expert Panel and researchers at Johns Hopkins Medicine annually review the scoring methodology. The panel advised that Leapfrog modify the current imputation method, which is used to fill in missing data among hospitals that did not complete the most recent Leapfrog Survey.

Leapfrog is proposing the following changes to its imputation approaches effective with the fall 2024 Hospital Safety Grade.

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

Leapfrog is proposing the following changes effective with the fall 2024 Hospital Safety Grade.

1) New Step 1 Imputation (Does not apply to BCMA)

If the hospital had a score assigned by Leapfrog in the previous two rounds of grades (i.e., spring 2024, fall 2023), the hospital is assigned the most recent score on that measure in the current Hospital Safety Grade (i.e., fall 2024). This is a reduction from the previous methodology, which imputed scores from up to four previous rounds of grades. This will help ensure any historical data used in calculating the Safety Grade is reflective of hospital protocols within the past 2 years (e.g., the reporting periods for CPOE IPS, and Hand Hygiene on the 2023 Leapfrog Hospital Survey was 2023).

Note that Step 1 imputation will be temporarily paused for the BCMA measure. In 2024, Leapfrog expanded the BCMA Standard to include pre-operative and post-anesthesia care units in addition to med-surg units, critical care units, and labor and delivery units. Due to these changes, scores from the 2023 Leapfrog Hospital Survey are not an accurate representation of performance on the current measure and thus not suitable for Step 1 imputation.

2) New Step 2 Imputation

For hospitals that do not have historical data from the last two rounds of the Safety Grade (Step 2 imputation then applies), instead of imputing a score based on the cohort mean, hospitals will be assigned a point value that is equivalent to receiving “Limited Achievement” for that measure on the Leapfrog Hospital Survey (Table 1). This category assignment would reflect Leapfrog’s lack of current information about a hospital’s status in implementing these important patient safety structures.

Step 2 imputation for the IPS measure will only apply to hospitals that operate an adult or pediatric medical and/or surgical ICU or neuro ICU. A hospital’s ICU designation will be determined using the most recently available CMS Cost Report. Hospitals that report operating one or more medical, surgical and/or pediatric ICU beds in Worksheet S-3 Part 1 will be eligible for Step 2 Imputation.

Table 1. Step 2 Imputation Point Assignments Beginning Fall 2024

	Leapfrog Hospital Survey Performance Category		Corresponding Safety Grade Measure Score
CPOE	Limited Achievement		15
BCMA	Limited Achievement		25
IPS	Limited Achievement		5
Hand Hygiene	Limited Achievement		15

Table 2. Planned Fall 2024 Leapfrog Safety Grade Measures, Data Sources, And Anticipated Reporting Periods

PROCESS/STRUCTURAL MEASURES (12)				
Measure Name	Primary Data Source	Reporting Period	Secondary Data Source	Reporting Period
Computerized Physician Order Entry (CPOE)	2024 Leapfrog Hospital Survey	2024	Imputation Model Applied	N/A
Bar Code Medication Administration (BCMA)	2024 Leapfrog Hospital Survey	2024	Imputation Model Applied	N/A
ICU Physician Staffing (IPS)	2024 Leapfrog Hospital Survey	2024	Imputation Model Applied	N/A
Safe Practice 1: Culture of Leadership Structures and Systems	2024 Leapfrog Hospital Survey	2024	N/A	N/A
Safe Practice 2: Culture Measurement, Feedback & Intervention	2024 Leapfrog Hospital Survey	2024	N/A	N/A
Total Nursing Care Hours per Patient Day	2024 Leapfrog Hospital Survey	2024	N/A	N/A
Hand Hygiene	2024 Leapfrog Hospital Survey	2024	Imputation Model Applied	N/A
H-COMP-1: Nurse Communication	CMS	10/01/2022 - 09/30/2023	N/A	N/A
H-COMP-2: Doctor Communication	CMS	10/01/2022 - 09/30/2023	N/A	N/A
H-COMP-3: Staff Responsiveness	CMS	10/01/2022 - 09/30/2023	N/A	N/A
H-COMP-5: Communication about Medicines	CMS	10/01/2022 - 09/30/2023	N/A	N/A
H-COMP-6: Discharge Information	CMS	10/01/2022 - 09/30/2023	N/A	N/A

OUTCOME MEASURES (10)				
Measure Name	Primary Data Source	Reporting Period	Secondary Data Source	Reporting Period
Foreign Object Retained	CMS	07/01/2021 - 06/30/2023	N/A	N/A
Air Embolism	CMS	07/01/2021 - 06/30/2023	N/A	N/A
Falls and Trauma	CMS	07/01/2021 - 06/30/2023	N/A	N/A
CLABSI	2024 Leapfrog Hospital Survey	01/01/2023 - 12/31/2023	CMS	10/01/2022 - 09/30/2023
CAUTI	2024 Leapfrog Hospital Survey	01/01/2023 - 12/31/2023	CMS	10/01/2022 - 09/30/2023
SSI: Colon	2024 Leapfrog Hospital Survey	01/01/2023 - 12/31/2023	CMS	10/01/2022 - 09/30/2023
MRSA	2024 Leapfrog Hospital Survey	01/01/2023 - 12/31/2023	CMS	10/01/2022 - 09/30/2023
C. Diff.	2024 Leapfrog Hospital Survey	01/01/2023 - 12/31/2023	CMS	10/01/2022 - 09/30/2023
PSI 4: Death rate among surgical inpatients with serious treatable conditions	CMS	07/01/2020 - 06/30/2022	N/A	N/A
CMS Medicare PSI 90: Patient safety and adverse events composite*	CMS	07/01/2020 - 06/30/2022	N/A	N/A

*Note: CMS calculates PSI 90 using the ten (10) component PSIs listed above. While scores for each of the 10 component PSIs will NOT be used to calculate fall 2024 Hospital Safety Grades, they will be publicly reported on the Hospital Safety Grade [website](#).

EXHIBIT 17

Message

From: West, Regina [Regina.West@tenethealth.com]
Sent: 11/4/2024 6:17:50 PM
To: Johnson, Stephany [Stephany.Johnson@tenethealth.com]
Subject: HO response regarding Leapfrog

Keeping you in the loop.

Gina West
St. Mary's Medical Center & PBHN Market Quality Director
901 45th Street
West Palm Beach, FL 33407
O: (561) 882-6435
F: (561) 882-9117
Email: Regina.West@tenethealth.com
Delray | Good Samaritan | Palm Beach Gardens | St. Mary's | West Boca

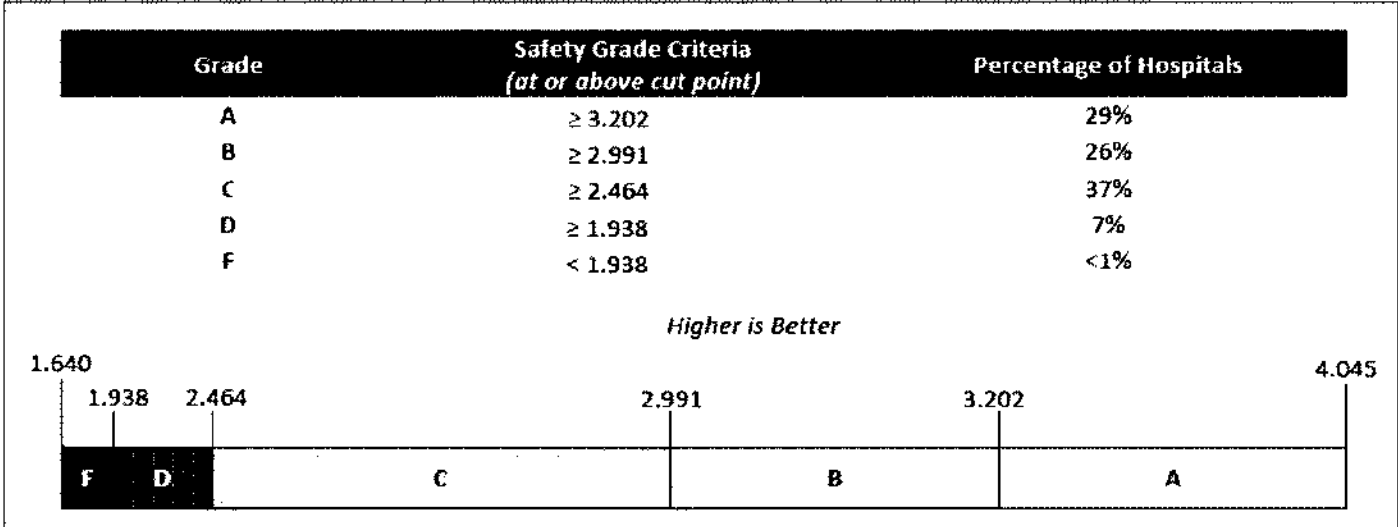
Notice: The information in this communication is confidential and is directed only to the intended recipient. Please do not forward this communication without my permission. If you have received this communication in error, please notify me immediately and delete/destroy this communication.

From: West, Regina
Sent: Monday, September 30, 2024 3:05 PM
To: Ramirez, Ricardo <Ricardo.Ramirez@tenethealth.com>
Subject: Leapfrog

Ricky – here are our Leapfrog Scores and anticipated grades based on imputed scoring:

- Delray: 1.5968 (F)
- Good Sam: 1.7652 (F)
- PB Gardens: 1.7770 (F)
- St. Mary's: 2.2450 (D)
- West Boca:

Spring's scoring spread to help gauge where we may land in once the scores are published



Gina West

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From: West, Regina
Sent: Friday, September 27, 2024 9:33 AM
To: Ramirez, Ricardo <Ricardo.Ramirez@tenethealth.com>
Subject: FW: Leapfrog

Looping you in: HO is not allowing participation in Leapfrog but they continue to ask for our scores.

Gina West
St. Mary's Medical Center & PBHN Market Quality Director
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West Palm Beach, FL 33407
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Notice: The information in this communication is confidential and is directed only to the intended recipient. Please do not forward this communication without my permission. If you have received this communication in error, please notify me immediately and delete/destroy this communication.

From: Gunod, Anna <Anna.Gunod@tenethealth.com>
Sent: Friday, September 27, 2024 9:29 AM
To: West, Regina <Regina.West@tenethealth.com>
Cc: Nunes, Andrea <ANDREA.Nunes@tenethealth.com>; WEHMEYER, HEATHER <heather.wehmeyer@tenethealth.com>; McDonald, Kathleen <Kathleen.Mcdonald@tenethealth.com>; Pool, Taylor <Taylor.Pool@tenethealth.com>
Subject: RE: Leapfrog

It is a No from home office. Facilities who need an exception due to Leapfrog participation being tied to a local requirement, contract compliance, or reimbursement need to submit their case for review by Dr. Franklin.

Thanks,
Anna

Anna Gunod, MPH, CIC
National Director of Infection Prevention

C: (860) 309-6819
anna.gunod@tenethealth.com



A COMMUNITY BUILT ON CARE

Tenet Healthcare
14201 Dallas Parkway
Dallas, Texas 75254

From: West, Regina <Regina.West@tenethealth.com>
Sent: Friday, September 27, 2024 6:01 AM
To: Gunod, Anna <Anna.Gunod@tenethealth.com>
Cc: Nunes, Andrea <ANDREA.Nunes@tenethealth.com>; WEHMEYER, HEATHER <heather.wehmeyer@tenethealth.com>; McDonald, Kathleen <Kathleen.Mcdonald@tenethealth.com>; Pool, Taylor <Taylor.Pool@tenethealth.com>
Subject: RE: Leapfrog

Although not supported, is it left up to the local markets to decide or a strict "No" from HO?

Gina West
St. Mary's Medical Center & PBHN Market Quality Director
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Notice: The information in this communication is confidential and is directed only to the intended recipient. Please do not forward this communication without my permission. If you have received this communication in error, please notify me immediately and delete/destroy this communication.

From: Gunod, Anna <Anna.Gunod@tenethealth.com>
Sent: Thursday, September 26, 2024 5:36 PM
To: West, Regina <Regina.West@tenethealth.com>
Cc: Nunes, Andrea <ANDREA.Nunes@tenethealth.com>; WEHMEYER, HEATHER <heather.wehmeyer@tenethealth.com>; McDonald, Kathleen <Kathleen.Mcdonald@tenethealth.com>; Pool, Taylor <Taylor.Pool@tenethealth.com>
Subject: RE: Leapfrog

Hi Gina,

Leapfrog participation is not supported unless it is directly tied to a payment/contract or a local regulatory requirement.

Thanks,
Anna

Anna Gunod, MPH, CIC
National Director of Infection Prevention

C: (860) 309-6819
anna.gunod@tenethealth.com

A COMMUNITY BUILT ON **CARE**

Tenet Healthcare
14201 Dallas Parkway
Dallas, Texas 75254

From: West, Regina <Regina.West@tenethealth.com>
Sent: Wednesday, September 25, 2024 1:24 PM
To: Gunod, Anna <Anna.Gunod@tenethealth.com>
Cc: Nunes, Andrea <ANDREA.Nunes@tenethealth.com>; WEHMEYER, HEATHER <heather.wehmeyer@tenethealth.com>; McDonald, Kathleen <Kathleen.Mcdonald@tenethealth.com>; Pool, Taylor <Taylor.Pool@tenethealth.com>
Subject: Leapfrog

Anna,

If we would like to participate in the next survey, are we able? We have done this in the past, so it would not be new participation. Because we aren't participating, we default to imputed scoring. This takes SMMC from 100 points in each of the categories below to limited achievement scores. We will likely decrease an entire letter and score a "D" this time around.

STEP 2: USE IMPUTATION POINT ASSIGNMENT (APPLIES TO CPOE, BCMA, IPS AND HAND HYGIENE)

If the hospital does not have historical data from the last two rounds (i.e., spring 2024, fall 2023) of the Safety Grade, the hospital is assigned a point value that is equivalent to receiving "Limited Achievement" for this measure on the Leapfrog Hospital Survey.

Note about IPS: Only hospitals that operate an adult or pediatric medical and/or surgical ICU or neuro ICU are eligible for Step 2 imputation of the IPS measure. A hospital's ICU designation (i.e., operating a medical ICU, surgical ICU, or pediatric ICU) is determined from the number of medical, surgical and/or pediatric ICU beds reported in Worksheet S-3 Part 1 of the hospital's most recent CMS Cost Report. If your hospital does not operate an ICU, but shares a CMS Certification Number with a hospital that does, please [contact the Help Desk](#) immediately if an IPS score was imputed.

Step 2 Imputation Point Assignments

Measure	Leapfrog Hospital Survey Performance Category	Corresponding Safety Grade Measure Score
CPOE	Limited Achievement	15
BCMA	Limited Achievement	25
IPS	Limited Achievement	5
Hand Hygiene	Limited Achievement	15

Gina West
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Delray | Good Samaritan | Palm Beach Gardens | St. Mary's | West Boca

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From: Gunod, Anna <Anna.Gunod@tenethealth.com>

Sent: Friday, August 23, 2024 9:36 AM

To: West, Regina <Regina.West@tenethealth.com>

Cc: Nunes, Andrea <ANDREA.Nunes@tenethealth.com>; WEHMEYER, HEATHER

<heather.wehmeyer@tenethealth.com>; McDonald, Kathleen <Kathleen.Mcdonald@tenethealth.com>; Pool, Taylor <Taylor.Pool@tenethealth.com>

Subject: RE: Leapfrog

Thank you, Gina.

Anna

Anna Gunod, MPH, CIC

National Director of Infection Prevention

C: (860) 309-6819

anna.gunod@tenethealth.com



A COMMUNITY BUILT ON **CARE**

Tenet Healthcare

14201 Dallas Parkway

Dallas, Texas 75254

From: West, Regina <Regina.West@tenethealth.com>

Sent: Friday, August 23, 2024 8:35 AM

To: Gunod, Anna <Anna.Gunod@tenethealth.com>

Cc: Nunes, Andrea <ANDREA.Nunes@tenethealth.com>; WEHMEYER, HEATHER

<heather.wehmeyer@tenethealth.com>; McDonald, Kathleen <Kathleen.Mcdonald@tenethealth.com>; Pool, Taylor <Taylor.Pool@tenethealth.com>

Subject: RE: Leapfrog

The hospitals in PBHN are not participating.

Gina West

St. Mary's Medical Center & PBHN Market Quality Director

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From: Gunod, Anna <Anna.Gunod@tenethealth.com>
Sent: Friday, August 23, 2024 9:15 AM
To: DL-DCQI only <DLDCQIonly@tenethealth.com>
Subject: Leapfrog

Good morning, Quality Leaders,

I am doing an annual check-in on Leapfrog participation.

Please respond to this email with answers to the following questions:

Name of facility:

Is your facility participating in Leapfrog?

If yes, is participation tied to a local requirement or payer/reimbursement? Please provide some detail.

As a reminder, new participation in Leapfrog must be approved by home office clinical operations leadership.

Thank you,
Anna

Anna Gunod, MPH, CIC
National Director of Infection Prevention

C: (860) 309-6819
anna.gunod@tenethealth.com



A COMMUNITY BUILT ON 

Tenet Healthcare
14201 Dallas Parkway
Dallas, Texas 75254

EXHIBIT 18

Message

From: Havericak, Heather [/O=EXCHANGELABS/OU=EXCHANGE ADMINISTRATIVE GROUP (FYDIBOHF23SPDLT)/CN=RECIPIENTS/CN=A2AA76DE77444F81869715A085D29611-383BF02D-95]
Sent: 12/11/2024 1:18:27 PM
To: Shoemaker, Jennifer [jennifer.shoemaker@tenethealth.com]; Jackson, Nicole [NICOLE.JACKSON2@tenethealth.com]
Subject: leapfrog standards
Attachments: 2024_HospitalSurveyScoringAlgorithm_20240401_v9.1(version 1).pdf

Good Morning,

Sending this to you both as a prep. We may be going back to leapfrog and want you both to review the leapfrog criteria guide as there are several different categories. It will show you what the standard is where you can meet, achieve or not meet. There is a whole nursing section that goes over HPPD/ or ratios on each units, percent of nurses who are RNs, and percent of nurses that are BSN prepared (with 80% being the target). Nothing has been decided at this time just wanted to send it so you all had some time to review and think about some areas where we can really excel. There are many measures we can be positioned in the top achievement. Let me know after you review if you all want to get together just to talk about where you believe we would be positioned.

Heather

Heather Havericak
Chief Executive Officer
Delray Medical Center
Office: 561-495-3100
Cell: 305-742-1344



Stronger Together. For You.

#PBHNProud

EXHIBIT 19

Message

Sent: 3/25/2024 7:13:47 PM
To: Colandrea, Maureen [Maureen.Colandrea@tenethealth.com]
CC: Ortiz, Maritza [MARITZA.Ortiz@tenethealth.com]; Pool, Taylor [Taylor.Pool@tenethealth.com]
Subject: RE: Leapfrog SIR Benchmark numbers for Good Samaritan

Hi, Reetz – does the data tell me the following about GS in 2024? In order to meet LF targets you can only have the following reportable number of cases?

CLABSI = 1 to maintain rate 0.428 (assuming line days remain the same)
CAUTI = 2 to maintain rate 0.627 (assuming device remain the same)
SSI Colon = 5 to maintain rate 0.846 (assuming surgical volume remains the same)
MRSA = 2 to maintain rate of 0.794 (assuming patient days remains the same)
CDI = 16 to maintain rate of 0.454 (assuming patient days remains the same)

Gina West

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Notice: The information in this communication is confidential and is directed only to the intended recipient. Please do not forward this communication without my permission. If you have received this communication in error, please notify me immediately and delete/destroy this communication.

From: Colandrea, Maureen <Maureen.Colandrea@tenethealth.com>
Sent: Monday, March 25, 2024 11:14 AM
To: West, Regina <Regina.West@tenethealth.com>
Cc: Ortiz, Maritza <MARITZA.Ortiz@tenethealth.com>; Pool, Taylor <Taylor.Pool@tenethealth.com>
Subject: Leapfrog SIR Benchmark numbers for Good Samaritan

Good morning,
Maritza kindly provided me with the following numbers (see below). Please let me know if you have any questions. Thank you, Maureen

Number of cases Good Samaritan can have in order to meet Leapfrog benchmarks

Infection type	# of cases for all units	CMS	Current 2024	Projected 2024
CLABSI	3.5	1.45	2.604	0.651
CAUTI	3.6	2	0.00	0.00
SSI Colon *	5	5	0.00	5

MRSA	2.3	2.3	0.00	0.00
CDI	16	16	3.006	0.751

*based on Dec 2023 and Jan 2024 only, Feb data pending

Maureen Colandrea RN MSN
Infection Prevention RN
Good Samaritan Hospital
1309 N. Flagler Dr. 33401
908-839-6945
Maureen.colandrea@tenethealth.com

EXHIBIT 20



Scoring Methodology

SPRING 2025 SAFETY GRADE



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WHAT IS THE HOSPITAL SAFETY GRADE?

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

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

ELIGIBLE HOSPITALS

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

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

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

LEAPFROG HOSPITAL SAFETY GRADE

MEASURES

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

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

PROCESS/STRUCTURAL MEASURES (12)				
Measure Name	Primary Data Source	Reporting Period	Secondary Data Source	Reporting Period
Computerized Physician Order Entry (CPOE)	2024 Leapfrog Hospital Survey	2024	Imputation Model Applied*	N/A
Bar Code Medication Administration (BCMA)	2024 Leapfrog Hospital Survey	2024	Imputation Model Applied*	N/A
ICU Physician Staffing (IPS)	2024 Leapfrog Hospital Survey	2024	Imputation Model Applied*	N/A
Safe Practice 1: Culture of Leadership Structures and Systems	2024 Leapfrog Hospital Survey	2024	N/A	N/A
Safe Practice 2: Culture Measurement, Feedback & Intervention	2024 Leapfrog Hospital Survey	2024	N/A	N/A



PROCESS/STRUCTURAL MEASURES (12)				
Measure Name	Primary Data Source	Reporting Period	Secondary Data Source	Reporting Period
Total Nursing Care Hours per Patient Day	2024 Leapfrog Hospital Survey	01/01/2023 - 12/31/2023 or 07/01/2023 - 06/30/2024	N/A	N/A
Hand Hygiene	2024 Leapfrog Hospital Survey	2024	Imputation Model Applied*	N/A
H-COMP-1: Nurse Communication	CMS	01/01/2023 - 12/31/2023	N/A	N/A
H-COMP-2: Doctor Communication	CMS	01/01/2023 - 12/31/2023	N/A	N/A
H-COMP-3: Staff Responsiveness	CMS	01/01/2023 - 12/31/2023	N/A	N/A
H-COMP-5: Communication about Medicines	CMS	01/01/2023 - 12/31/2023	N/A	N/A
H-COMP-6: Discharge Information	CMS	01/01/2023 - 12/31/2023	N/A	N/A

*See [Leapfrog's Imputation Method for CPOE, BCMA, IPS and Hand Hygiene](#) for more information on the imputation methodology used for hospitals that did not submit a Leapfrog Hospital Survey by November 30, 2024.

LEAPFROG
HOSPITAL
SAFETY GRADE

OUTCOME MEASURES (10)				
Measure Name	Primary Data Source	Reporting Period	Secondary Data Source	Reporting Period
Foreign Object Retained	CMS	07/01/2021 - 06/30/2023	N/A	N/A
Air Embolism	CMS	07/01/2021 - 06/30/2023	N/A	N/A
Falls and Trauma	CMS	07/01/2021 - 06/30/2023	N/A	N/A
CLABSI	2024 Leapfrog Hospital Survey	07/01/2023 - 06/30/2024	CMS	01/01/2023 - 12/31/2023
CAUTI	2024 Leapfrog Hospital Survey	07/01/2023 - 06/30/2024	CMS	01/01/2023 - 12/31/2023
SSI: Colon	2024 Leapfrog Hospital Survey	07/01/2023 - 06/30/2024	CMS	01/01/2023 - 12/31/2023
MRSA	2024 Leapfrog Hospital Survey	07/01/2023 - 06/30/2024	CMS	01/01/2023 - 12/31/2023
C. Diff.	2024 Leapfrog Hospital Survey	07/01/2023 - 06/30/2024	CMS	01/01/2023 - 12/31/2023

LEAPFROG
HOSPITAL
SAFETY GRADE

OUTCOME MEASURES (10)				
PSI 4: Death rate among surgical inpatients with serious treatable complications	CMS	07/01/2021 - 06/30/2023	N/A	N/A
Measure Name	Primary Data Source	Reporting Period	Secondary Data Source	Reporting Period
CMS Medicare PSI 90: Patient safety and adverse events composite*	CMS	07/01/2021 - 06/30/2023	N/A	N/A

* CMS calculates PSI 90 using the ten (10) component PSIs. While scores for each of the 10 component PSIs are not used to calculate spring 2025 Hospital Safety Grades, they will be publicly reported on the Hospital Safety Grade [website](#).

**COMPONENT PSIs (SCORES NOT USED TO CALCULATE THE HOSPITAL SAFETY GRADE)				
Component PSI	Primary Data Source	Reporting Period	Secondary Data Source	Reporting Period
PSI 3: Pressure ulcer rate	CMS	07/01/2021 - 06/30/2023	N/A	N/A
PSI 6: Iatrogenic pneumothorax rate	CMS	07/01/2021 - 06/30/2023	N/A	N/A
PSI 8: In-hospital fall with hip fracture rate	CMS	07/01/2021 - 06/30/2023	N/A	N/A
PSI 9: Postoperative hemorrhage or hematoma rate	CMS	07/01/2021 - 06/30/2023	N/A	N/A
PSI 10: Postoperative acute kidney injury requiring dialysis rate	CMS	07/01/2021 - 06/30/2023	N/A	N/A
PSI 11: Postoperative respiratory failure rate	CMS	07/01/2021 - 06/30/2023	N/A	N/A
PSI 12: Perioperative pulmonary embolism or deep vein thrombosis rate	CMS	07/01/2021 - 06/30/2023	N/A	N/A
PSI 13: Postoperative sepsis rate	CMS	07/01/2021 - 06/30/2023	N/A	N/A
PSI 14: Postoperative wound dehiscence rate	CMS	07/01/2021 - 06/30/2023	N/A	N/A
PSI 15: Abdominopelvic accidental puncture or laceration rate	CMS	07/01/2021 - 06/30/2023	N/A	N/A

Note: CMS calculates PSI 90 using the ten (10) component PSIs listed above. While scores for each of the 10 component PSIs are not used to calculate spring 2025 Hospital Safety Grades, they will be publicly reported on the Hospital Safety Grade [website](#).

MEASURE & SCORING DESCRIPTIONS

PROCESS/STRUCTURAL MEASURES

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

COMPUTERIZED PHYSICIAN ORDER ENTRY (CPOE)

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

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

For hospitals that did not submit a 2024 Leapfrog Hospital Survey by November 30, see [Using Secondary Data Sources](#) for more information on Leapfrog's imputation methodology.

BAR CODE MEDICATION ADMINISTRATION (BCMA)

The BCMA measure is collected by The Leapfrog Group on the Leapfrog Hospital Survey. It measures a hospital's progress toward 1) implementation of BCMA throughout the hospital, 2) compliance with patient and medication scans during administration, 3) use of decision support, and 4) structures to monitor and reduce workarounds. Through participation in the Leapfrog Hospital Survey, hospitals are placed in one of several performance categories: "Achieved the Standard," "Considerable Achievement," "Some Achievement," "Limited Achievement," or "Does Not Apply." For the purposes of calculating the Safety Grade, a numerical score is assigned to each performance category:

Leapfrog Performance Category	Measure Score
Achieved the Standard	100
Considerable Achievement	75
Some Achievement	50
Limited Achievement	25
Does Not Apply	Not Available (See Scoring Terms)

For hospitals that did not submit a 2024 Leapfrog Hospital Survey by November 30, see [Using Secondary Data Sources](#) for more information on Leapfrog's imputation methodology.

ICU PHYSICIAN STAFFING (IPS)

The IPS measure is collected by The Leapfrog Group on the Leapfrog Hospital Survey. It measures a hospital's use of intensivists in ICUs. Through participation in the Leapfrog Hospital Survey, hospitals are placed in one of several performance categories: "Achieved the Standard," "Considerable Achievement," "Some Achievement," "Limited Achievement," or "Does Not Apply." For the purposes of calculating the Safety Grade, a numerical score is assigned to each performance category:

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

For hospitals that did not submit a 2024 Leapfrog Hospital Survey by November 30, see [Using Secondary Data Sources](#) for detailed information on Leapfrog's imputation methodology.

NATIONAL QUALITY FORUM (NQF) SAFE PRACTICES

Two (2) NQF Safe Practice measures are collected by The Leapfrog Group on the Leapfrog Hospital Survey. They measure a hospital's progress toward implementing endorsed processes and protocols to reduce and prevent adverse events. Through participation in the Leapfrog Hospital Survey, hospitals can earn up to 120 points for each Safe Practice. For the purposes of calculating the Safety Grade, individual scores for each Safe Practice are used:

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

There is no secondary data source for the NQF Safe Practices. Therefore, hospitals that did not submit a 2024 Leapfrog Hospital Survey by November 30 will not have these measures included in their Safety Grade and the measure will be reported as "Declined to Report." See [Dealing with Missing Data](#) for more information.

TOTAL NURSING CARE HOURS PER PATIENT DAY

The Total Nursing Care Hours per Patient Day measure is collected by The Leapfrog Group on the Leapfrog Hospital Survey. It measures the hospital's total number of productive hours worked by employee or contract nursing staff (i.e., RNs, LPNs, and UAPs) with direct patient care responsibilities per patient day across three unit types: medical, surgical, and med/surg. Through participation in the Leapfrog Hospital Survey, hospitals are placed in one of several performance categories: "Achieved the Standard," "Considerable Achievement," "Some Achievement," "Limited Achievement," or "Does Not Apply." For the purposes of calculating the Safety Grade, a numerical score is assigned to each performance category:

Leapfrog Performance Category	Measure Score
Achieved the Standard	100
Considerable Achievement	70
Some Achievement	40
Limited Achievement	15
Does Not Apply	Not Available (See Scoring Terms)

There is no secondary data source for the Total Nursing Care Hours per Patient Day measure. Therefore, hospitals that did not submit a 2024 Leapfrog Hospital Survey by November 30 will not have these measures included in their Safety Grade and the measure will be reported as “Declined to Report.” See [Dealing with Missing Data](#) for more information.

HAND HYGIENE

The Hand Hygiene measure is collected by The Leapfrog Group on the Leapfrog Hospital Survey. It measures processes and protocols that hospitals have in place regarding monitoring hand hygiene practices, fostering a culture of good hand hygiene, offering training and education, and providing equipment. Through participation in the Leapfrog Hospital Survey, hospitals are placed in one of several performance categories: “Achieved the Standard,” “Considerable Achievement,” “Some Achievement,” “Limited Achievement.” For the purposes of calculating the Safety Grade, a numerical score is assigned to each performance category:

Leapfrog Performance Category	Measure Score
Achieved the Standard	100
Considerable Achievement	70
Some Achievement	40
Limited Achievement	15

For hospitals that did not submit a 2024 Leapfrog Hospital Survey by November 30, see [Using Secondary Data Sources](#) for detailed information on Leapfrog’s imputation methodology.

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

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

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



OUTCOME MEASURES

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

HOSPITAL-ACQUIRED CONDITIONS

Three hospital-acquired condition measures are calculated by CMS through the [DRA HAC Reporting Program](#): Foreign Object Retained after Surgery, Air Embolism, and Falls and Trauma. Hospital-acquired condition rates are calculated by CMS based on Part A Medicare Fee-for-service (FFS) claims and publicly reported as a rate per 1,000 Part A Medicare FFS discharges. No age restrictions are applied. For the purposes of calculating the Safety Grade, the rate is used. More information is available in the [DRA HAC methodology](#).

HEALTHCARE-ASSOCIATED INFECTIONS

Five healthcare-associated infection measures are collected by The Leapfrog Group on the Leapfrog Hospital Survey: Central line-associated bloodstream infections (CLABSI) in ICUs and select wards, Catheter-associated urinary tract infections (CAUTI) in ICUs and select wards, Surgical site infections from colon surgery (SSI: Colon), Facility-wide inpatient MRSA Blood Laboratory-identified Events, and Facility-wide inpatient C.diff. Laboratory-identified Events. Through participation in the Leapfrog Hospital Survey, hospitals were required to 1) join Leapfrog's NHSN group, 2) provide an accurate NHSN ID in the Profile section of the Online Survey Tool, and 3) submit a Survey by November 30. For the purposes of calculating the Safety Grade, the [standardized infection ratio \(SIR\)](#) is used:

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



For hospitals that did not join Leapfrog's NHSN group, provide an accurate NHSN ID, or submit a 2024 Leapfrog Hospital Survey by November 30, see [Using Secondary Data Sources](#) for more information on Leapfrog's use of CMS data.

AHRQ PATIENT SAFETY INDICATORS (PSI)

Two AHRQ Patient Safety Indicators are calculated by CMS through the Inpatient Quality Reporting Program and the [HAC Reduction Program](#): PSI 4 Death Rate among Surgical Inpatients with Serious Treatable Conditions and PSI 90 Patient Safety and Adverse Events Composite. PSI rates are calculated by CMS based on Medicare Fee-for-Service claims and publicly reported as a rate per 1,000 inpatient discharges. CMS only includes claims from patients 18 years or older. For the purpose of calculating the Safety Grade, the smoothed rate is used for both measures. More information on calculating PSIs is available on the [Patient Safety Indicators \(PSI\) 2024 Resources website](#).

Note: CMS calculates PSI 90 using the ten (10) component PSIs that are listed in the PSI 90 Components table [above](#). While scores for each of the 10 component PSIs are NOT used to calculate spring 2025 Hospital Safety Grades, they will be publicly reported on the Hospital Safety Grade [website](#). Additional information about the PSI 90 measure and how it is calculated by CMS can be found [here](#).



USING SECONDARY DATA SOURCES

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

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

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

STEP 1: USE A HOSPITAL'S MOST RECENT SCORE ON THE MEASURE (APPLIES TO CPOE, IPS, AND HAND HYGIENE ONLY)

If the hospital had a score assigned by Leapfrog in the previous two rounds of grades (i.e., fall 2024, spring 2024), excluding imputed scores, the hospital is assigned the most recent score on that measure in the current Hospital Safety Grade (i.e., spring 2025).



STEP 2: USE IMPUTATION POINT ASSIGNMENT (APPLIES TO CPOE, BCMA, IPS AND HAND HYGIENE)

If the hospital does not have historical data from the last two rounds (i.e., fall 2024, spring 2024) of the Safety Grade, the hospital is assigned a point value that is equivalent to receiving “Limited Achievement” for this measure on the Leapfrog Hospital Survey.

Note about IPS: Only hospitals that operate an adult or pediatric medical and/or surgical ICU or neuro ICU are eligible for Step 2 Imputation of the IPS measure. A hospital’s ICU designation (i.e., operating a medical ICU, surgical ICU, or pediatric ICU) is determined from the number of medical, surgical and/or pediatric ICU beds reported in Worksheet S-3 Part 1 of the hospital’s most recent CMS Cost Report. If your hospital does not operate an ICU, but shares a CMS Certification Number with a hospital that does, please [contact the Help Desk](#) immediately if an IPS score was imputed.

Step 2 Imputation Point Assignments

Measure	Leapfrog Hospital Survey Performance Category	Corresponding Safety Grade Measure Score
CPOE	Limited Achievement	15
BCMA	Limited Achievement	25
IPS	Limited Achievement	5
Hand Hygiene	Limited Achievement	15



CMS DATA FOR HAIS

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

Hospitals That Did Not Join Leapfrog’s NHSN Group and Submit Section 7: Managing Serious Errors of the 2024 Leapfrog Hospital Survey by November 30

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

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



SCORING METHODOLOGY

WEIGHTING INDIVIDUAL MEASURES

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

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

EVIDENCE

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

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

OPPORTUNITY

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

IMPACT

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

1. Number of patients affected



2. Severity of harm

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

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

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

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

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

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

NUMBER OF COMPONENT MEASURES

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

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STANDARD MEASURE WEIGHTS

Measure	Evidence Score	Opportunity Score	Impact Score	Number of Component Measures	Standard Measure Weight
Process/Structural Measure Domain (50%)					
CPOE	2	1.43	3	1	6.2%
BCMA	2	1.37	3	1	6.0%
IPS	2	1.67	3	1	6.9%
SP 1	1	1.06	2	1	3.1%
SP 2	1	1.12	2	1	3.2%
Total Nursing Care Hours per Patient Day	2	1.41	2	1	4.7%
Hand Hygiene	2	1.49	2	1	4.9%
H-COMP-1	1	1.03	2	1	3.0%
H-COMP-2	1	1.03	2	1	3.0%
H-COMP-3	1	1.05	2	1	3.0%
H-COMP-5	1	1.06	2	1	3.1%
H-COMP-6	1	1.04	2	1	3.0%
Outcome Measure Domain (50%)					
Foreign Object Retained	1	3.00	2	1	4.2%
Air Embolism	1	3.00	1	1	2.4%
Falls and Trauma	2	2.05	3	1	4.9%
CLABSI	2	1.85	3	1	4.5%
CAUTI	2	1.91	3	1	4.7%
SSI: Colon	2	1.83	2	1	3.4%
MRSA	2	1.82	3	1	4.5%
C. Diff.	2	1.81	3	1	4.5%
PSI 4	1	1.14	2	1	2.0%
PSI 90	1	1.20	2	10	15.0%



CALCULATING Z-SCORES

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

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

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

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

Process and Structural Measures	Mean	Standard Deviation
CPOE	80.23	34.14
BMCA	81.87	30.45
IPS	65.15	43.73
SP 1	117.49	6.79
SP 2	116.85	13.98
Total Nursing Care Hours per Patient Day	77.07	31.61
Hand Hygiene	74.40	36.14
H-COMP-1	90.19	2.51
H-COMP-2	89.91	2.48
H-COMP-3	81.63	4.36
H-COMP-5	74.42	4.13
H-COMP-6	85.25	3.70

Outcome Measures	Mean	Standard Deviation
Foreign Object Retained	0.014	0.050
Air Embolism	0.002	0.055
Falls and Trauma	0.384	0.402
CLABSI	0.651	0.552
CAUTI	0.540	0.494
SSI: Colon	0.831	0.689
MRSA	0.719	0.591
C. Diff.	0.401	0.326
PSI 4	177.452	24.020
PSI 90	1.002	0.196

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A NOTE ABOUT EXTREME VALUES

For hospitals that have an “extreme” value for a particular measure (i.e., a value that exceeds the 99th percentile) Leapfrog “trims” the reported value to the 99th percentile. For example, a rate of 0.500 per 1,000 patient discharges for Foreign Object Retained after Surgery is “trimmed” to 0.327 (e.g., the 99th percentile). Only “trimmed” rates are displayed on the Leapfrog Hospital Safety Grade [website](#). The table below includes the “trimmed” values for the spring 2025 Leapfrog Hospital Safety Grade. The PSI 90 measure score represents an observed to expected ratio that has already been risk adjusted at both the component PSI level and at the composite level; therefore, the measure is not “trimmed” by Leapfrog.

Measure	99 th Percentile
Foreign Object Retained	0.327
Air Embolism	2.89
Falls and Trauma	1.926
CLABSI	2.782
CAUTI	2.512
SSI: Colon	3.094
MRSA	2.85
C. Diff.	1.607
PSI 4	235.51

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

DEALING WITH MISSING DATA

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

For example, if a hospital is missing a measure score for ICU Physician Staffing because the hospital does not operate an adult or pediatric medical and/or surgical ICU, the standard weight of 6.9% will be re-apportioned to the remaining 11 measures within the process/structural measure domain.



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

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

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

CALCULATING WEIGHTED MEASURE SCORES

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

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

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



ADDITIONAL SCORING INFORMATION

TERMS USED IN SCORING AND PUBLIC REPORTING

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

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

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

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

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

SHARED CMS CERTIFICATION NUMBERS

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



UPDATES TO DATA USED IN THE LEAPFROG HOSPITAL SAFETY GRADE

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

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

DATA FROM THE LEAPFROG HOSPITAL SURVEY

During the Safety Grade Review Period (February 24 – March 14), Leapfrog will only make corrections to a hospital's data from the 2024 Leapfrog Hospital Survey if a recording error is identified (i.e., we have recorded a different measure score than what is posted on our Survey Results website) or a scoring error is identified (i.e., Leapfrog has calculated an incorrect measure score based on the submitted responses and Leapfrog's published scoring algorithms). Updates to Leapfrog Hospital Survey data that are submitted after the Data Snapshot Date will **not** be included in the current Leapfrog Hospital Safety Grade. Hospitals submitting a Leapfrog Hospital Survey are urged to take advantage of the opportunity to review their Survey Results for accuracy and completeness prior to each of the two published Data Snapshot Dates.

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

The Leapfrog Hospital Survey is open from April 1 to November 30 of each year. Following the Submission Deadline (June 30), Survey Results are published monthly on a secure 'Hospital Details' page and a public website (ratings.leapfroggroup.org). Hospitals are urged to review their Survey Results immediately. Hospitals that identify any reporting errors are instructed to log back into the Survey to submit a correction. Hospitals can correct and re-submit a previously submitted Survey until the Survey closes for the year. Note that corrections submitted after the Data Snapshot Date are not included in the current Leapfrog Hospital Safety Grade. Leapfrog has several automated processes in place to prevent hospitals from making data entry errors in the Online Survey Tool and to enhance the overall accuracy of the Survey Results. Learn more at <http://www.leapfroggroup.org/survey-materials/data-accuracy>.



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

During the Safety Grade Review Period (February 24 – March 14), Leapfrog will only make corrections to a hospital's data from CMS if the correction is issued by CMS and posted to the Data.CMS.Gov website. If a hospital has identified an error with a measure score published by CMS, and CMS cannot post a correction within the review period, the measure score will not be used in calculating the hospital's Safety Grade, provided that the hospital can document that CMS has agreed to publicly issue a correction or remove the measure score from public reporting. Hospitals participating with CMS are urged to take advantage of the opportunity to participate in the CMS 30-day review periods.

CMS FOOTNOTE 23 POLICY

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

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

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

CMS administers several hospital-based reporting and payment programs including the Inpatient Quality Reporting Program, HAC Reduction Program, and Value-based Purchasing Program. Several measures collected and calculated by CMS via its various hospital-based programs are used in the Leapfrog Hospital Safety Grade. CMS provides hospitals with a 30-day preview period before publishing measure scores on the Data.Medicare.Gov website and the Data.CMS.Gov website. More information is available at <https://qualitynet.org>.



HOW TO PARTICIPATE IN THE LEAPFROG HOSPITAL SURVEY

If a hospital did **not** complete a 2024 Leapfrog Hospital Survey by November 30, Survey Results were not used to calculate the spring 2025 Leapfrog Hospital Safety Grade. Hospitals that would like Survey Results included in the fall 2025 Hospital Safety Grade must submit a 2025 Leapfrog Hospital Survey (including the CPOE Evaluation) by June 30, 2025. Hospitals will be able to review their publicly reported [Survey Results](#) in July and respond to any issues identified by Leapfrog's [Extensive Monthly Data Verification](#) before the [Data Snapshot Date](#) for the fall 2025 Safety Grade of August 31. More information is available at <https://leapfroggroup.org/survey>.

LEAPFROG HELP DESK

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

EXHIBIT 21

LEAPFROG
HOSPITAL
SAFETY GRADE

Scoring Methodology

FALL 2024 SAFETY GRADE

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11/4/2024

LEAPFROG00065461

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WHAT IS THE HOSPITAL SAFETY GRADE?

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

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

ELIGIBLE HOSPITALS

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

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

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

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MEASURES

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

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

PROCESS/STRUCTURAL MEASURES (12)

Measure Name	Primary Data Source	Reporting Period	Secondary Data Source	Reporting Period
Computerized Physician Order Entry (CPOE)	2024 Leapfrog Hospital Survey	2024	Imputation Model Applied*	N/A
Bar Code Medication Administration (BCMA)	2024 Leapfrog Hospital Survey	2024	Imputation Model Applied*	N/A
ICU Physician Staffing (IPS)	2024 Leapfrog Hospital Survey	2024	Imputation Model Applied*	N/A
Safe Practice 1: Culture of Leadership Structures and Systems	2024 Leapfrog Hospital Survey	2024	N/A	N/A
Safe Practice 2: Culture Measurement, Feedback & Intervention	2024 Leapfrog Hospital Survey	2024	N/A	N/A

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PROCESS/STRUCTURAL MEASURES (12)

Measure Name	Primary Data Source	Reporting Period	Secondary Data Source	Reporting Period
Total Nursing Care Hours per Patient Day	2024 Leapfrog Hospital Survey	01/01/2023 - 12/31/2023	N/A	N/A
Hand Hygiene	2024 Leapfrog Hospital Survey	2024	Imputation Model Applied*	N/A
H-COMP-1: Nurse Communication	CMS	10/01/2022 - 09/30/2023	N/A	N/A
H-COMP-2: Doctor Communication	CMS	10/01/2022 - 09/30/2023	N/A	N/A
H-COMP-3: Staff Responsiveness	CMS	10/01/2022 - 09/30/2023	N/A	N/A
H-COMP-5: Communication about Medicines	CMS	10/01/2022 - 09/30/2023	N/A	N/A
H-COMP-6: Discharge Information	CMS	10/01/2022 - 09/30/2023	N/A	N/A

*See Leapfrog's Imputation Method for CPOE, BCMA, IPS and Hand Hygiene for more information on the imputation methodology used for hospitals that did not submit a Leapfrog Hospital Survey by the Data Snapshot Date (August 31, 2024).

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OUTCOME MEASURES (10)

Measure Name	Primary Data Source	Reporting Period	Secondary Data Source	Reporting Period
Foreign Object Retained	CMS	07/01/2021 - 06/30/2023	N/A	N/A
Air Embolism	CMS	07/01/2021 - 06/30/2023	N/A	N/A
Falls and Trauma	CMS	07/01/2021 - 06/30/2023	N/A	N/A
CLABSI	2024 Leapfrog Hospital Survey	01/01/2023 - 12/31/2023	CMS	10/01/2022 - 09/30/2023
CAUTI	2024 Leapfrog Hospital Survey	01/01/2023 - 12/31/2023	CMS	10/01/2022 - 09/30/2023
SSI: Colon	2024 Leapfrog Hospital Survey	01/01/2023 - 12/31/2023	CMS	10/01/2022 - 09/30/2023
MRSA	2024 Leapfrog Hospital Survey	01/01/2023 - 12/31/2023	CMS	10/01/2022 - 09/30/2023
C. Diff.	2024 Leapfrog Hospital Survey	01/01/2023 - 12/31/2023	CMS	10/01/2022 - 09/30/2023
PSI 4: Death rate among surgical inpatients with serious treatable complications	CMS	07/01/2020 - 06/30/2022	N/A	N/A
CMS Medicare PSI 90: Patient safety and adverse events composite*	CMS	07/01/2020 - 06/30/2022	N/A	N/A

* CMS calculates PSI 90 using the ten (10) component PSIs. While scores for each of the 10 component PSIs are not used to calculate fall 2024 Hospital Safety Grades, they will be publicly reported on the Hospital Safety Grade [website](#).

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

Component PSI	Primary Data Source	Reporting Period	Secondary Data Source	Reporting Period
PSI 3: Pressure ulcer rate	CMS	07/01/2020 - 06/30/2022	N/A	N/A
PSI 6: Iatrogenic pneumothorax rate	CMS	07/01/2020 - 06/30/2022	N/A	N/A
PSI 8: In-hospital fall with hip fracture rate	CMS	07/01/2020 - 06/30/2022	N/A	N/A
PSI 9: Postoperative hemorrhage or hematoma rate	CMS	07/01/2020 - 06/30/2022	N/A	N/A
PSI 10: Postoperative acute kidney injury requiring dialysis rate	CMS	07/01/2020 - 06/30/2022	N/A	N/A
PSI 11: Postoperative respiratory failure rate	CMS	07/01/2020 - 06/30/2022	N/A	N/A
PSI 12: Perioperative pulmonary embolism or deep vein thrombosis rate	CMS	07/01/2020 - 06/30/2022	N/A	N/A
PSI 13: Postoperative sepsis rate	CMS	07/01/2020 - 06/30/2022	N/A	N/A
PSI 14: Postoperative wound dehiscence rate	CMS	07/01/2020 - 06/30/2022	N/A	N/A
PSI 15: Abdominopelvic accidental puncture or laceration rate	CMS	07/01/2020 - 06/30/2022	N/A	N/A

Note: CMS calculates PSI 90 using the ten (10) component PSIs listed above. While scores for each of the 10 component PSIs are not used to calculate fall 2024 Hospital Safety Grades, they will be publicly reported on the Hospital Safety Grade [website](#).

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MEASURE & SCORING DESCRIPTIONS

PROCESS/STRUCTURAL MEASURES

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

COMPUTERIZED PHYSICIAN ORDER ENTRY (CPOE)

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

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

For hospitals that did not submit a 2024 Leapfrog Hospital Survey by August 31, see [Using Secondary Data Sources](#) for more information on Leapfrog's imputation methodology.

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BAR CODE MEDICATION ADMINISTRATION (BCMA)

The BCMA measure is collected by The Leapfrog Group on the Leapfrog Hospital Survey. It measures a hospital's progress toward 1) implementation of BCMA throughout the hospital, 2) compliance with patient and medication scans during administration, 3) use of decision support, and 4) structures to monitor and reduce workarounds. Through participation in the Leapfrog Hospital Survey, hospitals are placed in one of several performance categories: "Achieved the Standard," "Considerable Achievement," "Some Achievement," "Limited Achievement," or "Does Not Apply." For the purposes of calculating the Safety Grade, a numerical score is assigned to each performance category:

Leapfrog Performance Category	Measure Score
Achieved the Standard	100
Considerable Achievement	75
Some Achievement	50
Limited Achievement	25
Does Not Apply	Not Available (See Scoring Terms)

For hospitals that did not submit a 2024 Leapfrog Hospital Survey by August 31, see [Using Secondary Data Sources](#) for more information on Leapfrog's imputation methodology.

ICU PHYSICIAN STAFFING (IPS)

The IPS measure is collected by The Leapfrog Group on the Leapfrog Hospital Survey. It measures a hospital's use of intensivists in ICUs. Through participation in the Leapfrog Hospital Survey, hospitals are placed in one of several performance categories: "Achieved the Standard," "Considerable Achievement," "Some Achievement," "Limited Achievement," or "Does Not Apply." For the purposes of calculating the Safety Grade, a numerical score is assigned to each performance category:

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

For hospitals that did not submit a 2024 Leapfrog Hospital Survey by August 31, see [Using Secondary Data Sources](#) for detailed information on Leapfrog's imputation methodology.

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NATIONAL QUALITY FORUM (NQF) SAFE PRACTICES

Two (2) NQF Safe Practice measures are collected by The Leapfrog Group on the Leapfrog Hospital Survey. They measure a hospital's progress toward implementing endorsed processes and protocols to reduce and prevent adverse events. Through participation in the Leapfrog Hospital Survey, hospitals can earn up to 120 points for each Safe Practice. For the purposes of calculating the Safety Grade, individual scores for each Safe Practice are used:

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

There is no secondary data source for the NQF Safe Practices. Therefore, hospitals that did not submit a 2024 Leapfrog Hospital Survey by August 31 will not have these measures included in their Safety Grade and the measure will be reported as "Declined to Report." See [Dealing with Missing Data](#) for more information.

TOTAL NURSING CARE HOURS PER PATIENT DAY

The Total Nursing Care Hours per Patient Day measure is collected by The Leapfrog Group on the Leapfrog Hospital Survey. It measures the hospital's total number of productive hours worked by employee or contract nursing staff (i.e., RNs, LPNs, and UAPs) with direct patient care responsibilities per patient day across three unit types: medical, surgical, and med/surg. Through participation in the Leapfrog Hospital Survey, hospitals are placed in one of several performance categories: "Achieved the Standard," "Considerable Achievement," "Some Achievement," "Limited Achievement," or "Does Not Apply." For the purposes of calculating the Safety Grade, a numerical score is assigned to each performance category:

Leapfrog Performance Category	Measure Score
Achieved the Standard	100
Considerable Achievement	70
Some Achievement	40
Limited Achievement	15
Does Not Apply	Not Available (See Scoring Terms)

There is no secondary data source for the Total Nursing Care Hours per Patient Day measure. Therefore, hospitals that did not submit a 2024 Leapfrog Hospital Survey by August 31 will not have this measure included in their Safety Grade and the measure will be reported as "Declined to Report." See [Dealing with Missing Data](#) for more information.

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HAND HYGIENE

The Hand Hygiene measure is collected by The Leapfrog Group on the Leapfrog Hospital Survey. It measures processes and protocols that hospitals have in place regarding monitoring hand hygiene practices, fostering a culture of good hand hygiene, offering training and education, and providing equipment. Through participation in the Leapfrog Hospital Survey, hospitals are placed in one of several performance categories: "Achieved the Standard," "Considerable Achievement," "Some Achievement," "Limited Achievement." For the purposes of calculating the Safety Grade, a numerical score is assigned to each performance category:

Leapfrog Performance Category	Measure Score
Achieved the Standard	100
Considerable Achievement	70
Some Achievement	40
Limited Achievement	15

For hospitals that did not submit a 2024 Leapfrog Hospital Survey by August 31, see [Using Secondary Data Sources](#) for detailed information on Leapfrog's imputation methodology.

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

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

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

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OUTCOME MEASURES

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

HOSPITAL-ACQUIRED CONDITIONS

Three hospital-acquired condition measures are calculated by CMS through the [DRA HAC Reporting Program](#): Foreign Object Retained after Surgery, Air Embolism, and Falls and Trauma. Hospital-acquired condition rates are calculated by CMS based on Part A Medicare Fee-for-service (FFS) claims and publicly reported as a rate per 1,000 Part A Medicare FFS discharges. No age restrictions are applied. For the purposes of calculating the Safety Grade, the rate is used. More information is available in the [DRA HAC methodology](#).

HEALTHCARE-ASSOCIATED INFECTIONS

Five healthcare-associated infection measures are collected by The Leapfrog Group on the Leapfrog Hospital Survey: Central line-associated bloodstream infections (CLABSI) in ICUs and select wards, Catheter-associated urinary tract infections (CAUTI) in ICUs and select wards, Surgical site infections from colon surgery (SSI: Colon), Facility-wide inpatient MRSA Blood Laboratory-identified Events, and Facility-wide inpatient C.diff. Laboratory-identified Events. Through participation in the Leapfrog Hospital Survey, hospitals were required to 1) join Leapfrog's NHSN group, 2) provide an accurate NHSN ID in the Profile section of the Online Survey Tool, and 3) submit a Survey by August 31. For the purposes of calculating the Safety Grade, the [standardized infection ratio \(SIR\)](#) is used:

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

For hospitals that did not join Leapfrog's NHSN group, provide an accurate NHSN ID, or submit a 2024 Leapfrog Hospital Survey by August 31, see [Using Secondary Data Sources](#) for more information on Leapfrog's use of CMS data.

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AHRQ PATIENT SAFETY INDICATORS (PSI)

Two AHRQ Patient Safety Indicators are calculated by CMS through the Inpatient Quality Reporting Program and the [HAC Reduction Program](#): PSI 4 Death Rate among Surgical Inpatients with Serious Treatable Conditions and PSI 90 Patient Safety and Adverse Events Composite. PSI rates are calculated by CMS based on Medicare Fee-for-Service claims and publicly reported as a rate per 1,000 inpatient discharges. CMS only includes claims from patients 18 years or older. For the purpose of calculating the Safety Grade, the smoothed rate is used for both measures. More information on calculating PSIs is available on the [Patient Safety Indicators \(PSI\) 2024 Resources website](#).

Note: CMS calculates PSI 90 using the ten (10) component PSIs that are listed in the PSI 90 Components table [above](#). While scores for each of the 10 component PSIs are NOT used to calculate fall 2024 Hospital Safety Grades, they will be publicly reported on the Hospital Safety Grade [website](#). Additional information about the PSI 90 measure and how it is calculated by CMS can be found [here](#).

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USING SECONDARY DATA SOURCES

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

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

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

STEP 1: USE A HOSPITAL'S MOST RECENT SCORE ON THE MEASURE (APPLIES TO CPOE, IPS, AND HAND HYGIENE ONLY)

If the hospital had a score assigned by Leapfrog in the previous two rounds of grades (i.e., spring 2024, fall 2023), excluding imputed scores, the hospital is assigned the most recent score on that measure in the current Hospital Safety Grade (i.e., fall 2024).

STEP 2: USE IMPUTATION POINT ASSIGNMENT (APPLIES TO CPOE, BCMA, IPS AND HAND HYGIENE)

If the hospital does not have historical data from the last two rounds (i.e., spring 2024, fall 2023) of the Safety Grade, the hospital is assigned a point value that is equivalent to receiving "Limited Achievement" for this measure on the Leapfrog Hospital Survey:

Measure	Leapfrog Hospital Survey Performance Category	Corresponding Safety Grade Measure Score
CPOE	Limited Achievement	15
BCMA	Limited Achievement	25
IPS	Limited Achievement	5
Hand Hygiene	Limited Achievement	15

Note about IPS: Only hospitals that operate an adult or pediatric medical and/or surgical ICU or neuro ICU are eligible for Step 2 Imputation of the IPS measure. A hospital's ICU designation (i.e., operating a medical ICU, surgical ICU, or pediatric ICU) is determined from the number of medical, surgical and/or pediatric ICU beds reported in Worksheet S-3 Part 1 of the hospital's most recent CMS Cost Report. If your hospital does not operate an ICU, but shares a CMS Certification Number with a hospital that does, please [contact the Help Desk](#) immediately if an IPS score was imputed.

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CMS DATA FOR HAIS

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

Hospitals That Did Not Join Leapfrog's NHSN Group and Submit Section 7: Managing Serious Errors of the 2024 Leapfrog Hospital Survey by August 31

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

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

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SCORING METHODOLOGY

WEIGHTING INDIVIDUAL MEASURES

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

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

EVIDENCE

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

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

OPPORTUNITY

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

IMPACT

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

1. Number of patients affected
2. Severity of harm

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

- 0 = Extremely rare event (e.g., Air Embolism)
- 1 = Rare event (e.g., Foreign Object Retained After Surgery)

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- 2 = Some patients in hospital affected (e.g., ICU Physician Staffing)
- 3 = All patients in hospital affected (e.g., Hand Hygiene)

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

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

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

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

NUMBER OF COMPONENT MEASURES

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

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STANDARD MEASURE WEIGHTS

Measure	Evidence Score	Opportunity Score	Impact Score	Number of Component Measures	Standard Measure Weight
Process/Structural Measure Domain (50%)					
CPOE	2	1.44	3	1	6.2%
BCMA	2	1.39	3	1	6.0%
IPS	2	1.68	3	1	6.9%
SP 1	1	1.06	2	1	3.0%
SP 2	1	1.13	2	1	3.2%
Total Nursing Care Hours per Patient Day	2	1.42	2	1	4.7%
Hand Hygiene	2	1.51	2	1	4.9%
H-COMP-1	1	1.03	2	1	3.0%
H-COMP-2	1	1.03	2	1	3.0%
H-COMP-3	1	1.05	2	1	3.0%
H-COMP-5	1	1.06	2	1	3.0%
H-COMP-6	1	1.04	2	1	3.0%
Outcome Measure Domain (50%)					
Foreign Object Retained	1	3.00	2	1	4.2%
Air Embolism	1	3.00	1	1	2.4%
Falls and Trauma	2	2.05	3	1	4.9%
CLABSI	2	1.82	3	1	4.5%
CAUTI	2	1.88	3	1	4.6%
SSI: Colon	2	1.85	2	1	3.4%
MRSA	2	1.79	3	1	4.5%
C. Diff.	2	1.79	3	1	4.5%
PSI 4	1	1.13	2	1	2.0%
PSI 90	1	1.19	2	10	15.0%

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CALCULATING Z-SCORES

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

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

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

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

Process and Structural Measures	Mean	Standard Deviation
CPOE	79.04	34.62
BMCA	80.51	31.02
IPS	64.45	43.96
SP 1	117.40	6.66
SP 2	116.60	15.20
Total Nursing Care Hours per Patient Day	76.10	31.78
Hand Hygiene	72.43	36.61
H-COMP-1	90.04	2.56
H-COMP-2	89.80	2.48
H-COMP-3	81.48	4.41
H-COMP-5	74.33	4.16
H-COMP-6	85.14	3.78

Outcome Measures	Mean	Standard Deviation
Foreign Object Retained	0.014	0.050
Air Embolism	0.002	0.055
Falls and Trauma	0.385	0.404
CLABSI	0.687	0.566
CAUTI	0.577	0.505
SSI: Colon	0.852	0.722
MRSA	0.746	0.588
C. Diff.	0.418	0.330
PSI 4	168.34	21.85
PSI 90	1.01	0.19

HOSPITAL SAFETY GRADE

A NOTE ABOUT EXTREME VALUES

For hospitals that have an “extreme” value for a particular measure (i.e., a value that exceeds the 99th percentile) Leapfrog “trims” the reported value to the 99th percentile. For example, a rate of 0.500 per 1,000 patient discharges for Foreign Object Retained after Surgery is “trimmed” to 0.327 (e.g., the 99th percentile). Only “trimmed” rates are displayed on the Leapfrog Hospital Safety Grade [website](#). The table below includes the “trim” values for the fall 2024 Leapfrog Hospital Safety Grade. The PSI 90 measure score represents an observed to expected ratio that has already been risk adjusted at both the component PSI level and at the composite level; therefore, the measure is not “trimmed” by Leapfrog.

Measure	99 th Percentile
Foreign Object Retained	0.327
Air Embolism	2.890
Falls and Trauma	1.942
CLABSI	2.534
CAUTI	2.550
SSI: Colon	3.534
MRSA	2.696
C. Diff.	1.699
PSI 4	222.68

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

HOSPITAL SAFETY GRADE

DEALING WITH MISSING DATA

Due to a variety of reasons, a hospital may not have a measure score for all 22 measures. If a hospital is missing a measure score for any measure (except PSI 90; hospitals missing PSI 90 are not graded), the standard weight of that measure is redistributed to the other measures in the same measure domain. The new weight for each measure within the domain is calculated by re-apportioning the standard weight assigned to the measure with the missing score to other measures within the same domain. For example, if a hospital is missing a measure score for ICU Physician Staffing because the hospital does not operate an adult or pediatric medical and/or surgical ICU, the standard weight of 6.9% will be re-apportioned to the remaining 11 measures within the process/structural measure domain.

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

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

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

CALCULATING WEIGHTED MEASURE SCORES

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

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

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

HOSPITAL SAFETY GRADE

ADDITIONAL SCORING INFORMATION

TERMS USED IN SCORING AND PUBLIC REPORTING

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

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

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

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

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

SHARED CMS CERTIFICATION NUMBERS

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

HOSPITAL SAFETY GRADE

UPDATES TO DATA USED IN THE LEAPFROG HOSPITAL SAFETY GRADE

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

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

DATA FROM THE LEAPFROG HOSPITAL SURVEY

During the Safety Grade Review Period (September 25 – October 15), Leapfrog will only make corrections to a hospital's data from the 2024 Leapfrog Hospital Survey if a recording error is identified (i.e., we have recorded a different measure score than what is posted on our Survey Results website) or a scoring error is identified (i.e., Leapfrog has calculated an incorrect measure score based on the submitted responses and Leapfrog's published scoring algorithms). Updates to Leapfrog Hospital Survey data that are submitted after the Data Snapshot Date will **not** be included in the current Leapfrog Hospital Safety Grade. Hospitals submitting a Leapfrog Hospital Survey are urged to take advantage of the opportunity to review their Survey Results for accuracy and completeness prior to each of the two published Data Snapshot Dates.

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

The Leapfrog Hospital Survey is open from April 1 to November 30 of each year. Following the Submission Deadline (June 30), Survey Results are published monthly on a secure 'Hospital Details' page and a public website (ratings.leapfroggroup.org). Hospitals are urged to review their Survey Results immediately. Hospitals that identify any reporting errors are instructed to log back into the Survey to submit a correction. Hospitals can correct and re-submit a previously submitted Survey until the Survey closes for the year. Note that corrections submitted after the Data Snapshot Date (August 31 for the fall Safety Grade and January 31 for the spring Safety Grade) are not included in the current Leapfrog Hospital Safety Grade. Leapfrog has several automated processes in place to prevent hospitals from making data entry errors in the Online Survey Tool and to enhance the overall accuracy of the Survey Results. Learn more at <https://www.leapfroggroup.org/survey-master/s/data-accuracy>.

HOSPITAL SAFETY GRADE

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

During the Safety Grade Review Period (September 25 – October 15), Leapfrog will only make corrections to a hospital's data from CMS if the correction is issued by CMS and posted to the Data.CMS.Gov website. If a hospital has identified an error with a measure score published by CMS, and CMS cannot post a correction within the review period, the measure score will not be used in calculating the hospital's Safety Grade, provided that the hospital can document that CMS has agreed to publicly issue a correction or remove the measure score from public reporting. Hospitals participating with CMS are urged to take advantage of the opportunity to participate in the CMS 30-day review periods.

CMS FOOTNOTE 23 POLICY

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

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

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

CMS administers several hospital-based reporting and payment programs including the Inpatient Quality Reporting Program, HAC Reduction Program, and Value-based Purchasing Program. Several measures collected and calculated by CMS via its various hospital-based programs are used in the Leapfrog Hospital Safety Grade. CMS provides hospitals with a 30-day preview period before publishing measure scores on the Data.Medicare.Gov website and the Data.CMS.Gov website. More information is available at <https://qualitynet.org>.

HOSPITAL SAFETY GRADE

HOW TO PARTICIPATE IN THE LEAPFROG HOSPITAL SURVEY

If a hospital did **not** complete a 2024 Leapfrog Hospital Survey by August 31, Survey Results were not used to calculate the fall 2024 Leapfrog Hospital Safety Grade. Hospitals that would like Survey Results included in the spring 2025 Hospital Safety Grade must submit a 2024 Leapfrog Hospital Survey (including the CPOE Evaluation) by November 30, 2024. Hospitals will be able to review their publicly reported Survey Results in December and respond to any issues identified by Leapfrog's Extensive Monthly Data Verification before the Data Snapshot Date for the spring 2025 Safety Grade of January 31. More information is available at <https://leapfroggroup.org/survey>.

LEAPFROG HELP DESK

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

EXHIBIT 22

UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF FLORIDA
WEST PALM BEACH DIVISION
CASE NO.: 9:25-CV-80526-DMM

GOOD SAMARITAN MEDICAL CENTER, INC.,
DELRAY MEDICAL CENTER, INC.,
PALM BEACH GARDENS COMMUNITY
HOSPITAL, INC. d/b/a PALM BEACH
GARDENS MEDICAL CENTER,
ST. MARY'S MEDICAL CENTER, INC.,
AND WEST BOCA MEDICAL CENTER, INC., et al.,

Plaintiffs,

v.

THE LEAPFROG GROUP,

Defendant.

VIDEOTAPED DEPOSITION OF CYNTHIA MCCAULEY
(CONFIDENTIAL)

DATE TAKEN: Wednesday, September 24, 2025
TIME: 9:08 a.m. - 4:57 p.m.
PLACE: Quest Workspaces West Palm Beach
515 North Flagler Drive
Suite 350 - Conference Room A
West Palm Beach, Florida 33401

Stenographically Reported By:
Barbie Gallo, RMR-CRR
www.lexitaslegal.com
888-811-3408

Job No.: 421987

1 APPEARANCES: 2 On behalf of the Plaintiffs: 3 GIBSON, DUNN & CRUTCHER, LLP 4 200 Park Avenue 5 New York, NY 10166 6 (212) 351-4000 7 BY: MARY BETH MALONEY, ESQUIRE 8 ELIZABETH DABANKA, ESQUIRE 9 mmaloney@gibsondunn.com 10 edabanka@gibsondunn.com 11 AND 12 GIBSON, DUNN & CRUTCHER, LLP 13 811 Main Street 14 Suite 3000 15 Houston, Texas 77002-6117 16 (346) 718-6706 17 BY: KEVIN SIMMONS, ESQUIRE (via realtime) 18 kmsimmons@gibsondunn.com 19 on behalf of the Defendant: 20 WILSON, ELSE, MOSKOWITZ, EDELMAN & DICKER LLP 21 161 North Clark 22 Suite 4500 23 Chicago, Illinois 60601 24 (312) 821-6139 25 BY: KIMBERLY E. BLAIR, ESQUIRE kimberly.blair@wilsonelser.com ALSO PRESENT: Benny Dorlouis, videographer	Page 2	1 Exhibit 8 2/22/24 EMAIL CHAIN 2 SUBJECT: RE: HOSPITAL SAFETY 3 GRADE ANNOUNCEMENTS - FEBRUARY 4 2024 5 Exhibit 9 PBHN000006765 - PBHN000006770 6 3/7/24 EMAIL CHAIN 7 SUBJECT: FW: SPRING 2024 8 LEAPFROG HOSPITAL SAFETY GRADE 9 REVIEW PERIOD NOW OPEN 10 PBHN000012734 - PBHN000012736 11 9/27/24 EMAIL CHAIN FROM 12 Regina West to Ricardo Ramirez 13 SUBJECT: FW: LEAPFROG 14 (5 PAGES) 15 Exhibit 11 12/10/24 EMAIL CHAIN 16 SUBJECT: FW: STET NEWS 17 COVERAGE OF LEAPFROG RANKINGS 18 W/ ATTACHMENT STET NEWS 19 ARTICLE "TENET HOSPITALS AT 20 BOTTOM OF LOCAL SAFETY GRADES" 21 PBHN000005141 - PBHN000005145 22 Exhibit 12 12/10/24 EMAIL CHAIN 23 SUBJECT: RE: LEAPFROG 24 PBHN000004565 - PBHN000004566 25 8/12/25 METRODESK MEDIA, LLC BOCA NEWS NOW/ANDREW I. COLTON SUBPOENA RESPONSE DECLARATION OF CYNTHIA MCCAULEY PBHN000002219 - PBHN000002234 PBHN000002217 - PBHN000002218																																																																																																						
1 INDEX OF PROCEEDINGS 2 EXAMINATIONS 3 WITNESS: PAGE: 4 CYNTHIA MCCAULEY 6 5 DIRECT EXAMINATION 6 BY MS. BLAIR 7 CERTIFICATE OF OATH 244 8 CERTIFICATE OF REPORTER 245 9 READ & SIGN LETTER TO WITNESS 246 10 ERRATA SHEET 247 11 EXHIBITS <table border="1"> <thead> <tr> <th>NUMBER</th> <th>DESCRIPTION</th> <th>PAGE</th> </tr> </thead> <tbody> <tr> <td>12 Exhibit 1</td> <td>AMENDED NOTICE OF TAKING</td> <td>31</td> </tr> <tr> <td>13</td> <td>IN-PERSON VIDEOTAPED</td> <td></td> </tr> <tr> <td>14</td> <td>DEPOSITION OF CYNTHIA MCCAULEY,</td> <td></td> </tr> <tr> <td>15</td> <td>INDIVIDUALLY, AND PURSUANT TO</td> <td></td> </tr> <tr> <td>16</td> <td>RULE 30(b)(6) TO ST. MARY'S</td> <td></td> </tr> <tr> <td>17</td> <td>MEDICAL CENTER</td> <td></td> </tr> <tr> <td>18 Exhibit 2</td> <td>4/22/22 THE PALM BEACH POST</td> <td>42</td> </tr> <tr> <td>19</td> <td>"COMPETITION DRIVES TENET'S</td> <td></td> </tr> <tr> <td>20</td> <td>RENEWED FOCUS, COMMUNITY TIES</td> <td></td> </tr> <tr> <td>21</td> <td>AS HEALTH CARE RIVALS</td> <td></td> </tr> <tr> <td>22</td> <td>MULTIPLY"</td> <td></td> </tr> <tr> <td>23 Exhibit 3</td> <td>PLAINTIFF ST. MARY'S MEDICAL</td> <td>94</td> </tr> <tr> <td>24</td> <td>CENTER, INC.'S AMENDED AND</td> <td></td> </tr> <tr> <td>25</td> <td>SUPPLEMENTED RESPONSES AND</td> <td></td> </tr> <tr> <td></td> <td>OBJECTIONS TO DEFENDANT THE</td> <td></td> </tr> <tr> <td></td> <td>LEAPFROG GROUP'S FIRST SET OF</td> <td></td> </tr> <tr> <td></td> <td>INTERROGATORIES TO ST. MARY'S</td> <td></td> </tr> <tr> <td></td> <td>MEDICAL CENTER, INC.</td> <td></td> </tr> <tr> <td>12 Exhibit 4</td> <td>AMENDED COMPLAINT</td> <td>130</td> </tr> <tr> <td>13 Exhibit 5</td> <td>4/10/23 EMAIL CHAIN</td> <td>146</td> </tr> <tr> <td>14</td> <td>SUBJECT: FW: SPRING 2023</td> <td></td> </tr> <tr> <td>15</td> <td>LETTER GRADE EMBARGO PERIOD</td> <td></td> </tr> <tr> <td>16</td> <td>OPENS TODAY</td> <td></td> </tr> <tr> <td>17</td> <td>PBHN000006927 - PBHN000006930</td> <td></td> </tr> <tr> <td>18 Exhibit 6</td> <td>4/11/23 EMAIL CHAIN</td> <td>147</td> </tr> <tr> <td>19</td> <td>SUBJECT: RE: SPRING 2023</td> <td></td> </tr> <tr> <td>20</td> <td>LETTER GRADE EMBARGO PERIOD</td> <td></td> </tr> <tr> <td>21</td> <td>OPENS TODAY</td> <td></td> </tr> <tr> <td>22</td> <td>PBHN000006964 - PBHN000006967</td> <td></td> </tr> <tr> <td>23 Exhibit 7</td> <td>10/12/23 EMAIL CHAIN</td> <td>148</td> </tr> <tr> <td>24</td> <td>SUBJECT: LEAPFROG PREVIEW</td> <td></td> </tr> <tr> <td>25</td> <td>REPORTS</td> <td></td> </tr> <tr> <td></td> <td>PBHN000006838 - PBHN000006840</td> <td></td> </tr> </tbody> </table>	NUMBER	DESCRIPTION	PAGE	12 Exhibit 1	AMENDED NOTICE OF TAKING	31	13	IN-PERSON VIDEOTAPED		14	DEPOSITION OF CYNTHIA MCCAULEY,		15	INDIVIDUALLY, AND PURSUANT TO		16	RULE 30(b)(6) TO ST. MARY'S		17	MEDICAL CENTER		18 Exhibit 2	4/22/22 THE PALM BEACH POST	42	19	"COMPETITION DRIVES TENET'S		20	RENEWED FOCUS, COMMUNITY TIES		21	AS HEALTH CARE RIVALS		22	MULTIPLY"		23 Exhibit 3	PLAINTIFF ST. MARY'S MEDICAL	94	24	CENTER, INC.'S AMENDED AND		25	SUPPLEMENTED RESPONSES AND			OBJECTIONS TO DEFENDANT THE			LEAPFROG GROUP'S FIRST SET OF			INTERROGATORIES TO ST. MARY'S			MEDICAL CENTER, INC.		12 Exhibit 4	AMENDED COMPLAINT	130	13 Exhibit 5	4/10/23 EMAIL CHAIN	146	14	SUBJECT: FW: SPRING 2023		15	LETTER GRADE EMBARGO PERIOD		16	OPENS TODAY		17	PBHN000006927 - PBHN000006930		18 Exhibit 6	4/11/23 EMAIL CHAIN	147	19	SUBJECT: RE: SPRING 2023		20	LETTER GRADE EMBARGO PERIOD		21	OPENS TODAY		22	PBHN000006964 - PBHN000006967		23 Exhibit 7	10/12/23 EMAIL CHAIN	148	24	SUBJECT: LEAPFROG PREVIEW		25	REPORTS			PBHN000006838 - PBHN000006840		Page 3	1 Thereupon, 2 the following proceedings began at 9:08 a.m.: 3 * * * 4 THE VIDEOGRAPHER: We're now on the video 5 record and the time is 9:08 a.m. This is the 6 video deposition of Cynthia McCauley taken in 7 the matter of Good Samaritan Medical Center, et 8 al. versus The Leapfrog Group. 9 This deposition is being held at 10 515 North Flagler Drive, West Palm Beach, 11 Florida on September 24th, 2025. 12 The videographer is Benny Dorlouis, and the 13 court reporter is Barbie Gallo, both in 14 association with Lexitas. 15 Will counsel please announce their 16 appearances for the record. 17 MS. BLAIR: Kim Blair on behalf of 18 defendant, Leapfrog Group. 19 MS. MALONEY: Mary Beth Maloney on behalf of 20 St. Mary's, and I'm joined by my colleague, 21 Elizabeth Dabanka. 22 THE STENOGRAPHER: If you would, raise your 23 right hand, and I'll swear you in. 24 Do you swear or affirm that the testimony 25 you're about to give in this matter will be the
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Page 6 1 truth, the whole truth and nothing but the truth 2 so help you God? 3 THE WITNESS: I do. 4 THE STENOGRAPHER: Thank you. 5 THEREUPON, 6 CYNTHIA MCCAULEY, 7 Being by me first duly sworn to tell the whole truth, 8 as hereinafter certified, testified as follows: 9 DIRECT EXAMINATION 10 BY MS. BLAIR: 11 Q. Ms. McCauley, as you know, my name is 12 Kim Blair. I represent the defendant, Leapfrog Group, 13 in this matter. 14 Let the record reflect that your deposition 15 is being taken pursuant to the Federal Rules of Civil 16 Procedure as well as the local rules of the Southern 17 District of Florida. 18 Can you state and spell your name for the 19 record, please. 20 A. Um-hum. Cynthia, C-y-n-t-h-i-a; Albach, 21 A-l-b-a-c-h; McCauley, M-c-C-a-u-l-e-y. 22 Q. And, Ms. McCauley, have you ever had your 23 deposition taken before? 24 A. Yes. 25 Q. How many times?	Page 8 1 CEO, although I wasn't the CEO at the time of the case, 2 so it was a case concerning a physician. 3 Q. Was it a med/mal case? 4 A. It was a defamation case. 5 Q. And was the physician claiming that the 6 hospital defamed him? 7 A. No. 8 Q. Was the hospital a defendant? 9 A. No. No, we weren't party to the case. 10 Q. Okay. So you were being deposed as a 11 third-party fact witness, not as a party? 12 A. Correct. 13 Q. I want to just go over a couple of ground 14 rules that you probably already know, but I'll just go 15 over them for the day. 16 As you know, Barbie is our court reporter. 17 She'll be taking down everything you say and everything 18 I say. Therefore, I'm going to try not to talk over 19 any of your answers if you could do the same for the 20 sake of the court reporter. Is that okay? 21 A. Yes. 22 Q. In addition, she's taking down everything 23 that we say, so all of your answers must be verbal. 24 She can't take down a shrug of shoulders, an "uh-huh," 25 "huh-uh." Is that fair?
Page 7 1 A. Once or twice. 2 Q. And were they in a professional or a 3 personal capacity? 4 A. Professional. 5 Q. And can you recall -- let's just start with 6 the first deposition you gave. Can you recall when 7 that was? 8 A. Oh, a long time ago. A long, long time ago. 9 Q. Were you working at St. Mary's at the time? 10 A. No. 11 Q. Where were you working at that point? 12 A. At that point, I worked for West Boca 13 Medical Center. 14 Q. And do you recall just generally what that 15 case was about? 16 A. It was an employee. I believe it was 17 Workers' Comp. 18 Q. And then the second matter that you were 19 deposed in, do you remember about when that was? 20 A. That was a couple years ago. 21 Q. And were you at St. Mary's then? 22 A. I was at St. Mary's. 23 Q. And do you recall like generally what that 24 case is about? 25 A. It was a case, I was being deposed as the	Page 9 1 A. I understand. 2 Q. If at any time you need to take break, just 3 ask. The only caveat would be that if there's a 4 question pending, I ask that you answer that question. 5 Is that fair? 6 A. Yes. 7 Q. From time to time I will ask some questions 8 that you don't understand. If at any time you need me 9 to rephrase those questions, please ask me to do so. 10 Otherwise, if I ask a question and you answer it, I'm 11 going to assume you understood the question. Is that 12 fair? 13 A. Yes. 14 Q. I want to just kind of briefly go over your 15 background. 16 Can you take me through your post high 17 school education? 18 A. After high school I got a bachelor's degree 19 in foreign language at Adelphi University. And after 20 that I got an MBA from Long Island University CW Post 21 Campus. 22 Q. What foreign language? 23 A. Oh, I speak Spanish, Italian, a little bit 24 of French. 25 Q. Oh, wow.

Page 10 1 And I see that you took a couple years off 2 between your undergrad degree and your MBA, correct? 3 A. Yes. 4 Q. What did you do in the interim? 5 A. I was working. 6 Q. Where did you work? 7 A. I believe at that time I was working for an 8 organization in Manhattan called the Population 9 Council. 10 Q. Was that a not-for-profit? 11 A. It was a not-for-profit. 12 Q. What did they do? 13 A. They did birth control studies and research 14 in third world countries. They partnered with the 15 Ford Foundation, the UNFPA to try to get funding to 16 study research on breast -- on birth control. They 17 held like sterilization days in India. 18 It was super interesting. They invented, or 19 their scientists invented the Norplant implant. It 20 was -- it was a super interesting job with amazingly 21 smart people. 22 Q. And what did you do there? 23 A. So I started back as an executive assistant, 24 and then I managed, from what I remember, I was 25 involved a lot with contracts.	Page 12 1 hour and a half each way every day. So I, at that time 2 lived, on Long Island, and so I got a job that I could 3 commute to in half an hour. 4 Q. And after the investment company where did 5 you go? 6 A. I think -- I think after that, unless I have 7 them reversed, I moved to Florida. 8 Q. Do you remember what year you moved to 9 Florida? 10 A. '88. 11 Q. Okay. And what was your first job in 12 Florida? 13 A. I worked at, it was called the North Broward 14 Hospital District. I think now it's called Broward 15 Health. I was a financial analyst. 16 Q. Did you work with Heather Havericak? 17 A. I -- so not at the time, but I know Heather 18 worked at Broward Health. 19 Q. And what did you do? You were -- I'm sorry. 20 You told me -- 21 A. I was the financial analyst. 22 Q. Financial analyst. And how long were you at 23 Broward Health? 24 A. I was at Broward Health Coral Springs for 25 11 years.
Page 11 1 Q. And after you got your MBA -- well, did you 2 stick with that job while you were getting your MBA? 3 A. I might have left. I don't remember. 4 Q. And what was your first job after your MBA? 5 A. I worked for Manufacturer's Hanover Trust 6 Company as a financial analyst. 7 Q. That is not a not-for-profit? 8 A. That is not a not-for-profit. 9 Q. And as a financial -- you said you worked as 10 a financial analyst, correct? 11 A. Correct. 12 Q. And how long were you there? 13 A. I don't even think I could recall. A good 14 couple -- a good couple of years. 15 Q. And where did you go after the Hanover 16 Trust? 17 A. After Hanover Trust, I believe I left and 18 got a job closer to home working in an investment 19 company, a privately owned investment company that did 20 individual placements, but I don't recall staying there 21 for a particularly long time. 22 Q. And when you say "closer to home," what do 23 you mean by that? 24 A. So I -- so the Manny Hanny job was in 25 Manhattan, so I was a Long Island Railroad commuter,	Page 13 1 Q. So that takes us to '99, correct? 2 A. Correct. 3 Q. And at that point, I think, then you, 4 according to your LinkedIn profile, then you go over to 5 Tenet Healthcare, correct, in 1999, correct? 6 A. Correct. 7 Q. And what was your first job at 8 Tenet Healthcare in 1999? 9 A. My first job at Tenet Healthcare was at 10 Delray Medical Center as the director of finance. 11 Q. And generally speaking, what were your job 12 duties as the director of finance at Delray? 13 A. The director of finance is responsible for 14 doing journal entries, accounts payable, payroll, 15 closing the books at the end of the month, doing 16 balance sheet reconciliations, so really a very finance 17 focused on making sure the details were correct. 18 Q. And at the time in 1999, Delray was not part 19 of the Tenet Healthcare system, correct? 20 A. We were. 21 Q. In '99? 22 A. (Nodding head). 23 Q. So as we go through your employment history 24 from 1999 to present, was that always within 25 Tenet Healthcare, then?

Page 14 1 A. Yes. 2 Q. And then I assume at some point you get 3 promoted out of financial analyst, correct? 4 A. I did. So I was at Delray as the director 5 of finance, and then I got promoted to chief financial 6 officer. 7 Q. And when was that promotion? 8 A. 2001. 9 Q. And that was the chief financial officer of 10 Delray? 11 A. At West Boca. 12 Q. At West Boca. 13 And how long -- okay. So take me through 14 that. You were at Delray, but then you got promoted to 15 the CFO at West Boca? 16 A. Correct. 17 Q. And that is between two different hospitals, 18 correct? 19 A. Correct. 20 Q. Okay. Walk me through how that works. 21 They, Tenet Healthcare, will take somebody from one 22 hospital and promote them in a position to a different 23 hospital? 24 MS. MALONEY: Objection. 25 A. Correct. So within Tenet I can apply to	Page 16 1 Q. And is it correct that you then could apply 2 as a Tenet Healthcare employee for any open positions 3 that Tenet might have regardless of geographic area? 4 A. Correct. 5 Q. Okay. So in sometime in -- oh, in 2001, you 6 became the CFO of West Boca, correct? 7 A. Correct. 8 Q. And what were your job duties as the CFO of 9 West Boca? 10 A. So as the CFO the responsibilities included, 11 we had oversight over health information management, 12 which formerly known as medical records, health 13 information management, materials management, finance 14 and accounting, admitting. 15 Q. What does admitting mean? 16 A. Admitting, so the registrars. 17 Q. Got it. And did you oversee the budget of 18 West Boca at that time as the chief financial officer? 19 A. The chief financial officer has 20 responsibility for developing the budget. 21 Q. And in or around this time, 2001, were you 22 working in concert with the other hospitals that later 23 are rebranded as Palm Beach Health Network? 24 A. I don't know that I understand the question. 25 I mean, I worked for West Boca, and we all were a part
Page 15 1 change facilities if there is a position that I'm 2 interested in. 3 BY MS. BLAIR: 4 Q. And that's -- is that anywhere within Tenet, 5 or do you have to stay within the Palm Beach Health 6 Network hospitals? 7 A. Any -- 8 MS. MALONEY: Objection. Lacks foundation. 9 If you could give me a second to interpose my 10 objection before you answer, that would be 11 great. 12 THE WITNESS: Yes, ma'am. 13 MS. MALONEY: Just give yourself a pause. 14 Thank you. 15 A. Repeat that question. 16 BY MS. BLAIR: 17 Q. Sure. I'm just trying to figure out how it 18 works. So you're talking about you can apply for 19 positions that are opened, correct? 20 A. Correct. 21 Q. And it sounds like at some point a position 22 became open for a CFO at West Boca, correct? 23 A. Correct. 24 Q. And so you applied for that job? 25 A. Correct.	Page 17 1 of Tenet, but so I'd have to understand what you mean 2 "work with them." 3 Q. Sure. I'll jump forward a little, then. 4 A. Okay. 5 Q. In 2022, I understand that the five 6 hospitals that are plaintiffs in this litigation, which 7 would be West Boca, St. Mary's, Good Samaritan, 8 Palm Beach Gardens -- which one am I missing -- 9 St. Mary's, West Boca, Good Samaritan -- sorry -- West 10 Palm and Delray, all rebrand as Palm Beach Health 11 Network, correct? 12 A. I don't think that happened at that, in 13 2020 -- 14 Q. Two? 15 A. So that's, 2022 is way after I'm at West 16 Boca. 17 Q. Correct. Right. 18 A. Correct. 19 Q. So that happens in 2022, correct? 20 A. Okay. 21 Q. And in 2001, you become the chief financial 22 officer of West Boca, correct? 23 A. Correct. 24 Q. And so my question is, prior to the 25 rebranding of these five hospitals in 2022, did these

Page 18

1 five hospitals work together in 2001 in any way?

2 MS. MALONEY: Objection.

3 A. So the hospitals worked together, for

4 example, if we have a patient that needs -- so if I was

5 at West Boca that didn't offer cardiology services and

6 we had a patient that needed cardiology, we could work

7 to transfer that -- our patient to Delray for services,

8 so there was not -- so work together, I mean, without

9 specificity I'm not really sure --

10 Q. Sure.

11 A. -- you know.

12 Q. And so I understand today there's a

13 president of Palm Beach Health Network, Maggie Gill,

14 correct?

15 A. Correct.

16 Q. And the Palm Beach Health Network kind of

17 provides an overarching governance for the five

18 hospitals that are plaintiffs in this action, correct?

19 A. Define "governance."

20 Q. Well, as I understand it, there's a

21 president of Palm Beach Health Network, correct?

22 A. Correct.

23 Q. There's a chief strategy officer of

24 Palm Beach Health Network, correct?

25 A. Correct.

Page 19

1 Q. There's a chief quality officer, Gina West,

2 of Palm Beach Health Network, correct?

3 A. Yes, but Gina also serves as my quality

4 director --

5 Q. Correct?

6 A. -- so it's a dual role.

7 Q. Right.

8 A. Right.

9 Q. And I understand that. And so I'm just

10 trying to understand, were there any people back in

11 2001 that provided these sorts of overarching roles for

12 the five hospitals, or does that come later after the

13 rebranding?

14 MS. MALONEY: Objection.

15 A. No, those -- we did have a similar

16 structure.

17 BY MS. BLAIR:

18 Q. Okay. And so taking you way back to 2001,

19 and I know it's not a memory test, but can you tell me

20 just generally what the structure was back in 2001

21 between the five hospitals?

22 A. We had -- I don't recall specific titles of

23 people.

24 Q. Understood.

25 A. There was -- I don't even remember if -- let

Page 20

1 me think what they might have been called. I can't

2 recall. They weren't called a CEO. They weren't

3 called a market president. I don't recall their title,

4 but there was somebody who would have had oversight or

5 responsibility we would have rolled up to at a local

6 Florida level.

7 MS. MALONEY: And, Counsel, I assume that

8 this portion of the deposition is in her

9 capacity as a fact witness --

10 MS. BLAIR: Yes.

11 MS. MALONEY: -- not as a 30(b)(6) witness,

12 and you'll make clear when you're examining her

13 in her capacity --

14 MS. BLAIR: Correct.

15 MS. MALONEY: -- as a 30(b)(6) witness; is

16 that right?

17 MS. BLAIR: Right.

18 BY MS. BLAIR:

19 Q. And so in 2001, how long did you stay as the

20 chief financial officer of West Boca?

21 A. This is a memory test. I believe, and I

22 reserve the right to be off a little on the dates

23 because it was a long time ago, I believe I was at

24 West Boca for about two years.

25 Q. Where did you go after West Boca?

Page 21

1 A. After West Boca I transferred to North Ridge

2 Medical Center as their CFO.

3 Q. And where is North Ridge Medical Center?

4 A. It is in -- I don't know -- I don't know

5 what city it's in. It's just over the Broward County,

6 the next county line. Tenet no longer owns that

7 hospital. It was sold.

8 Q. Okay.

9 A. It was sold. If I went there in -- 2003 or

10 '04 -- in 2006 or '07 it was sold. A long time ago.

11 Q. Okay. And so but when you were there, when

12 you were at North Ridge Medical Center, it was a

13 Tenet hospital?

14 A. Correct.

15 Q. And when did you leave them?

16 A. I believe I left there in 2007.

17 Q. Okay. And in 2007, where did you go?

18 A. In 2007, I transferred to Good Samaritan

19 Medical Center.

20 Q. And have you been at Good Samaritan -- oh,

21 no, how long were you at Good Samaritan?

22 A. I was at Good Samaritan Medical Center for

23 five years.

24 Q. And what was your position at

25 Good Samaritan?

Page 22

1 A. I was the chief financial officer.
2 Q. So that takes us to about -- oh, here, now I
3 can follow along.
4 Okay. So you were the chief financial
5 officer until about September of 2012, does that sound
6 right?
7 A. Correct.
8 Q. And after that, you become the CEO of one of
9 the Tenet hospitals?
10 A. Of the physician group.
11 Q. Okay. Oh, that's right. And tell me about
12 that. What is the physician group that you were the
13 CEO of?
14 A. So Tenet corporation employs physicians, but
15 they are not employed by the hospital. They are, all
16 the physicians are employed in a separate physician
17 group, so I became the chief executive officer over the
18 physician group.
19 Q. And how many physicians were in that group?
20 A. We had approximately 200 providers.
21 Q. And were they in a specialty?
22 A. Multiple specialties.
23 Q. Do you recall any of the specialties as you
24 sit here today?
25 A. Cardiology, neurosurgery. Oh, goodness. I

Page 23

1 think -- I think we had one or two
2 obstetrician/gynecologists, primary care, orthopedic.
3 Q. Did they work, all work at a certain
4 hospital, or did they have privileges at multiple
5 hospitals?
6 MS. MALONEY: Objection.
7 A. So it would be unusual for them to all work
8 at all hospitals because of geography, so they could,
9 depending on the office, their office location, be
10 affiliated with one hospital or multiple hospitals.
11 BY MS. BLAIR:
12 Q. And how long were you with the physicians
13 group?
14 A. Seven years.
15 Q. And then at some point thereafter you become
16 the chief administrative officer at St. Mary's Medical
17 Center in the Palm Beach Children's Hospital?
18 A. Correct.
19 Q. And was that in or around October of 2019?
20 A. Correct.
21 Q. What is -- what does the chief
22 administrator -- administrative officer do?
23 A. So the chief administrative officer is
24 similar to the chief executive officer. However, the
25 component of nursing leadership had more solid

Page 24

1 reporting to the group chief nurse.
2 Q. Okay. And who is the group chief nurse at
3 the time that you were the chief administrative
4 officer?
5 A. \$1,000, I couldn't tell you.
6 Q. And when you say "the group chief nurse,"
7 what do you mean by "group"?
8 A. So we have the Palm Beach Health Network, so
9 that group or the network has, as you referred earlier,
10 Gina was like the group quality, a group CNO.
11 Q. Got it.
12 And so your memory is that that group
13 structure was in place at least by October of -- or I'm
14 sorry -- at least in 2019 when you became the chief
15 administrative officer at St. Mary's?
16 A. Yes.
17 Q. And the Palm Beach Children's Hospital is a
18 separate hospital, correct?
19 A. It is not a separate tax ID.
20 Q. Correct. But it's a separate building?
21 A. It is a separate building that is attached
22 to the main campus.
23 Q. And it goes by Palm Beach Children's
24 Hospital?
25 A. That's correct.

Page 25

1 Q. And does it have different set of finances,
2 or does it have the same finances since it has the same
3 tax ID?
4 A. Same finances.
5 Q. Same budget?
6 A. Same budget, not a separate standalone
7 budget.
8 Q. Does it have separate director of quality?
9 A. No.
10 Q. Does it have a separate chief nursing
11 officer?
12 A. No.
13 Q. Does it have a separate chief financial
14 officer?
15 A. No.
16 Q. Okay. So is it fair to say that St. Mary's
17 and the Palm Beach Children's Hospital have the same
18 C-suite executives overseeing both?
19 A. Yes.
20 Q. And then it looks like at some point in time
21 you do become the chief executive officer at
22 St. Mary's?
23 A. Correct.
24 Q. And when does that happen?
25 A. I believe it was around May --

Page 26 1 Q. Of what -- 2 A. -- of 2020, but scripturally I'm a little 3 unsure. 4 Q. So right during COVID? 5 A. Correct. 6 Q. And you maintain that job to today, correct? 7 A. Correct. 8 Q. And I note on your LinkedIn, and maybe it's 9 a distinction without a difference, but you list chief 10 executive officer St. Mary's Medical Center and then 11 chief executive officer Tenet Healthcare full time. Is 12 that the same job? 13 A. Yes. 14 Q. Okay. And are there any other, that you can 15 think of, positions that you've held at St. Mary's that 16 we didn't go over today? 17 A. No. 18 Q. And how many direct reports do you have as a 19 chief officer -- chief executive officer, excuse me, of 20 St. Mary's? 21 A. Four directs. 22 Q. And who are your direct reports? 23 A. The CFO, the COO, the CNO and an executive 24 assistant. 25 Q. Okay. And who is the CFO currently?	Page 28 1 A. Correct. 2 Q. And do you know who Lisa Foo reports to? 3 A. I believe Lisa Foo reports to Saum Sutaria. 4 Q. And Saum Sutaria is the CEO of 5 Tenet Healthcare nationwide, correct? 6 A. Correct. 7 Q. What did you do to prepare for your 8 deposition today? 9 A. I read volumes of information, including 10 the -- refreshed my memory on the Complaint, the 11 interrogatories. I spoke with counsel. I did a lot of 12 reading. 13 Q. Do you recall any specific -- well, you 14 mentioned you -- 15 A. Right, the interrogatories, the Complaint, 16 the cease and desist letter. Those I specifically 17 recall. 18 Q. Do you recall reviewing any emails? 19 A. With counsel, they showed me some emails, 20 yes. 21 Q. Do you recall what any of those emails were? 22 A. I recall an email that I had written to 23 Gina West asking, we had gotten a notice from Leapfrog 24 that our new grades were coming out, so I had asked 25 Gina, do we have an estimate of what our grade will be.
Page 27 1 A. Currently the CFO is Romaine Layne. 2 Q. And the COO? 3 A. Maria Morales. 4 Q. And the CNO? 5 A. We have a new CNO starting Monday. 6 Q. Okay. And who was the CNO before that? 7 A. Before that, it was Jessica Miller. 8 Q. And we talked a little bit about 9 Regina West. What is her title at St. Mary's? 10 A. Director of quality. 11 Q. And who does she report to? 12 A. She, I believe, my educated guess is that 13 she reports to the group CNO. 14 Q. So she doesn't have a direct report within 15 St. Mary's? 16 A. I'm not a thousand percent certain of who 17 Gina reports to. 18 Q. Okay. And the group CNO, is that 19 Ricky Ramirez? 20 A. It is. 21 Q. And who do you report to? 22 A. I report to Maggie Gill. 23 Q. And do you know who Maggie Gill reports to? 24 A. I believe Maggie reports to Lisa Foo. 25 Q. And that's F-o-o, correct?	Page 29 1 Q. Do you remember essentially the time frame 2 of that? Would that have been related to the fall of 3 2024? 4 A. I think it was before then. 5 Q. Any other emails you recall? 6 A. From me, no. 7 Q. Well, any other emails you recall reviewing 8 in preparation for your deposition? 9 A. There were some emails from Gina, again, 10 about Leapfrog and potential grades. 11 Q. Did you review the Leapfrog Hospital Survey 12 in preparation for your deposition? 13 A. I did. 14 Q. Did you review the Leapfrog Hospital Safety 15 Grade methodology in preparation for your deposition? 16 A. Yes, I did. 17 Q. Did you review any financial documents in 18 preparation for your deposition? 19 MS. MALONEY: Objection. Vague. 20 A. Financial documents? Not that I recall 21 unless you ask me specifically, yeah. 22 BY MS. BLAIR: 23 Q. Sure. 24 How many times did you meet with your 25 lawyer?

Page 30 1 A. Four. 2 Q. Do you recall when the first one was? 3 A. A few months ago. 4 Q. And, again, I don't know want to know about 5 any meetings you had with your lawyers that weren't 6 related to your deposition. So those would have been 7 meetings related to your deposition? 8 A. Correct. 9 Q. And do you recall approximately how long 10 that initial meeting lasted? 11 A. A few hours. 12 Q. And you said you had four meetings, correct? 13 A. Correct. 14 Q. When was the last meeting you had with your 15 lawyers to prepare for your deposition? 16 A. Yesterday. 17 Q. And how long did that last? 18 A. Maybe five hours. 19 Q. Did you review any deposition transcripts in 20 preparation for your deposition? 21 A. No. 22 Q. Have you seen any of the depositions of the 23 other CEOs that have been taken in this case? 24 A. No. 25 Q. Have you reviewed any of the documents that	Page 32 1 A. Yes. 2 Q. Did you review it in preparation for your 3 deposition? 4 A. Yes. 5 Q. And do you understand that your deposition 6 here today is not only in your personal capacity but 7 also in your capacity as a corporate representative for 8 St. Mary's? 9 A. Yes. 10 Q. And if you will look at page -- sorry -- 6 11 of this document, it says "Matters For Examination." 12 And I will submit to you that this document 13 was the product of negotiation, meet and confer 14 negotiation between myself and your counsel relating to 15 these topics. 16 And if you wouldn't mind just taking a look 17 at the topics on six through eight, and let me know if 18 those are the topics that you are prepared to testify 19 to today. 20 MS. MALONEY: Counsel, it's my understanding 21 that there was further negotiation beyond this 22 final list and that certain of these have been 23 further revised through negotiation between 24 counsel. 25 MS. BLAIR: That is not my understanding.
Page 31 1 were shown to the other CEOs at their depositions in 2 preparation for your deposition? 3 A. I don't know if they've seen the same 4 documents, so I can't speak to that. 5 Q. Excellent point. 6 How long would you estimate -- all four of 7 these meetings, how long would you estimate you spent 8 preparing for your deposition? 9 A. Including my own weekend research? 10 Q. Yeah. 11 A. A lot of hours. I mean, easily, easily -- 12 it's hard to give a number because a lot was on my own 13 evening and weekend time reading, so I would -- if I 14 had to give a number, it could easily be a week's worth 15 of time. 16 Q. I'll mark this as Exhibit 1. 17 (Defendant's Exhibit Number 1 for i.d.) 18 BY MS. BLAIR: 19 Q. Ms. McCauley, I'm handing you what we've now 20 marked as McCauley Exhibit 1. And this is called, 21 titled the Amended Notice of Taking in-Person 22 Videotaped Deposition of Cynthia McCauley individually 23 and pursuant to Rule 30(b)(6) to St. Mary's Medical 24 Center. 25 Have you seen this document before?	Page 33 1 This was just sent out two days ago after 2 speaking with Lee Crain. 3 MS. MALONEY: Okay. 4 MS. BLAIR: If you want to tell me which 5 ones, I'm happy -- 6 MS. MALONEY: This is dated September 17. 7 Let's see. 8 MS. BLAIR: And I'm happy -- 9 MS. MALONEY: And today's date is September, 10 what is it, 24th? 11 MS. BLAIR: 24th. 12 THE WITNESS: Yeah. 13 MS. MALONEY: Well, if an issue arises, 14 we'll address it. 15 MS. BLAIR: Yes, that's fine. 16 BY MS. BLAIR: 17 Q. Have you seen this document before? 18 A. It appears to be. 19 Q. Excellent. And from time to time, 20 Ms. McCauley, we will refer to these matters of 21 examination. To the extent that I ask you questions 22 here today that cover these areas, I'm going to assume 23 that you're testifying in your capacity as a corporate 24 representative. 25 A. Okay.

Page 34 1 Q. Do you understand the documents -- that 2 St. Mary's has produced significant amount of documents 3 in this matter as production to me in this matter, do 4 you understand that? 5 A. I know we produced documents and submitted 6 them to counsel -- 7 Q. Correct. 8 A. -- who I presume submitted them to you. 9 Q. Yes. And I want to ask you, do you -- can 10 you describe to me briefly what you did -- and by 11 "you," I mean, St. Mary's -- 12 A. Okay. 13 Q. -- did to gather documents responsive to the 14 request? 15 A. So I know when the documents were requested, 16 the primary person who could pull the documents was my 17 quality director, so she would have worked to pull 18 those documents and provide them to counsel. 19 Q. And, again, for the record the quality 20 director would be Gina West, correct? 21 A. That is correct. 22 Q. And have you provided to your counsel all 23 documents that set forth how St. Mary's would have 24 performed on four of the measures in the hospital 25 safety grade, which would be CPOE, BCMA hand hygiene	Page 35 1 and ICU physician staffing? 2 A. Yes. 3 Q. And do you recall any conversations you had 4 with Ms. West about what documents would be gathered to 5 provide documents sufficient to simulate how St. Mary's 6 would have performed on those four measures in the fall 7 2024 or spring '25 Leapfrog Hospital Safety Grade? 8 A. Not specifically. 9 Q. But Gina West would have been the individual 10 that prepared those documents for production, correct? 11 A. She would have pulled the reports or gone 12 and searched for the reports, correct. 13 Q. And in terms of since Gina has both this 14 dual role that you spoke about earlier, which was both 15 the director of quality for St. Mary's as well as 16 the -- is she the -- well, strike that. 17 Is she director of quality for the group? 18 A. I think her title is -- I don't know if it's 19 market quality or group. You'd have to look that up. 20 Q. Okay. To your knowledge, does Gina West 21 have essentially the same quality role for the group 22 that she does for St. Mary's? 23 MS. MALONEY: Objection. 24 A. So Gina is St. Mary's' quality director, and 25 the other facilities have quality directors focused on	Page 36 1 their facility. And Gina has oversight over all five. 2 BY MS. BLAIR: 3 Q. Okay. That was a bad question. 4 So does she do, for the group, does she do 5 anything besides quality for the Palm Beach Health 6 Network group? 7 A. Not that I'm aware of, but that would be 8 more of a Gina question. 9 Q. And in her role as the quality person -- I 10 don't know her title -- for the Palm Beach Health 11 Network, does she report to Maggie Gill? 12 MS. MALONEY: Objection. Asked and 13 answered. 14 A. Yeah, I believe -- and I said earlier, I 15 believe she reports to the group chief nurse. 16 BY MS. BLAIR: 17 Q. Ricky Ramirez, correct? 18 A. Correct. 19 Q. So Gina would have been responsible at least 20 for, with respect to those four measures that we just 21 discussed, CPOE, BCMA, hand hygiene and I'll just call 22 it IPS, ICU physician staffing. 23 A. Okay. 24 Q. She would have been responsible for 25 gathering the documents related to those areas for	Page 37 1 production in this litigation, correct? 2 A. For St. Mary's. 3 Q. For St. Mary's. 4 A. Correct. 5 Q. In terms of producing meeting minutes, was 6 Gina West involved in gathering those documents for 7 production in this case? 8 A. Which meetings -- which meeting minutes? 9 Q. St. Mary's, board meeting. 10 A. Governing board? 11 Q. Governing board. 12 A. No. 13 Q. Okay. Who gathered those documents? 14 A. So the governing board meetings would be 15 maintained by the CEO's executive assistant who would 16 have provided them to Gina to submit. 17 Q. Okay. And who is your executive assistant? 18 A. Her name is Michelle Getty. 19 Q. What about med exec, med exec board 20 meetings, who would have gathered those? 21 A. So med exec board minutes would have been 22 requested from the manager of medical staff. 23 Q. And who is the manager of medical staff? 24 A. Delia Cortes. 25 Q. And if I use the acronym QIPSC, do you know
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Page 38 1 what I mean when I say QIPSC? 2 A. Yes. 3 Q. What -- 4 A. Quality patient infection control [sic]. 5 QIPSC. It's quality patient safety and infection 6 control [sic]. 7 Q. And in terms of QIPSC -- is there a QIPSC 8 committee specific to St. Mary's? 9 A. There is. 10 Q. And who sits on that committee? 11 A. It's chaired by a physician. Gina sits on 12 it. Most of the -- I believe most of the C's, if not 13 all the C's, we sit on it. And there has been 14 community participation, like from our board member. 15 Q. Is there a specific board member that sits 16 on the QIPSC committee? 17 A. Chief Darrel Donatto was sitting on it 18 through the end of 2024. 19 Q. And do you know who would have been 20 responsible for gathering the QIPSC information from 21 St. Mary's to produce in this litigation? 22 A. I believe that would have been Gina West. 23 Q. Does St. Mary's have a marketing director? 24 A. We have a marketing, maybe her title is 25 manager.	Page 39 1 Q. And who is the marketing manager? 2 A. Her name is Ashley Peterson. 3 Q. Do you know if Ashley Peterson was involved 4 in gathering documents to be produced in this 5 litigation? 6 A. I would venture to say no. 7 Q. And why would you venture to say no? 8 A. Because I don't think she has any 9 involvement with any -- I think that's so outside of 10 her role. 11 Q. Do you know who at St. Mary's would have 12 been involved in gathering documents related to the 13 hospital's brand for production in this litigation? 14 MS. MALONEY: Objection. Vague. Lacks 15 foundation. 16 A. I'm unaware of any documents for St. Mary's' 17 brand. 18 BY MS. BLAIR: 19 Q. Okay. Do you know what year St. Mary's was 20 purchased by Tenet? 21 A. 2001. 22 Q. And so when you started at Delray Medical 23 Center in '99, it -- oh, well, do you know if Delray 24 was owned by Tenet in 1999 when you started at Delray? 25 A. It was.	Page 40 1 Q. Okay. So it -- do you know which one of 2 these five plaintiff hospitals was the first hospital 3 purchased by Tenet? 4 A. No. 5 Q. Prior to 2001 do you know whether or not 6 St. Mary's was a not-for-profit hospital? 7 A. It was. 8 Q. And as I understand it, St. Mary's has been 9 in this community for quite a while, correct? 10 A. St. Mary's has been in the community since 11 1938. 12 Q. We talked about this a little bit already, 13 but do you know when these five hospitals rebranded as 14 the Palm Beach Health Network? 15 A. I believe they rebranded maybe two years 16 ago. 17 Q. Do you know what the purpose was for the 18 rebrand? 19 A. The hospitals -- as I understand it, the 20 hospitals that are part of the Palm Beach Health 21 Network, we are the largest provider of healthcare in 22 Palm Beach, so it was felt that it was important for 23 the community to know that we were tethered together 24 and if they needed care in Palm Beach County, they 25 could get it within our network.	Page 41 1 Q. Do you know what -- why that wasn't done 2 earlier? 3 MS. MALONEY: Objection. 4 A. I can't -- I can't opine. Not in my 5 purview. 6 BY MS. BLAIR: 7 Q. Do you recall being part of any 8 conversations in or around the time that Palm Beach -- 9 or in or around the time St. Mary's and the other four 10 plaintiff hospitals rebranded as Palm Beach Health 11 Network? 12 MS. MALONEY: Objection. Vague. 13 BY MS. BLAIR: 14 Q. I'm sorry. It was vague. 15 Do you recall any meetings in or around the 16 time that these five hospitals rebranded as the 17 Palm Beach Health Network around why the rebranding was 18 occurring at that time? 19 MS. MALONEY: Objection. Vague. 20 A. I don't know that I recall any specific 21 meeting or conversation as to the why. 22 BY MS. BLAIR: 23 Q. Were there discussions in or around the time 24 that these five hospitals were rebranding about how 25 resources would be shared to fund those personnel that
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Page 42 1 were now going to be working as group employees? 2 A. Not that I'm aware. 3 MS. MALONEY: Objection. 4 Give me a chance. 5 A. Not that I'm aware of. 6 BY MS. BLAIR: 7 Q. Do you -- 8 MS. BLAIR: Mark this as 2. 9 (Defendant's Exhibit Number 2 for i.d.) 10 BY MS. BLAIR: 11 Q. Ms. McCauley, I'm now handing you what has 12 been marked as McCauley Exhibit 2. And this is an 13 article from the Palm Beach Post dated April 22nd, 14 2022. Do you have that in front of you? 15 A. Yes. 16 Q. And you'll see the first sentence of this 17 article says, "Five Tenet Healthcare owned hospitals in 18 Palm Beach County are retooling their image to 19 emphasize ties to local physicians and communities." 20 Do you see that? 21 A. I do see that. 22 Q. Does this refresh your recollection that 23 that rebranding probably occurred in or around April of 24 2022? 25 A. It would appear that it should be timely, to	Page 44 1 A. I don't remember an article from three years 2 ago. 3 BY MS. BLAIR: 4 Q. And if we look at the bottom of this page, 5 it says, "Maggie Gill, chief executive of the Palm 6 Beach Health Network, said the hospital" -- "the 7 hospital company wants to showcase that it is a local 8 provider, especially to new residents who may not be 9 familiar with the Tenet brand." 10 Do you see that? 11 A. Yes. 12 MS. MALONEY: Objection. Not a quotation in 13 the article that you're reading from. Go ahead. 14 MS. BLAIR: I don't understand the 15 objection, but, okay. 16 MS. MALONEY: Mis -- well, I'll be clear. 17 It misrepresents it in that you said 18 "Maggie Gill said," which suggests this is a 19 quotation when, in fact, the article doesn't 20 quote from her. 21 BY MS. BLAIR: 22 Q. Okay. Let's do it again, then, 23 Ms. McCauley. 24 Do you see on page -- the bottom of page 1, 25 this article says, "Maggie Gill, chief executive of the
Page 43 1 my recollection. 2 Q. Okay. And the next sentence says, "This 3 move comes as more residents pour into the region and 4 rival medical providers vie for new and often wealthy 5 patients." 6 Do you see that? 7 A. I do. 8 Q. Does this refresh your recollection in any 9 way that one of the purposes of the rebranding of the 10 five hospitals into the Palm Beach Health Network was 11 to compete with new entrants into the Palm Beach 12 healthcare? 13 MS. MALONEY: Objection. Lacks foundation. 14 A. So from my perspective this is an article 15 written by a newspaper writer from the Post and 16 basically they can write it as they see it. It doesn't 17 necessarily need to be the reasons behind what we did. 18 But I -- so I would be opining on why 19 Ms. Alexandra Clough wrote what she wrote. 20 Q. Okay. Do you have any recollection of 21 discussing this article in or around the time it came 22 out? 23 A. No. 24 MS. MALONEY: Objection. 25 Objection. Lacks foundation and vague.	Page 45 1 Palm Beach Health Network, said the hospital company 2 wants to showcase that it is a local provider, 3 especially to new residents who may not be familiar 4 with the Tenet brand." 5 Do you see that sentence? 6 A. Yes, that is what's written. 7 Q. Do you disagree that the purpose of the Palm 8 Beach Health Network was "to showcase that it is a 9 local provider, especially to new residents who may not 10 be familiar with the Tenet brand"? 11 A. Maggie goes on where she is quoted to say, 12 "We want to share what we're doing. This is our home 13 base." 14 Q. Correct. 15 A. So I believe that it's important for 16 residents who are unfamiliar with our brand to 17 understand that we have a network here to care for 18 them. 19 Q. Okay. Yeah. And that's just my question. 20 A. Yeah. 21 Q. Do you agree that part of the reason that 22 the Palm Beach Health Network rebranding occurred was 23 to showcase that it is a local provider, especially to 24 new residents who may not be familiar with the Tenet 25 brand?

Page 46 1 MS. MALONEY: Objection. Asked and 2 answered. 3 Go ahead. 4 A. I believe it's important to show that we are 5 a network here in Palm Beach, we're a local -- you 6 know, we're local, we are here and create awareness of 7 the five hospitals, that we have five hospitals to who 8 can basically serve you wherever you are. 9 BY MS. BLAIR: 10 Q. And in April of 2022 as the CEO of 11 St. Mary's in or around that time, was it important to 12 you to showcase that St. Mary's was a local provider? 13 MS. MALONEY: Objection. 14 A. I can't recall '22 specifically as we were 15 coming out of COVID. And I do know that our community 16 is familiar with St. Mary's. 17 BY MS. BLAIR: 18 Q. Correct. Do you know if around April of 19 2022 whether the community was familiar with the Tenet 20 brand? 21 A. I am not confident that the community is 22 familiar with the Tenet brand or not. 23 Q. Do you recall whether or not in or around 24 2022 that the five hospitals that are plaintiffs in 25 this matter were spending money to upgrade facilities?	Page 48 1 a topic or not. So I'm happy to go through and 2 every time you ask a question, say -- 3 MS. BLAIR: Sure. 4 MS. MALONEY: -- "is it as to a topic and 5 which one," and we can do it that way or we can 6 make sure we're clear with each question 7 whether it's in her personal capacity -- 8 MS. BLAIR: I'll ask the question -- 9 MS. MALONEY: -- or as a fact witness. 10 And if, again, you would allow me to finish 11 my statement on the record before you begin 12 speaking to my client. 13 MS. BLAIR: Are you finished? 14 MS. MALONEY: Go ahead. I am now. 15 BY MS. BLAIR: 16 Q. Ms. McCauley, in your capacity as an 17 individual -- 18 A. Um-hum. 19 Q. -- were you aware in April of 2022 that 20 Tenet was spending money to upgrade its facility? 21 A. I'm aware that Tenet continually spends 22 money to upgrade our facilities. I can't speak to the 23 specifics of what we did in 2022, but I do know that we 24 continually invest in our facilities to upgrade them. 25 Q. And do you recall any upgrades that
Page 47 1 If you look on page 2 of this article, it's 2 in bold, "Tenet spending 150 million to upgrade 3 facilities." 4 MS. MALONEY: Objection. She is here to 5 testify in the capacity as the CEO and corporate 6 representative of St. Mary's. This is beyond 7 the scope of the 30(b)(6) -- 8 MS. BLAIR: Well, I'm asking her -- 9 MS. MALONEY: -- because this is as to all 10 hospitals, if you would let me finish my 11 objection. She may answer to the extent she can 12 answer this question for St. Mary's. 13 BY MS. BLAIR: 14 Q. Well, I'm asking you in your individual 15 capacity. 16 MS. MALONEY: Then you need to clarify 17 because you had specified at the beginning that 18 all of these questions would be in her capacity 19 as a corporate representative, so if we're now 20 going to -- 21 MS. BLAIR: Well, I said if it had to do 22 with the topic for which she has prepared, they 23 will be as corporate representative. 24 MS. MALONEY: You haven't specified whether, 25 for any of your questions whether they're as to	Page 49 1 St. Mary's was undergoing in or around April of 2022 to 2 upgrade its facilities? 3 MS. MALONEY: And, Counsel, is this in her 4 capacity as a fact witness or -- 5 BY MS. BLAIR: 6 Q. Well, it's not one of those topics, so in 7 your capacity as a fact witness, but you were also the 8 CEO of St. Mary's, can you tell me what facility 9 upgrades were occurring at St. Mary's in 2022, if you 10 know? 11 A. Specifically, I don't have that off the top 12 of my head. 13 Q. If we go on here, and we're looking at 14 page 3 of this article, third paragraph -- second full 15 paragraph, says "The Tenet hospital improvement 16 program." 17 Were you aware as to whether or not there 18 was a Tenet hospital improvement program as the CEO? 19 In your individual capacity as the CEO of St. Mary's in 20 or around April of 2022, are you aware of whether or 21 not there was a Tenet hospital improvement program 22 underway in April of 2022? 23 A. I'm unfamiliar that there was anything 24 specifically called the "Tenet hospital improvement 25 program," but we do continually work to improve our

Page 50 1 services and facilities. 2 Q. And if we look at page 4 of this article, 3 there is a bold sentence about two-thirds of the way 4 down that says, "Hospitals facing increased competition 5 for locals' out-of-state care providers." 6 Do you see that sentence? 7 A. Yes. 8 Q. As the CEO of St. Mary's in or around 9 April of 2022, was there increased competition for 10 healthcare in the Palm Beach area? 11 A. There is continued increased competition. I 12 can't recall if that was '22, '20, '25. You know, 13 there's continuing competition, you know, competition 14 in our market. 15 Q. We talked a little bit about the executive 16 leadership at St. Mary's. As the corporate 17 representative of St. Mary's, can you tell me in 2024 18 who was on the med exec committee? 19 A. I would have to pull that. So by person or 20 by title? 21 Q. Well, let's just start, who was the chair of 22 the med exec committee in 2024? 23 A. In 2024, the chair of med exec was 24 Dr. Holly Lenard. 25 Q. And what is her specialty?	Page 52 1 resignation, any requests for expedited privileges or 2 to start before the process works the process. There 3 are reports from the chairs of medicine, surgery, 4 perinatal and pediatrics on anything that happened in 5 peer review. 6 There is a report from their treasurer. 7 There's a report from the chair of QIPSC, the physician 8 chair of QIPSC. There is a report from the physician 9 chair utilization review. There is a chief of staff 10 report and then reports from each member of my team in 11 attendance. 12 Q. And who is the physician chair of QIPSC at 13 St. Mary's? 14 A. Currently QIPSC is -- there are one or two 15 physicians, and I'm trying to think which position each 16 physician is in. QIPSC, I believe, is Dr. Faris Azar. 17 Q. Can you spell that for me? 18 A. Faris is F-a-r-i-s. Azar is A-z-a-r. 19 Q. Does the med exec vote to approve safety 20 plans? 21 A. They do. 22 Q. How many members are on the St. Mary's 23 governing board? 24 A. Eight. 25 Q. And in 2024 who was the chair of the
Page 51 1 A. Orthopedic surgeon. 2 Q. How many members were there of the med exec 3 committee? 4 A. I would be guessing. I could pull that 5 data. It could be 15 plus, but I -- that is not a 6 scriptural number. 7 Q. Okay. Do you sit on the med exec committee? 8 A. I do. 9 Q. Do any of the other members of the C-suite 10 sit on the med exec? 11 A. So we attend. We're nonvoting members of 12 the med exec because it's a medical executive meeting, 13 so we are not voting, so the chief executive -- the 14 chief operating officer and the chief nursing officer 15 do attend med exec. 16 Q. What types of things does the -- in your 17 capacity as the corporate representative of St. Mary's, 18 what types of things do the med exec vote on at 19 St. Mary's? 20 A. So the med exec votes on, there are reports 21 that come from different committees. For example, 22 credentials committee would present the qualifications 23 of the physicians and allied health professionals that 24 are seeking to get on staff. They would present 25 doctors requesting reappointment, providers requesting	Page 53 1 governing board? 2 A. Chief Darrel Donatto. 3 Q. And what is he the chief of? 4 A. He's the fire chief. He at that time was 5 the fire chief for Palm Beach. 6 Q. Do you know who else was on the governing 7 board in 2024? 8 A. We had some turnover, so I'm trying to 9 recall specifically. Dr. Chad Sanborn, 10 Dr. Sunny Kukreja, Dr. Dror Paley, Ms. Barbara Cheives, 11 Ms. Barbara Cipriano, Denise-Marie Nieman, I believe 12 Robby Journey (phonetic), Chief Charley Coyle and 13 perhaps Chief Sarah Mooney. 14 MS. MALONEY: Ms. Blair, what topic on your 15 30(b)(6) topics do these questions relate to? I 16 appreciate that she's been able to answer them, 17 but -- 18 MS. BLAIR: I just said I was asking her in 19 her individual capacity. 20 MS. MALONEY: No, but -- but when -- 21 MS. BLAIR: I did not ask her this question 22 as a 30(b)(6) witness. 23 MS. MALONEY: "Do you know who else was on 24 the governing board" you didn't ask as in her 25 personal capacity. And earlier than that when

Page 54 1 you were going through -- I didn't know you 2 changed because when you were asking these 3 questions about the med exec committee, that was 4 specifically in her corporate capacity. 5 MS. BLAIR: Going forward, I'll ask her in 6 her corporate capacity if it's in her corporate 7 capacity. 8 MS. MALONEY: And I'd appreciate it -- 9 MS. BLAIR: Okay. Fine. 10 MS. MALONEY: -- if you would also say what 11 topic it is because I -- 12 MS. BLAIR: Okay. Fine. 13 MS. MALONEY: -- really don't know what 14 topic the medical exec committee related to. 15 And I just -- she did prepare a lot so I want to 16 make sure -- 17 MS. BLAIR: Sure, that's fine. 18 MS. MALONEY: -- that there's no question as 19 to her being responsive to the topics that are 20 actually agreed to. 21 MS. BLAIR: And obviously if she answers a 22 question that's not on a topic, it cannot be in 23 her corporate capacity. I think we all agree 24 with that. 25 MS. MALONEY: Okay.	Page 56 1 board came off the board in January of 2025? 2 A. I'd have to -- it's a pretty specific 3 question. 4 Q. Have you ever had trouble filling board 5 positions? 6 A. Never. 7 Q. In terms of marketing for St. Mary's, we 8 talked a little bit earlier about, and her name escapes 9 me, that there is a marketing director I want to say. 10 A. I think she's a manager. 11 Q. And who is the marketing manager again? 12 A. Ashley Peterson. 13 Q. And what are Ashley Peterson's job duties as 14 the marketing manager at St. Mary's? 15 A. So Ashley would help us if we're doing 16 community events. For example, if we're having a NICU 17 reunion, a trauma survivor reunion, she would plan, 18 coordinate. 19 She would assist us, for example, if we were 20 having -- during stroke awareness month, she would 21 assist to get a physician and the team to go present in 22 the community to educate on the warning signs for 23 strokes so that the population is aware. She could 24 help coordinate with clinical caregivers, Stop the 25 Bleed program so that the community can know how to
Page 55 1 BY MS. BLAIR: 2 Q. So I'm asking you these as the CEO of 3 St. Mary's in your factual capacity -- 4 A. Okay. 5 Q. -- as a fact witness. 6 You listed three different doctors: 7 Dr. Sanborn -- I can't pronounce some of these names, 8 but are they doctors at St. Mary's or another facility? 9 A. They are at St. Mary's. 10 Q. And then Chief Coyle, what is he the chief 11 of? 12 A. He is -- he's in fire, so he is a fire 13 rescue chief in Palm Beach County. 14 Q. And Chief Sarah Mooney? 15 A. Mooney. She is the chief for the Palm Beach 16 School Board Chief of Police. 17 Q. How long is the term of a governing board 18 member for St. Mary's? 19 A. Three years. 20 Q. Do they -- are they staggered terms? 21 A. They're staggered terms. 22 Q. Are they like January to January for that 23 three-year period? 24 A. Yes. 25 Q. How many of the members of the governing	Page 57 1 provide immediate response in an event. 2 She does do social media posts on events at 3 the facility, for example the educational programs. 4 That's largely what she does. She would man if you had 5 a -- if we participated at a fair, let's say The Green 6 Market Fair and had a table, she would, you know, be at 7 the table and if people wanted information, they could 8 get it. 9 Q. Does she put out press releases for 10 St. Mary's? 11 A. No. 12 Q. Who puts out press releases for St. Mary's? 13 A. Press releases would come from a market, a 14 group individual. 15 Q. And when you say "a group individual," 16 you're referring to the Palm Beach Health Network? 17 A. Correct. 18 Q. And do you know who that would be? 19 A. That would probably be Andrew Lofholm. 20 Q. And then we talked about the fact that 21 Regina West is the quality director for St. Mary's, 22 correct? 23 A. She is. 24 Q. What type of quality committees does 25 St. Mary's have?

Page 58 1 A. The most important meeting is the QIPSC, the 2 QIPSC meeting. 3 Q. And that's the most important meeting. Are 4 there other quality committees at St. Mary's? 5 A. On a monthly basis, we have a QMOR meeting, 6 a quality monthly operating report meeting. 7 Q. And who attends those meetings? 8 A. The directors, the C-suite. Gina would lead 9 that. 10 Q. And when you say "the directors," who are 11 you referring to specifically? 12 A. So a nursing director, a lab director, a 13 pharmacy director, so our leadership team. 14 Q. And does Gina put out agendas for those 15 meetings? 16 A. Yes. 17 Q. Do you approve the agendas? 18 A. No. 19 Q. Are there minutes that result from those 20 QMOR meetings? 21 A. QMOR, I'm not certain. 22 Q. And the QIPSC meetings at St. Mary's, are 23 there agendas that are put out for those meetings? 24 A. Yes. 25 Q. And are there minutes that come out of those	Page 60 1 great time for a break. 2 THE VIDEOGRAPHER: Off the record, 10:13. 3 (A recess was taken from 10:13 a.m. to 10:21 a.m.) 4 THE VIDEOGRAPHER: Back on the record, 5 10:21. 6 BY MS. BLAIR: 7 Q. Ms. McCauley, I want to turn now just to the 8 Palm Beach Health Network and the organization of that. 9 And obviously I'll be asking you these questions in 10 your factual capacity as a witness here today. This is 11 not a 30(b)(6) topic. 12 Maggie Gill is the president of Palm Beach 13 Health Network, correct? 14 A. Correct. 15 Q. Do you know when she became the president of 16 the Palm Beach Health Network? 17 A. No. 18 Q. Was Maggie Gill involved -- well, we saw an 19 article earlier today that we marked as Exhibit 2 which 20 showed that in or around April of 2022 is when that 21 Palm Beach Health Network rebranded or Palm Beach 22 Health Network was branded, correct? 23 A. Correct. 24 Q. Do you know did Maggie Gill have any role 25 with respect to in any way with respect to St. Mary's
Page 59 1 meetings? 2 A. Yes. 3 Q. Are there slide decks that are presented at 4 those meetings? 5 A. I believe I've seen PowerPoints. 6 Q. And how often are the QIPSC meetings at 7 St. Mary's? 8 A. I believe the QIPSC meetings are monthly. 9 Q. So we have monthly QMOR meetings and monthly 10 QIPSC meetings. Are there any other quality meetings 11 that you -- at St. Mary's that you're aware of? 12 A. Those are the two that I attend. 13 Q. And I know they're the two that you attend, 14 but are you aware of whether there's any others? 15 A. I'm not positive. 16 MS. MALONEY: If we're -- oh, sorry. If 17 we're -- I was just going to say if we could 18 take a break if you're at a good -- 19 MS. BLAIR: Of course, yes. 20 MS. MALONEY: -- if you're within your 21 section, of course, but if you -- 22 MS. BLAIR: No, no, no. 23 MS. MALONEY: -- if there's a good time for 24 a break. 25 MS. BLAIR: I have no sections. Yes, it's a	Page 61 1 prior to April of 2022? 2 A. What was the question? 3 Q. Maggie Gill, did she have any role on any 4 sort of level with respect to St. Mary's prior to 5 April of 2022? 6 A. I believe prior to 2022 she was still in the 7 market as the group leader. 8 Q. Okay. So there was a group leader of these 9 five hospitals prior to the rebranding of these 10 hospitals as the Palm Beach Health Network, correct? 11 MS. MALONEY: Objection. 12 A. That's my -- that's my -- group leader may 13 not be her official title, but, yes, she was president 14 and had oversight. 15 BY MS. BLAIR: 16 Q. So I just want to sort of divide the time 17 between -- between prior to Palm Beach Health Network 18 becoming a brand and after that time, so I want to talk 19 about pre April of 2022. What type of support, if any, 20 did Maggie Gill provide to St. Mary's prior to April of 21 2022? 22 A. Can you define "support"? 23 Q. Yes. Well, you said you thought she was the 24 group leader, although that might not have been her 25 exact title --

Page 62 1 A. Correct. 2 Q. -- prior to April of 2022. And so my 3 question is, what services did she provide to 4 St. Mary's prior to April of 2022 in her capacity as 5 group leader? 6 A. Prior to April 2022 for the two years that I 7 was there was predominantly COVID period, so Maggie 8 would have been instrumental in coordinating our 9 efforts in working through COVID protocols and 10 establishing pathways for patients, not from a clinical 11 perspective because she's not a nurse. 12 Q. Right. And so just talking about those 13 COVID protocols, would she have been involved in COVID 14 protocols that overarched all five hospitals? 15 A. So Maggie would have coordinated or called 16 us together to ensure that we were all moving in a 17 similar fashion. 18 Q. So prior to April of 2022 before Palm Beach 19 Health Network existed did the five CEOs of the five 20 plaintiff hospitals have regular meetings? 21 A. During COVID, meetings -- the topics were 22 primarily COVID, and we would group up, not in person, 23 to review -- to make sure if we had questions about how 24 to share supplies if somebody didn't have N95s. There 25 was a lot of communication amongst us to ensure sure we	Page 64 1 group. 2 Q. And when you say she's responsible for them, 3 in what way? 4 A. She would be involved with ensuring that we 5 produce a budget and deliver on our budget. 6 Q. Other than the budget does she oversee your 7 hospital in any other way? 8 A. I'm not really sure what the question means. 9 Q. Yeah. So you said she makes sure that you 10 deliver a budget and you stick to the budget, correct? 11 A. Correct. 12 Q. What about marketing, does she oversee these 13 five hospitals' marketing efforts? 14 A. I can't speak to her involvement with the 15 group marketing person. 16 Q. And the group marketing person is Lisa Cook? 17 A. Correct. 18 Q. Does she oversee quality, oversee and/or 19 coordinate the quality of these five hospitals? 20 A. I suppose what is "oversee"? Does she -- 21 what does "oversee" mean? 22 Q. Well, you tell me. What involvement does 23 Maggie Gill have in the patient safety and quality of 24 the five hospitals that are the plaintiffs in this 25 litigation?
Page 63 1 could meet our patients' needs. 2 Q. Prior to April of 2022 did the five 3 hospitals coordinate their marketing efforts? 4 A. I don't recall. 5 Q. Prior to April of 2022 did the five 6 hospitals coordinate their quality efforts? 7 A. I don't recall. 8 Q. Prior to April of 2022 did the five 9 hospitals coordinate any of their financial efforts? 10 A. I don't know what that means. 11 Q. Did you share money in any way prior to 12 April of 2022? 13 A. Not that I'm aware of. 14 Q. And then post 2020 -- April of 2022 after 15 the rebranding of these five hospitals as the Palm 16 Beach Health Network did Maggie -- in your view as the 17 CEO of St. Mary's, did Maggie Gill's role change in any 18 way? 19 A. Not in my view. 20 Q. And how do you view Maggie Gill's role today 21 for the Palm Beach Health Network? 22 A. Maggie is responsible for the market. 23 Q. When you say "the market," what do you mean 24 by that? 25 A. I mean the five hospitals and the physician	Page 65 1 A. So Maggie equally participates in a group 2 quality -- quality, we call it QMOR, score -- 3 presentation that Gina leads where she would review the 4 quality metrics for each facility. 5 Q. So there are QMOR meetings specific to 6 St. Mary's, and there are QMOR meetings of the five 7 hospitals as a group; is that correct? 8 A. Correct. 9 Q. And who attends the QMOR meetings of, we'll 10 just call it Palm Beach Health Network, the five 11 hospitals? 12 A. Certainly the five CEOs. The quality 13 directors from each facility, Maggie. 14 Q. Anyone else you can think of? 15 A. I invite my chief nurse. I can't speak to 16 who the others invite. 17 Q. Is Ricky Ramirez there? 18 A. Yes, I've seen Ricky there. 19 Q. Are there agendas that are circulated for 20 the Palm Beach Health Network QMOR meetings? 21 A. I'm not positive if there's a specific 22 agenda, but there is a standard slide deck. 23 Q. Okay. So it's your memory that there's a 24 slide deck for each of these monthly QMOR meetings? 25 A. Yes.

Page 66 1 Q. Are there meeting minutes for the Palm Beach 2 Health Network QMOR meetings? 3 A. I'm not positive. 4 Q. Did you review any QMOR meeting minutes in 5 preparation for your deposition? 6 A. I reviewed a lot of documents. I can't say 7 specifically if I reviewed them for this depo. 8 Q. Does Maggie Gill communicate directly with 9 Tenet Healthcare home office on behalf of what we're 10 calling the market, these five hospitals? 11 A. I can't speak to who Maggie communicates 12 with. 13 Q. Do you have regular meetings with Tenet home 14 office related to St. Mary's? 15 A. No. 16 Q. And Maggie reports to Lisa Foo, correct? 17 A. Correct. 18 Q. And Lisa Foo is at Tenet home office, 19 correct? 20 A. Correct. 21 Q. We talked about Regina West already. Do you 22 know what types of data she tracks for Palm Beach 23 Health Network? 24 A. I know some of the data she tracks. 25 Q. What is some of it?	Page 68 1 plan for St. Mary's, do you know whether or not 2 Gina West speaks to any of the quality directors at any 3 of the other four Palm Beach Health Network hospitals? 4 A. I do not know. 5 Q. Gina West would be the right person to ask? 6 A. Yes. 7 Q. Is Gina West responsible for collecting the 8 data that's reported to CMS on behalf of St. Mary's? 9 A. Not -- I don't believe she personally 10 collects it, no. 11 Q. Okay. And I guess I thought my question 12 was, but maybe it wasn't. Do you know if she's 13 responsible for the collection of data that gets 14 submitted to CMS on behalf of St. Mary's? 15 A. I know that the information goes through the 16 quality department. So is it Gina or one of her staff? 17 I don't know. 18 Q. Okay. Is Gina in charge of the quality 19 department for St. Mary's? 20 A. Yes. 21 Q. So regardless of who collects it, would you 22 consider Gina to be responsible for the submission of 23 the CMS data? 24 MS. MALONEY: Objection to form. Vague. 25 A. I guess it depends on what you mean by
Page 67 1 A. I know she tracks infections. 2 Q. Anything else? 3 A. CMS reported data. 4 Q. So that would be HCAHPS, for example? 5 A. Correct. 6 Q. And when you say "infections," is that HAIs? 7 A. Correct. 8 Q. Any other data that you know of that she 9 tracks? 10 A. Gina would probably be better to respond to 11 everything she tracks. 12 Q. But to the best of your knowledge, that's 13 the type of thing she tracks for the Palm Beach Health 14 Network as a whole, correct? 15 A. Correct. 16 Q. Do you know whether or not Gina West in her 17 role as the quality director for the public -- or Palm 18 Beach Health Network produces an overall hospital 19 safety plan for the network? 20 A. I'm not certain. 21 Q. Do you know whether or not these five 22 plaintiff hospitals coordinate their hospital safety 23 plan in any way? 24 A. I'm not certain. 25 Q. When putting together the hospital safety	Page 69 1 "submission." 2 BY MS. BLAIR: 3 Q. Sure. Is data submitted to CMS regularly? 4 A. Yes. 5 MS. MALONEY: Objection to form. Vague. 6 Just can we make -- are you talking about 7 St. Mary's, or are you talking about -- 8 MS. BLAIR: St. Mary's, yes. St. Mary's. I 9 thought that was in my earlier question. 10 MS. MALONEY: No. 11 MS. BLAIR: "Is Gina in charge of quality 12 for St. Mary's," so we're talking about 13 St. Mary's. 14 BY MS. BLAIR: 15 Q. As the CEO of St. Mary's, how does data get 16 submitted to CMS? 17 A. My understanding is that it's electronic 18 based off of claims data, but that is about as much as 19 I could answer. 20 Q. Okay. Do you know if Gina is responsible 21 for checking the accuracy for St. Mary's of the CMS 22 data that's submitted? 23 A. Gina's department would be responsible. 24 Q. Do you know if St. Mary's has ever had 25 issues with the data being submitted to CMS being

Page 70 1 inaccurate? 2 A. That would be a better question for Gina. 3 Q. So you don't know as you sit here? 4 A. I don't want to give my opinion, not 5 factual, right? 6 Q. Yeah, I don't want an opinion. I'm just 7 asking, do you know whether CMS, there has ever been 8 issues -- so factually, not your opinion, do you know 9 if there's ever been issues with respect to the 10 accuracy of the data that St. Mary's has submitted to 11 CMS? 12 A. I am unaware. 13 Q. Derek Collins is the chief strategy officer 14 of Palm Beach Health Network, correct? 15 A. Correct. 16 Q. Do you know what his jobs are or his job 17 duties are? Excuse me. 18 A. Not fully. 19 Q. So what about generally? 20 A. So he would -- let me think what he would -- 21 what Derek does. Derek would coordinate with 22 St. Mary's if we were looking to fill an unmet 23 community need for a physician, and he would help us 24 strategize whether we should relocate somebody or hire 25 someone, his team could pull the data on how many are	Page 72 1 A. I'm not aware. 2 Q. Are you aware of whether anybody has 3 produced any brand recognition documents related to 4 St. Mary's? 5 A. I don't recall. 6 MS. MALONEY: Objection. 7 A. I don't recall having seen any. 8 BY MS. BLAIR: 9 Q. Does Derek Collins provide any reports 10 related to benchmarking of any of the five hospitals 11 that make up Palm Beach Network as it compares to their 12 competitors in the market? 13 MS. MALONEY: Objection. Vague. Lacks 14 foundation. 15 A. I don't recall having that conversation with 16 Derek. 17 BY MS. BLAIR: 18 Q. In terms of Ricky Ramirez, he is the group 19 chief nursing officer for Palm Beach Health Network, 20 correct? 21 A. Correct. 22 Q. And generally speaking, can you describe for 23 me what you believe his job duties are in that 24 position? 25 A. So my belief of what Ricky would do, so, for
Page 71 1 in the community so that we could determine how to meet 2 community need. 3 Q. Does he produce a business plan for the five 4 hospitals that make up Palm Beach Health Network? 5 A. I don't know that I've seen a business plan. 6 Q. Is he involved in any way in analyzing the 7 competitive position of St. Mary's as compared to 8 competitors in the area? 9 A. He may be. 10 Q. And when you say "he may be," I want to know 11 whether you know. 12 A. Yeah, if there's data, it's really old. A 13 lot of publicly available data lags a year, year and a 14 half. 15 Q. Do you know whether or not Derek Collins has 16 ever produced any market positioning reports for 17 St. Mary's? 18 A. Not that I'm aware of. 19 Q. Do you know whether he's ever produced any 20 marketing position reports for Palm Beach Health 21 Network? 22 A. I'm unaware. 23 Q. Do you know whether or not Derek Collins has 24 ever produced any brand recognition documents with 25 respect to St. Mary's?	Page 73 1 example, I have a new chief nurse starting next week, 2 so I could pair my new chief nurse with Ricky so that 3 he could onboard her from a nursing executive 4 perspective to make her aware of any tools or 5 requirements in her nursing specific role. 6 Q. Okay. So I'm paraphrasing, but he would be 7 helpful in training a new chief nursing officer for 8 St. Mary's, correct? 9 A. Yes. 10 MS. MALONEY: Objection. 11 A. Yes. 12 BY MS. BLAIR: 13 Q. Does he have any involvement in the hiring 14 of nurse staffing for St. Mary's? 15 A. No. 16 Q. Does he have any involvement in creating any 17 plans for how to increase nurse retention at 18 St. Mary's? 19 A. Say the question again. 20 Q. Sure. Let me lay a little foundation. 21 Do you at St. Mary's, does St. Mary's have 22 any issues regarding retention of nurses? 23 MS. MALONEY: Objection. Lacks foundation 24 and vague. 25 A. We have a steady pipeline and a very robust

Page 74 1 recruitment and externship program. 2 BY MS. BLAIR: 3 Q. So you don't have nurse retention issues; is 4 that fair? 5 MS. MALONEY: Objection. Vague. 6 A. I guess it would need more color to it. 7 BY MS. BLAIR: 8 Q. Sure. Do you have a nursing shortage 9 currently at St. Mary's? 10 A. I would not say we're in a nursing shortage. 11 Q. In the last three years has St. Mary's ever 12 had difficulty keeping nurses employed at St. Mary's? 13 MS. MALONEY: Objection. 14 A. I would say in the COVID, post, immediate 15 post COVID, every hospital struggled with nurse 16 retention. 17 BY MS. BLAIR: 18 Q. That's a good point. So let's take 2023 to 19 present, has St. Mary's had nurse retention issues? 20 MS. MALONEY: Objection. 21 A. We have a fairly high -- what's the word -- 22 rate of keeping our nurses, especially newer nurses. 23 Like our newer nurses, we have a 95 percent retention 24 rate, success rate. 25	Page 76 1 St. Mary's? 2 A. Yes. 3 Q. And so my question is, in terms of the 4 Palm Beach Health Network, do you know whether the Palm 5 Beach Health Network has an education program for 6 nurses that funnels down into St. Mary's? 7 MS. MALONEY: Objection. 8 A. We have a market education, nurse education 9 person. 10 BY MS. BLAIR: 11 Q. And who is that, if you know? 12 A. I'm trying to think of her last name. I 13 know it, but I can't think of it. I will think of her 14 name. I would be embarrassed if she knew I couldn't 15 remember her name. 16 Q. We won't tell her. 17 A. I can't think of her last name. 18 Q. That's all right. 19 And that person would be at the St. Mary's 20 level, at the local hospital level? 21 A. Her office is at St. Mary's. 22 Q. Okay. But she works on behalf of the 23 Palm Beach Health Network? 24 A. Correct. 25 Q. Shannon Wills is the group chief human
Page 75 1 BY MS. BLAIR: 2 Q. And so Ricky Ramirez, getting back to 3 Ricky Ramirez, he doesn't really, at least for 4 St. Mary's, he doesn't have any involvement currently 5 in any nurse retention issues at St. Mary's; is that 6 fair? 7 A. Not overtly unless I included him within an 8 issue, which I don't recall. 9 Q. Do you know whether or not Ricky Ramirez has 10 dealings with nurse unions on behalf of St. Mary's? 11 A. I don't believe he does. 12 Q. Okay. And there is a nurse's union at 13 St. Mary's, correct? 14 A. There is. 15 Q. And what is the name of that union? 16 A. SEIU 1199. 17 Q. Does Palm Beach Health Network have an 18 overarching nurse training protocol for all five 19 hospitals? 20 MS. MALONEY: Objection. Lacks foundation. 21 Vague. 22 A. We have an education department that 23 provides ongoing education. 24 BY MS. BLAIR: 25 Q. And when you say "we," are you referring to	Page 77 1 resources officer, correct? 2 A. Yes. 3 Q. Is Shannon Wills a man or a woman? 4 A. A girl. 5 Q. And is Shannon Wills involved in hiring of 6 nurses? 7 A. Not for St. Mary's. 8 Q. Okay. What do you understand Shannon Wills' 9 job responsibilities to be? 10 A. So she is the -- if I have a local chief HR 11 officer, if there is something that requires a next 12 level above with an employee issue, we could loop in 13 Shannon. 14 Q. Okay. And Shannon has nothing to do with 15 safety patient or quality; is that fair? 16 A. No, that's fair. 17 Q. And Lisa Cook is the marketing director for 18 Palm Beach Health Network? 19 A. Correct. 20 Q. And what do you understand Lisa Cook's 21 responsibilities to be? 22 A. My understanding is Lisa is primarily the 23 marketing person for Delray. I understand that Lisa 24 can also coordinate if there is an event that would 25 serve multiple hospitals to coordinate which marketing

Page 78 1 person should be at that event. 2 Q. Do you know if Lisa Cook had any involvement 3 with respect to the press surrounding this lawsuit? 4 A. I would have no idea. 5 Q. So we've talked about in terms of the 6 organization, St. Mary's is part of this market group, 7 the Palm Beach Health Network, correct? 8 A. Correct. 9 Q. And then the Palm Beach Health Network is 10 part of Tenet Healthcare overall, correct? 11 A. Correct. 12 Q. Do you have -- do you know what influence, 13 if any, the Tenet health network, so the parent 14 company, has over the operations of St. Mary's? 15 MS. MALONEY: Objection. Lacks foundation. 16 Vague. 17 A. No. 18 BY MS. BLAIR: 19 Q. So you were at St. Mary's in 2021, correct? 20 A. Correct. 21 Q. And in 2021, St. Mary's stopped 22 participating in the Leapfrog Hospital Survey, correct? 23 A. Correct. 24 Q. Do you know what -- why St. Mary's stopped 25 participating in the Leapfrog Hospital Survey?	Page 80 1 I'm feeling a little -- a little 2 lightheaded. 3 Q. Oh, okay. Do you want to stop? Let's stop. 4 MS. MALONEY: Yeah, let's... 5 MS. BLAIR: Yeah, we can -- 6 THE WITNESS: Yeah, I have a little stomach 7 thing going on. 8 THE VIDEOGRAPHER: Off the record, 10:48. 9 (A recess was taken from 10:48 a.m. to 11:35 a.m.) 10 THE VIDEOGRAPHER: This is media unit number 11 two. The time is 11:35. We're back on the 12 record. 13 BY MS. BLAIR: 14 Q. Ms. McCauley, are you feeling better? 15 A. Much better. 16 Q. Excellent. Thank you. 17 And I did not realize you were feeling ill 18 earlier. But is there any reason that you can't answer 19 my questions clearly and completely and truthfully 20 today? 21 A. No. 22 Q. Okay. Excellent. 23 So before the break we were talking about 24 the decision by St. Mary's to stop participating in the 25 Leapfrog Hospital Safety Grade. Do you recall that?
Page 79 1 A. Yes. 2 Q. Why? 3 A. So Leapfrog is not a required or regulatory 4 survey. The facility does not participate in optional 5 surveys. It was also our feeling that Leapfrog, unlike 6 other surveys, that you apply and they come on site and 7 validate your responses, that, in our experience, is 8 not the method for Leapfrog. They -- you complete a 9 survey and submit it, and it's more of a trust but 10 verify. 11 Q. Okay. And I asked you that question in your 12 individual factual capacity. But in your corporate 13 capacity on behalf of St. Mary's why did St. Mary's 14 stop participating in the Leapfrog Hospital Survey in 15 or around 2021? 16 A. My answer would be the same. It's a very -- 17 it's a 300-plus-page survey that takes a significant 18 amount of time to complete, and there is no onsite 19 validation by Leapfrog to validate that the person or 20 the facility submitting the survey -- there's no 21 validation, unlike a CARF survey or an ACS survey or a 22 Joint Commission survey. 23 Q. And Joint Commission, is that regulatory? 24 A. Joint Commission is -- the Joint Commission 25 for the accreditation on healthcare, they --	Page 81 1 A. Yes. 2 Q. And I think you gave me a complete answer to 3 that question, but I just want to go back and make 4 sure. 5 A. Okay. 6 Q. I asked you in your capacity as the 7 corporate representative of St. Mary's what was the 8 reason that St. Mary's stopped participating in the 9 Leapfrog Hospital Survey? 10 A. So -- 11 MS. MALONEY: Objection. It's been 12 answered. 13 MS. BLAIR: I know, but I wasn't sure if I 14 got a complete answer, so since we had to go off 15 the record I want to make sure. 16 A. So St. Mary's made the decision to not 17 continue with the Leapfrog survey largely due to the 18 fact that we do not participate in elective 19 nonregulatory surveys, and Leapfrog in and of itself is 20 a survey unlike CARF, ACS, Joint Commission, et cetera, 21 where you complete the survey, and they come on site to 22 validate that what you said -- you know, they come and 23 they observe firsthand what's accurate. So that's a 24 little deeper -- different than our experience with how 25 Leapfrog has worked.

Page 82 1 BY MS. BLAIR: 2 Q. And at least in '19, '20 and '21, St. Mary's 3 did participate in the safety grade, correct? 4 A. Yes, we did. 5 Q. Did Palm Beach Children's Hospital -- you 6 know what? That was a bad question. 7 At least '19, '20 and '21 St. Mary's 8 participated in the hospital survey? 9 A. That is correct. 10 Q. Did Palm Beach Children's Hospital 11 separately participate in the Leapfrog Hospital Survey? 12 A. It's not a separate tax ID, so, no, any of 13 the results from the Leapfrog, from the earlier 14 Leapfrog surveys would have represented both St. Mary's 15 and the Palm Beach Children's Hospital, which is a 16 little unusual because I thought Leapfrog didn't survey 17 children's hospitals or oncology programs. But the 18 data that was submitted earlier would have been 19 encompassing of that. 20 Q. And I think we're talking about two 21 different things. So there's the hospital survey, 22 correct? 23 A. You're talking the Leapfrog survey? 24 Q. The Leapfrog Hospital Survey. 25 A. Correct.	Page 84 1 Q. And you understand that Leapfrog does not 2 provide safety grades to pediatric hospitals, correct? 3 A. Correct. 4 Q. As the CEO of St. Mary's in your individual 5 capacity but as a CEO, what is the most important 6 principle of an acute care hospital? 7 A. I think the most important aspect would be 8 patient safety and quality. 9 Q. Do you define "quality" separate and apart 10 from patient safety? 11 A. In my -- in my view, patient safety is a 12 part of quality. 13 Q. And how do you define patient safety? 14 A. Patient safety would encompass doing right 15 thing at the right time at the right place for the 16 patient. 17 Q. And how is, in your opinion, quality more 18 all-encompassing than patient safety? 19 A. Quality would include different components, 20 would also include infection control, and I think it's 21 a little bit more, it could be viewed as a little bit 22 more overarching, but certainly patient safety is the 23 building block for quality. 24 Q. Okay. And would you agree with me that as 25 the CEO of St. Mary's, you would want patients to leave
Page 83 1 Q. And then there's the Leapfrog Hospital 2 Safety Grade, correct? 3 A. So Leapfrog assigns a safety grade. 4 Q. Correct. And in terms of the survey, 5 participating in the survey, St. Mary's participated in 6 the survey, correct? 7 A. St. Mary's participated in the survey, but 8 it would have been inclusive of any information from 9 the Palm Beach Children's Hospital. 10 Q. Okay. So when St. Mary's responded to the 11 survey, at least in '19, '20 and '21 when you were the 12 CEO of St. Mary's, you would have included information 13 in your survey answers for both St. Mary's as well as 14 the Palm Beach Children's Hospital? 15 MS. MALONEY: Objection. Mischaracterizes 16 her testimony. 17 A. They're not separately reported so it would 18 have been aggregate. 19 BY MS. BLAIR: 20 Q. In the survey response, correct? 21 A. Correct. 22 Q. Did you understand in between 2019 and 2021 23 that Leapfrog offered a hospital survey, not the safety 24 grade, the survey for pediatric hospitals? 25 A. I don't know that I was aware of that.	Page 85 1 St. Mary's after being admitted in a better position 2 than they were when they came? 3 A. If that -- 4 MS. MALONEY: Objection. 5 A. If that's medically possible, yes. 6 BY MS. BLAIR: 7 Q. Would you agree with me that it's important 8 to St. Mary's that the level of hospital-acquired 9 infections be as low as possible? 10 A. Agree. 11 Q. And when I say "hospital-acquired 12 infection," what do you mean that -- what do you think 13 I mean by that? 14 MS. MALONEY: Objection. 15 BY MS. BLAIR: 16 Q. Sure. 17 A. So when we -- when we refer to HAIs, that 18 would include CAUTI, CLABSI. 19 Q. C. diff? 20 A. C. diff, MRSA. 21 Q. SSI? 22 A. Yes. 23 Q. I just want to make sure. I'm saying 24 hospital-acquired infections, and I want to make sure 25 that we're understanding.

Page 86 1 And is it your understanding that that's how 2 CMS defines HAIs as well? 3 MS. MALONEY: Objection. Lacks foundation 4 and vague. 5 A. Scripturally, I don't know if that's how 6 they define it. I don't know that I've heard that 7 definition. 8 BY MS. BLAIR: 9 Q. Do you know if CMS provides empirical 10 reports with respect to CAUTI infections at hospitals? 11 MS. MALONEY: Objection. 12 A. Empirical reports? 13 BY MS. BLAIR: 14 Q. Yes. 15 A. I knew that we provide data to CMS. 16 Q. Correct. 17 A. Right. 18 Q. So CMS tracks data related to CAUTI, 19 correct? 20 A. Correct. 21 MS. MALONEY: Objection. 22 BY MS. BLAIR: 23 Q. And do you know as the CEO of a hospital 24 whether CMS tracks data on CLABSI? 25 MS. MALONEY: Objection.	Page 88 1 A. Correct. 2 Q. Would you agree with me that it's important 3 that patients have information publicly available to 4 them related to HAIs at hospitals? 5 MS. MALONEY: Objection. 6 A. I believe the data is available to the 7 patients should they choose to go to the CMS website to 8 find it. 9 BY MS. BLAIR: 10 Q. And do you think it's important that 11 patients have access to that type of data? 12 A. Yes. 13 Q. And would you agree with me that it's 14 important that a governing board of a hospital have 15 information related to the hospital's HAIs? 16 A. Yes. 17 Q. And would you agree with me that it's 18 important to -- that a governing board of a hospital 19 have accurate and up-to-date information related to 20 HCAHPS for a particular hospital? 21 A. Yes. 22 Q. And would you agree with me that it's 23 important that the med exec have up-to-date and 24 accurate information related to HAI's? 25 A. Yes.
Page 87 1 A. Yes. 2 BY MS. BLAIR: 3 Q. Same question with respect to SSI. 4 MS. MALONEY: Objection. 5 A. Yes. 6 BY MS. BLAIR: 7 Q. And what about C. diff, do you know as the 8 CEO of the hospital whether CMS tracks data related to 9 C. diff at St. Mary's? 10 MS. MALONEY: Objection. 11 A. I believe it's one of the data points. 12 BY MS. BLAIR: 13 Q. Do you know what I mean when I use the 14 expression "HCAHPS"? 15 A. Yes. 16 Q. And how do you, in your experience as the 17 CEO of a hospital, define HCAHPS? 18 A. HCAHPS is the patient's perception of the 19 care they received. 20 Q. And is it important to St. Mary's as the CEO 21 of St. Mary's, is it important to St. Mary's that 22 patients have high patient experience at St. Mary's? 23 A. Yes. 24 Q. And so to put it another way, patient 25 experience is important to St. Mary's, correct?	Page 89 1 Q. And also important that the med exec have 2 accurate and up-to-date information related to HCAHPS 3 at a particular hospital? 4 A. Yes. 5 Q. Would you agree with me that hand hygiene is 6 important to a hospital? 7 A. Yes. 8 Q. Do you know what I mean when I say CPOE? 9 A. Physician order entry. 10 Q. And St. Mary's has a computerized physician 11 order entry system, correct? 12 A. Yes, we do. 13 Q. And would you agree with me that it's 14 important that the computerized physician order entry 15 be fully functioning at a hospital? 16 A. Yes. 17 Q. Would you agree with me that the number one 18 error at a hospital is a medication error? 19 MS. MALONEY: Objection to form. Lacks 20 foundation. 21 A. I don't know that I have the expertise to 22 weigh in on that. 23 BY MS. BLAIR: 24 Q. Do you know at St. Mary's -- well, strike 25 that.

Page 90 1 In terms of your competitors in the 2 Palm Beach area who do you consider to be a competitor 3 of Good Samaritan? 4 A. Of Good Samaritan? 5 Q. I'm sorry. 6 A. Of St. Mary's? 7 Q. St. Mary's. 8 A. I would say Jupiter Medical Center. 9 Q. And how far away is Jupiter Medical -- 10 Jupiter Medical Center from St. Mary's? 11 A. Probably a 15-minute ride. 12 Q. So I'm not from Florida. Is a 15-minute 13 ride 15 miles? 14 A. Could be. 15 Q. And why do you consider Jupiter to be a 16 competitor of St. Mary's? 17 A. I would consider Jupiter a competitor 18 because we share a lot of product lines. 19 Q. And what do you mean by "product lines"? 20 A. We both offer maternity services. We both 21 offer orthopedic services. 22 Q. So essentially you consider them to be a 23 competitor because of the type of service lines that 24 they offer which are similar to St. Mary's? 25 A. Correct.	Page 92 1 the differences? 2 A. Two of the key services that are different. 3 Q. Do you have services with Good Samaritan 4 that are the same? 5 A. Generic med/surg beds. 6 Q. How far away is Good Samaritan from 7 St. Mary's? 8 A. About three miles. 9 Q. Are there any other hospitals that you 10 consider a competitor of St. Mary's? 11 A. I mean, there's other hospitals in our 12 catchment area. Whether they're competitive, the 13 competitive nature more aligns with your product lines 14 that you share. 15 Q. And I've never heard that name, that phrase 16 before, so what do you mean by "catchment area"? 17 A. Catchment area is the population you serve. 18 Q. And how do you define St. Mary's' catchment 19 area? 20 A. So we define a PSA, a primary service area, 21 which is where 75 percent -- it's the zip codes from 22 which 75 percent of your patients come from. 23 Q. And are those the same zip codes where 24 Jupiter's population comes from? 25 A. There is definitively overlap.
Page 91 1 Q. Do you consider Good Samaritan to be a 2 competitor of St. Mary's? 3 A. No. 4 Q. Why not? 5 A. Good Samaritan has different product lines 6 than St. Mary's. 7 Q. Which different -- do you know what 8 different product lines it has, Good Samaritan has than 9 St. Mary's? 10 A. For example, Good Samaritan has oncology, 11 adult oncology. 12 Q. And St. Mary's does not have adult oncology? 13 A. St. Mary's does not have adult oncology. 14 Q. Does St. Mary's have pediatric oncology? 15 A. St. Mary's has pediatric oncology. 16 Q. Other than adult oncology, are there any 17 other differences in the service lines? 18 A. St. Mary's -- Good Sam -- 19 Q. Now you're doing it. 20 A. Thank you. 21 Good Sam has women's services, a breast 22 center and a -- a line under oncology, so if you think 23 of, right, breast cancer, so they have a big women's 24 services diagnostic center, and St. Mary's does not. 25 Q. Okay. So oncology and the breast center are	Page 93 1 Q. And how do you know that? 2 A. Because some of our zip codes where our 3 patients come from is Jupiter -- 4 Q. Okay. 5 A. -- and Palm Beach Gardens, like that area, 6 that geographic area. 7 Q. Well, do you consider Palm Beach Gardens to 8 be a competitor of St. Mary's? 9 A. Palm Beach Gardens Medical Center? 10 Q. Yes. 11 A. No. 12 Q. Why not? 13 A. Their -- again, their product line is 14 differently. Their principal product line is cardiac 15 and we don't have cardiac. 16 Q. Do you consider Baptist Health to be 17 competitor of your hospital? 18 A. No. 19 Q. What about HCA JFK? 20 A. HCA JFK, there's two of them. JFK main is 21 too far. 22 Q. What about the other? 23 A. JFK North, they are largely behavioral 24 health. We don't do behavioral health. 25 Q. What about Wellington, is that a competitor

Page 94 1 of yours? 2 A. It's really far. 3 Q. Okay. What's "really far"? How far? 4 A. If I was to drive to Wellington, it would 5 take me 40 minutes, give or take. 6 Q. Got it. What about Broward? 7 A. Oh. 8 Q. Too far? 9 A. Way far. 10 Q. Okay. Do you consider NYU Langone to be a 11 competitor of St. Mary's? 12 A. They don't have a freestanding hospital 13 here, so, no. 14 Q. So, no? 15 What about Cleveland Clinic Martin North 16 Hospital? 17 A. They are not a competitor. 18 Q. And why do you say that? 19 A. One is they're way too far. They are over 20 an hour away. 21 Q. So is it fair to say, and I'll just mark 22 this as Exhibit 3 -- 23 (Defendant's Exhibit Number 3 for i.d.) 24 BY MS. BLAIR: 25 Q. So is it fair to say that Jupiter is the	Page 96 1 Do you see that question up there and it 2 goes on? 3 A. Yes. 4 Q. And as I read your answer, it says, "Jupiter 5 Medical Center is plaintiff's competitor." 6 Do you see that? 7 A. Yes. 8 Q. And that's still true today, correct? 9 A. Yes. 10 Q. Okay. Do you keep track of how many 11 patients get transferred from Good Samaritan to -- or 12 I'm sorry -- from Jupiter to St. Mary's? 13 I'm going to do that all day. I apologize. 14 Do you keep statistics of how many patients 15 are transferred from Jupiter to St. Mary's? 16 A. Yes. 17 MS. MALONEY: Objection. 18 BY MS. BLAIR: 19 Q. And do you, as you sit here today, do you 20 know how many patients in 2024 were transferred from 21 Jupiter to St. Mary's? 22 A. Approximately -- yes, approximately 500ish. 23 Q. And that was in 2024, correct? 24 A. Correct. 25 Q. And in 2025, do you know how many patients
Page 95 1 main competitor of Good Samaritan? 2 A. St. Mary's. 3 Q. St. Mary's. 4 A. Yeah. 5 Q. I'll do that all day. 6 St. Mary's. 7 And if you turn to page 20 -- first of all, 8 the document I just provided you is Plaintiff, 9 St. Mary's Medical Center, Inc.'s Amended and 10 Supplemented Responses and Objections to Defendant, The 11 Leapfrog Group's, First Set of Interrogatories to 12 St. Mary's Medical Center Inc. 13 Do you see that? 14 A. Yes. 15 Q. And I think if we turn to the very last page 16 of this document, which is the verification, is that 17 your signature on these documents? 18 A. That is. 19 Q. And if we turn to page 27, interrogatory 19, 20 this is one of the answers that was not amended. And 21 if you go to the very bottom where it says "answer," 22 the question was, "Identify all hospitals, medical 23 centers or healthcare systems that you consider to be 24 your direct competitors within the relevant geographic 25 market."	Page 97 1 have been transferred to date from Jupiter to 2 St. Mary's? 3 A. I know we are estimating by year-end it 4 should be close to 600. 5 Q. And those are patients that have transferred 6 from Jupiter to St. Mary's, correct? 7 A. Correct. 8 Q. Does St. Mary's transfer patients to 9 Jupiter? 10 A. Unlikely. 11 Q. And why is that unlikely? 12 A. Because we have a very comprehensive medical 13 staff and can largely address the needs of the patients 14 presenting to St. Mary's. 15 Q. Do any of the other four hospitals that are 16 plaintiffs in this litigation regularly transfer 17 patients to St. Mary's? 18 A. I wouldn't have that knowledge. 19 Q. Why wouldn't you have that knowledge? 20 A. Because I don't research what my sister 21 facilities do. 22 Q. Okay. Does St. Mary's track how many 23 patients are transferred between the five hospitals 24 that make up Palm Beach Health Network? 25 A. We have -- we do have that data. I can't

Page 98 1 say that I can speak to it. 2 Q. Do you know who at Palm Beach Health Network 3 would track that data? 4 A. Yes. 5 Q. And who is that? 6 A. We have a transfer center. 7 Q. And so that transfer center is part of the 8 Palm Beach Health Network? 9 A. I'm not sure if it's a health network or I'm 10 not sure whose entity it is. 11 Q. Okay. It could be Tenet Healthcare? 12 A. I'm not certain. 13 Q. Other than transfers from Jupiter -- well, 14 strike that. 15 Is Jupiter the largest -- does Jupiter have 16 the largest amount of transfers to St. Mary's in a 17 given year? 18 A. Yes. 19 Q. Other than Jupiter transferring patients to 20 St. Mary's, what other hospitals transfer, regularly 21 transfer patients to St. Mary's? 22 A. I'd have to explore, but there are a lot of 23 hospitals that transfer patients to St. Mary's. 24 Q. And have you seen a decline in those 25 transfers from 2024 to 2025?	Page 99 1 A. From? 2 Q. The other, the non-Jupiter hospitals that 3 transfer. 4 A. I don't know that I've looked at that. 5 Q. Are you aware that Universal Health Services 6 is building a hospital in Palm Beach? 7 A. Yes. 8 Q. Would you consider Universal Health Services 9 to be a competitor of, once it's built, of St. Mary's? 10 A. Hard to project, but we will share some 11 product lines. 12 Q. Which product lines will you share, to the 13 best of your knowledge? 14 A. They will have an obstetrical program. 15 Q. Anything else? 16 A. As a general med/surg hospital they'll have 17 med/surg, OR, ER. 18 Q. The hospitals in Port Lucie -- 19 Port St. Lucie, do you consider those competitors of 20 St. Mary's? 21 A. I consider them too far away to be 22 competitors. 23 Q. My apologies. I don't know the geography. 24 Do you have any information -- or strike 25 that.
Page 100 1 Does St. Mary's keep any statistical 2 information about whether or not admissions in its 3 hospital are down in the summer months due to the 4 migratory nature of a lot of the population here? 5 A. In my experience -- 6 MS. MALONEY: Objection. Lacks foundation. 7 Go ahead. 8 A. In my experience, St. Mary's isn't really in 9 an area that's impacted by the snowbirds -- 10 BY MS. BLAIR: 11 Q. Okay. 12 A. -- or the migratory, we call them snowbirds. 13 Q. And is that because most of the people in 14 the zip code that St. Mary's services live in Florida 15 year-round? 16 A. It's hard to say that they all live there, 17 but it's fairly steady, our patient base. I don't -- 18 there's not huge fluctuations in our admissions. 19 There's no wild fluctuations. 20 Q. Okay. Do you know whether or not Palm Beach 21 Health Network keeps statistics like that in terms of 22 fluctuations at various times of the years on admission 23 rates for the five hospitals? 24 A. I would imagine that if they -- I would 25 imagine there would be information that they could look	Page 101 1 at admissions by month. 2 Q. But that's not something you regularly are 3 provided as the CEO of St. Mary's? 4 A. Not at all. 5 Q. Okay. How does St. Mary's benchmark itself 6 against its competitors in the area? 7 MS. MALONEY: Objection to form. 8 A. I think you'd have to describe for me what 9 "benchmark" means. 10 BY MS. BLAIR: 11 Q. Sure. Some of the other witnesses in this 12 litigation have talked about the fact that their 13 hospitals at least, I don't know about St. Mary's, use 14 Trilliant software to measure their competitive 15 positions relevant to various hospitals in the area. 16 Is that the same for St. Mary's? 17 A. I am less familiar with Trilliant. 18 Q. Do you know of any reports that are -- that 19 you are provided as the CEO of St. Mary's related to 20 the competitive positioning of St. Mary's? 21 A. If there are market comparisons, my 22 understanding is they're not timely, they lag six to 23 nine months, so in my perspective, I don't heavily rely 24 on them. 25 Q. And are those, the "them" that we're talking

Page 102 1 about, are those reports that would be put out by 2 Palm Beach Health Network? 3 A. If it was a report potentially produced by 4 the Palm Beach Health Network. 5 Q. But as you sit here today, you don't have 6 any direct recollection of what those reports are? 7 A. Correct. 8 Q. And so as you sit here today, you don't have 9 any information about whether or not St. Mary's' market 10 share has decreased from 2024 to 2025? 11 A. I have knowledge in my role as a CEO that 12 certain metrics that we track, for example, births, 13 have declined by 2 percent. 14 Q. Any other metrics that have declined? 15 A. Pediatric outpatient therapy has declined. 16 Q. Do you know the percentage? 17 A. Outpatient pediatric outpatient therapy has 18 declined 17 percent. 19 Q. Any other declines? 20 A. Emergency room volume is down. 21 Q. By how much? 22 A. From recollection, so not scriptural, ten or 23 so patients a day. 24 Q. Ten per day. And what reports do you look 25 at that are giving you this information regarding the	Page 104 1 A. I think we said emergency room. 2 Q. Um-hum. 3 A. Surgery, number of surgeries. 4 Q. Is that down or up, or do you know? 5 A. Outpatient surgeries are down. 6 Q. By what percent? 7 A. I think it's 2 percent, but I wouldn't -- 8 I'm not a thousand percent confident on the number. 9 Q. Anything else that the monthly close report 10 tracks? 11 A. Outpatient referred visits. 12 Q. And are those the type of reports you rely 13 on in your position in this litigation that the 14 Leapfrog Hospital Safety Grade has impacted your 15 hospital? 16 A. Yes. 17 Q. Is there a year-end report? 18 A. There -- yes. 19 Q. So there would have been a year-end report 20 for 2024? 21 A. There is a monthly report, and there would 22 be one produced in December that would encompass the 23 year. 24 Q. Is there a midyear report? 25 A. Not per se.
Page 103 1 declining births, pediatric outpatient therapy and 2 emergency room? 3 A. So the volume for ER therapy, those are part 4 of our monthly close process when the books are, when 5 we close our financials and we look at volumes. 6 Q. And so that's a monthly report that's 7 generated? 8 A. It's monthly, correct. 9 Q. And is that put together by the CFO of 10 St. Mary's? 11 A. Correct. 12 Q. Do you know whether or not the Palm Beach 13 Health Network looks at the decrease in those volumes 14 as a group? 15 A. I do not know. 16 Q. What other volumes does the monthly close 17 report track other than births, patient, pediatric 18 out -- pediatric outpatient therapy and ER volume? 19 A. It tracks, we said, admissions. 20 Q. Yes. 21 A. Patient stays. 22 Q. Patient stays meaning? 23 A. Patient stays, that's head in the bed at 24 midnight. 25 Q. Anything else?	Page 105 1 Q. And does St. Mary's' fiscal year run from 2 January 1st through December 31st? 3 A. Yes. 4 Q. Have there been declines in revenue at 5 St. Mary's from 2024 to present? 6 A. We'd be relying on my memory to recall 7 revenues, but revenues aren't purely related to volume. 8 They could be related to contracting or payer mix, so 9 it's not necessarily an indicator. 10 Q. Yeah, but my question is just do you know if 11 revenue is down? 12 A. I'm not aware that revenue is down. 13 Q. Are you aware of any documents that 14 specifically set forth what the community perception 15 was of St. Mary's in or around the summer of 2024? 16 MS. MALONEY: Objection to form. 17 A. No. 18 BY MS. BLAIR: 19 Q. Did St. Mary's do any brand studies 20 regarding the perception of St. Mary's' brand in or 21 around the summer of 2024? 22 A. Not that I'm aware of. 23 Q. Just anecdotally as a -- as the CEO of 24 St. Mary's, do you have any view of what St. Mary's' 25 brand was in or around the summer of 2024?

Page 106 1 A. What do you mean by the question? 2 Q. Well, do you have any opinions about how the 3 community perceived St. Mary's in or around the summer 4 of 2024? 5 A. I believe the community trusted St. Mary's' 6 medical care. 7 Q. As the CEO of the hospital of St. Mary's and 8 in your capacity as a corporate representative with 9 respect to reputational harm, what are the things that 10 go into St. Mary's' brand? 11 MS. MALONEY: Objection to form. Vague. 12 A. I am not -- 13 MS. MALONEY: Lacks foundation. 14 A. -- an expert in -- 15 THE STENOGRAPHER: Sorry. I didn't hear the 16 last objection. 17 MS. MALONEY: Vague and lacks foundation. 18 A. I'm not an expert on brand and brand 19 awareness. That's not my expertise. 20 BY MS. BLAIR: 21 Q. Do you have any understanding of the fact 22 that community perception is part of St. Mary's' brand? 23 A. I would as a general layperson believe that 24 community perception is going to influence brand. 25 Q. Okay. But for purposes of this deposition	Page 108 1 A. Each hospital stands independently. 2 Q. Do you know whether or not Palm Beach Health 3 Network has a separate marketing budget? 4 A. I don't know. 5 Q. Do you know prior to fall of 2024 whether 6 St. Mary's had any programs in place to increase its 7 patient experience scores? 8 A. We are continually trying to achieve our -- 9 improve our patient experience scores. 10 Q. And why are you continually trying to 11 improve your patient scores? 12 A. Because I know we give an excellent clinical 13 outcome. We need the patients to feel that their 14 experience was as good as their clinical outcomes. 15 Q. Since January of 2025, have you -- has 16 St. Mary's put in any new programs to increase patient 17 experience scores? 18 A. What do you mean by "new programs"? 19 Q. Sure. For example, one of the hospitals has 20 hired a patient -- a patient experience champion. Has 21 St. Mary's done anything like that? 22 A. We've had a patient experience person, so, 23 no, we've not hired anyone new. 24 Q. Since your time at St. Mary's, you've always 25 had a patient experience person?
Page 107 1 and the -- you have no documents prior to fall of 2024 2 that show what the brand awareness was of St. Mary's? 3 A. Not that I'm -- 4 MS. MALONEY: Objection. 5 A. -- personally aware of. 6 Can I run to the restroom? 7 Q. Of course. 8 MS. MALONEY: Yes. 9 (A recess was taken from 12:07 p.m. to 12:12 p.m.) 10 THE VIDEOGRAPHER: Back on the record, 11 12:12. 12 BY MS. BLAIR: 13 Q. Ms. McCauley, I want to go back to 14 St. Mary's' marketing budget quickly. I may have asked 15 you this before, so I apologize. Do you know what 16 St. Mary's' marketing budget is for St. Mary's? 17 A. The dollar? 18 Q. Yes. 19 A. No. 20 Q. Do you know is it a percentage of the 21 overall budget? 22 A. I don't believe so. 23 Q. Okay. Do you know if you share your 24 marketing budget with the other four hospitals that are 25 plaintiffs in this litigation?	Page 109 1 A. Since before me. 2 Q. Do you know whether or not St. Mary's uses 3 Press Ganey in connection with its patient experience 4 scores? 5 A. Yes. 6 Q. Since January of 2025, do you know if 7 St. Mary's has involved Press Ganey any further in its 8 operations to increase patient experience scores? 9 A. I'm not certain that they've been -- that 10 they've done it further. Press Ganey has been a 11 patient satis -- the patients that send us surveys, and 12 we have access to them, so... 13 Q. Do you have any understanding that 14 Press Ganey offers consulting services for hospitals in 15 order to improve their patient satisfaction scores? 16 A. I'm not sure that I know that. 17 Q. And so is it fair to say you're not aware 18 that whether or not after January of 2025 St. Mary's 19 has engaged Press Ganey on any consulting services to 20 improve patient experience scores? 21 A. We have not. 22 Q. What is Dexur Insights, D-e-x-u-r, Insights, 23 do you know? 24 A. I have no idea. 25 Q. Does St. Mary's engage in any way with

Page 110 1 Dexur Insights, D-e-x-u-r? 2 MS. MALONEY: Objection. 3 A. I have no idea who they are. 4 BY MS. BLAIR: 5 Q. I understand that St. Mary's participates in 6 several Healthgrades® programs, is that correct? 7 A. We have been the recipient of Healthgrades® 8 awards. 9 Q. Is there survey that's completed in order to 10 earn these various Healthgrades® awards? 11 A. Not to my knowledge. 12 Q. And does St. Mary's pay for the 13 Healthgrades® badge in order to be able to advertise 14 it's Healthgrades® awards? 15 MS. MALONEY: Objection. 16 A. I believe we do have to license it. 17 BY MS. BLAIR: 18 Q. Do you know how much you pay for that 19 license? 20 A. No. 21 Q. Does your hospital participate in any 22 registries? 23 MS. MALONEY: Objection. 24 A. I believe the answer is yes. 25	Page 112 1 A. As the CEO, I call my quality director who 2 produces it for me. 3 Q. Okay. And that quality director would be 4 Regina West, correct? 5 A. Right. 6 Q. Do you -- are you ever provided any reports 7 about how St. Mary's' patient experience scores compete 8 with Jupiter Medical Center? 9 A. Not to my knowledge. 10 Q. Do you track any metrics that compare 11 St. Mary's to Jupiter Medical Center? 12 A. No. 13 Q. Does St. Mary's in any way benchmark itself 14 against Jupiter in the area of patient safety? 15 A. No. 16 Q. Does St. Mary's use the Leapfrog Safety 17 Grade to benchmark itself against its competitors? 18 MS. MALONEY: Objection. 19 A. We don't utilize the Leapfrog Safety Grade 20 because we believe that it's misguiding -- misguided 21 and unsafe and has particularly become more misguided 22 since they started imputing scores for the four -- four 23 particular metrics, CPOE, the barcode, intensive -- 24 critical care and hand washing. So I don't believe 25 that there is validity in using that as a benchmark.
Page 111 1 BY MS. BLAIR: 2 Q. Do you know which ones? 3 A. No. 4 Q. Do you know how much St. Mary's pays to 5 engage in those registries? 6 A. No. 7 MS. MALONEY: Objection. Lacks foundation. 8 BY MS. BLAIR: 9 Q. Do you know whether or not St. Mary's pays 10 for any accolades associated with those registries? 11 MS. MALONEY: Objection. 12 A. I'm unaware of which registries we may 13 participate in. 14 BY MS. BLAIR: 15 Q. Understood. 16 Does Palm Beach Health Network maintain any 17 metrics where it compares the five hospitals that make 18 up Palm Beach Health Network against each other in 19 areas related to patient safety? 20 A. Maybe. If that's the QMOR that I spoke 21 about. To the best of my knowledge, I haven't seen it 22 in a side-by-side comparison, but I have seen -- I can 23 see all five hospitals' data. 24 Q. Okay. And is there like a platform you go 25 on to see all five hospitals' data?	Page 113 1 BY MS. BLAIR: 2 Q. Okay. So is it your position as the 3 corporate representative of St. Mary's that St. Mary's 4 does not review its Leapfrog grades to benchmark itself 5 against its competitors? 6 MS. MALONEY: Objection. Vague. Lacks 7 foundation. 8 A. I do not use the Leapfrog score to bench 9 myself against the competitor because there's no way to 10 trust but verify that the data is a good and useful 11 tool since it's a self-survey without validation. 12 BY MS. BLAIR: 13 Q. And you understand that of the 22 measures 14 that are involved in the Leapfrog Hospital Safety Grade 15 for nonparticipating hospitals, four of those measures 16 come from the survey, correct? 17 A. There are four measures that are imputed and 18 another three that since we're not participating, those 19 scores get reallocated. So technically by not 20 completing the survey, there are seven metrics that we 21 are not responding to. 22 Q. Okay. Seven of the 22, correct? 23 A. Right. But somehow Leapfrog says if you 24 don't respond to six of them, we don't give you the 25 score. But we don't respond and we don't complete

Page 114 1 those seven, but we still get a score. 2 Q. Okay. And setting aside the other seven 3 measures, would you agree with me that the remaining 4 measures come from CMS data? 5 A. They do come from CMS data which lags about 6 a year and a half. 7 Q. Right. And that's because the publicly 8 available data from CMS lags, correct? 9 A. Correct. 10 Q. And we talked a little bit earlier, and you 11 said that if a patient wanted to look at your 12 hospital-acquired infections rates, they could go on 13 CMS, correct? 14 A. Correct. 15 Q. And if a patient went on CMS today to look 16 at those hospital-acquired infection rates, the 17 information they would be looking at would be lagging, 18 correct? 19 A. Correct. 20 Q. Is your participation in Healthgrades® in 21 any way tied to a contract for the hospital? 22 MS. MALONEY: Objection to form and lacks 23 foundation. 24 A. Not that I'm -- not that I'm aware of. 25	Page 116 1 and they look across all the hospitals in the 2 United States and glean quality metrics and benchmark 3 the hospitals, and based on that, St. Mary's has for 4 11 years gotten awards for c-section, vaginal 5 deliveries, hip, knee, stroke, so I cannot speak to 6 their metrics or what's behind it other than, you know, 7 we provide good quality care. 8 Q. And do you know whether or not when 9 Healthgrades® looks at these awards, they speak 10 directly with patients to come to -- in coming to their 11 conclusions? 12 A. I'm not certain. 13 Q. Do you know whether or not Healthgrades® 14 speaks directly to physicians when it comes to its 15 conclusions as to who should receive an award? 16 A. I'm not certain. 17 Q. Do you know whether Healthgrades® gives out 18 an overall patient safety award to hospitals? 19 A. I'm not sure. 20 Q. Do you know whether or not St. Mary's' 21 participation in Healthgrades® is tied to any local 22 regulatory requirements for the hospital? 23 A. Not that I'm aware of. 24 Q. Does St. Mary's have any awards from 25 U.S. News & World Report?
Page 115 1 BY MS. BLAIR: 2 Q. Does Healthgrades® visit your facilities 3 when it gives out these awards? 4 A. No, but I believe Healthgrades® pulls the 5 data from CMS or, right, from information that's 6 provided. 7 Q. And the data that Healthgrades® would be 8 pulling from CMS would also be that lagging CMS data 9 that we just discussed? 10 A. There is a better person who statistically 11 understands where exactly they're pulling their data. 12 Q. Okay. And who's that? 13 A. Gina West. 14 Q. Gina West. 15 Do you know whether or not the participation 16 in Healthgrades® by St. Mary's is approved by Tenet 17 home office? 18 A. Factually, no. 19 Q. What about not factually? 20 A. Well, Healthgrades® will give us awards, but 21 it's not as if we have to engage them to come and give 22 us an award. 23 Q. Okay. So tell me, in your -- what is your 24 understanding of how Healthgrades® works? 25 A. They pull data from publicly submitted data,	Page 117 1 A. Yes. 2 Q. Do you know what those are? 3 A. I know it, but I can't pull it to the top of 4 my head. 5 Q. Do you know whether or not St. Mary's pays 6 U.S. News & World Report for its logos in order to 7 advertise its status as an award wing U.S. News & World 8 Report hospital? 9 A. I -- 10 MS. MALONEY: Objection. 11 A. I believe that's one that we do have to pay. 12 BY MS. BLAIR: 13 Q. And same with Healthgrades®, correct, we 14 talked about earlier? 15 A. Yes. 16 MS. MALONEY: Objection. 17 BY MS. BLAIR: 18 Q. Do you know whether -- do you know what 19 U.S. News & World Report looks at in order to come to 20 its conclusion as to what hospital should get what 21 award? 22 A. No. 23 Q. Do you know whether or not U.S. News & World 24 Report comes on site and does any sort of inspection to 25 make its decision about its awards?

Page 118 1 A. I'm unaware that they come on site. 2 Q. Do you know whether or not they speak with 3 any patients when coming to the conclusion about its 4 rankings? 5 A. No, I do not know. 6 Q. And do you know whether or not U.S. News & 7 World Report speaks to any physicians with respect to 8 coming to the conclusion about its rankings? 9 A. I'm unaware. 10 Q. When you became the CEO of St. Mary's in 11 2009, I think we already established this, but 12 St. Mary's was participating in the Leapfrog Hospital 13 Survey, correct? 14 A. That is correct. 15 Q. When you came on board as the CEO of 16 St. Mary's, did you have concerns at that time in 2019 17 about St. Mary's continuing to participate in the 18 Leapfrog Hospital Survey? 19 A. Not at that time. 20 Q. And why not? 21 A. At that time, I believe our grade was a B, 22 and a B would not give the public perception that we 23 are not a safety facility. 24 Q. During your time as the CEO of St. Mary's 25 from 2019 to 2021, did Leapfrog ever charge St. Mary's	Page 120 1 better knowledge on how to take the tool and ultimately 2 get a better grade. 3 Q. I think you testified earlier that the 4 survey is a little over 400 pages, correct? 5 A. Yeah, I printed it and I think it was over 6 300. 7 Q. And, as I understand from your Complaint, 8 the allegation is that filling out the survey is 9 onerous, correct? 10 A. Yes. 11 Q. And would you agree with me that it's very 12 detailed? 13 A. Having looked at it, it appears very 14 detailed. 15 Q. And would you agree with me that there is -- 16 it's pretty dense in terms of the information that's 17 provided? 18 A. It's a thick binder. 19 Q. And, in fact, for example, on hand hygiene, 20 there's a lot of discussion about having 200 21 observations, correct, in order to get an achievement 22 score, correct? 23 MS. MALONEY: Objection. 24 A. So the hand hygiene speaks to -- speaks to 25 having a protocol, and there is a question on do you
Page 119 1 to participate in the survey? 2 A. My understanding is there's no fee to 3 participate in the Leapfrog survey. 4 Q. Between -- well, at any time since you've 5 been the CEO of St. Mary's from 2019 has St. Mary's 6 ever been approached by Leapfrog to pay for consulting 7 services by Leapfrog in exchange for better grades? 8 A. So during my time as the CEO at St. Mary's, 9 in regular email communication that we would get from 10 Leapfrog when they would announce their upcoming grade, 11 in my recollection, there is a portion of that email 12 that references that you can pay \$395 to get -- to go 13 to one of, I recall three different boot camps, and it 14 would discuss the survey, completing the survey and the 15 formulation of the grade. So those paid services are 16 available should you choose to avail yourself. 17 Q. Right. And do you have -- I understand how 18 you've described those services. 19 Were those services ever offered to you as 20 services to help you improve your safety score with 21 Leapfrog? 22 A. The offering does not specifically state 23 that, but there's no, you know -- a logical person 24 would not believe I'm going to pay 400, \$395 for these 25 services without an understanding that you would have a	Page 121 1 have -- do you have 200 observations. But, again, my 2 issue with the Leapfrog survey is nobody comes to 3 observe whether I actually do what I've said on the -- 4 on the survey. 5 BY MS. BLAIR: 6 Q. Does your hospital fill out hand hygiene 7 observation logs on a monthly basis? 8 A. Yes. 9 Q. In terms of fees you just talked about, the 10 \$399 to go to a boot camp, you don't have any 11 understanding as to whether or not that is simply to 12 help guide first-time users in the survey through that 13 dense 385 process as opposed to paying for better 14 grades, correct? 15 MS. MALONEY: Objection to form. Lacks 16 foundation as to "first-time users." 17 A. The email that I recall does not 18 specifically say new to Leapfrog, need help, here's 19 what. It just is more of a blanket, attend one of our, 20 you can participate in one of our three boot camps, as 21 I recall, three -- 22 I can't say if there's four, you know. 23 -- one of these three boot camps for \$395. 24 Here's how to reach us. 25

Page 122 1 BY MS. BLAIR: 2 Q. Do you understand that Leapfrog offers free 3 town hall meetings for hospitals to help them complete 4 the hospital survey? 5 A. I did see that on the email. 6 Q. Do you have any understanding as to whether 7 or not the \$399 service that you just discussed is 8 essentially the same as the free town halls that are 9 offered to hospitals? 10 A. I've never attended the boot camp or the 11 free, so I can't speak to it. 12 Q. But you have no knowledge as you sit here 13 today whether or not Leapfrog exchanges better grades 14 for payment; is that fair? 15 A. It would seem to me that if I were going to 16 engage with a consultant that the end goal would be to 17 improve my scoring on the survey. I believe -- I don't 18 believe otherwise that somebody would pay a fee to an 19 organization to get the same result. 20 Q. And I want to make sure we're talking about 21 the same thing. The email that you just told me about, 22 does it say "consultant services"? 23 A. It said -- it specifically called it "boot 24 camp." 25 Q. Okay. It didn't call it coaching services?	Page 124 1 A. I don't believe there's anything in the 2 email that I've seen that says, "If you pay us, you 3 will get a better grade." 4 However, I do believe that with coaching, 5 that is the nature of coaching, that that is the 6 intent. 7 Q. Are you aware that there are hospitals that 8 participate in the survey that get D's? 9 A. I am. 10 Q. And so is it your position that those 11 hospitals that participate in the survey and get D's 12 are ones that haven't paid for this consulting fee, is 13 that your position in this case? 14 A. I can't make a broad base on the percent of 15 hospitals that participate in Leapfrog. 16 Q. Okay. But other than the emails that you 17 saw about the boot camp, there are no facts that you 18 have that support your allegation in this case that 19 hospital -- that, I'm sorry -- that Leapfrog charges 20 hospitals consulting fees in exchange for better 21 grades, correct? 22 MS. MALONEY: Objection to form. 23 A. I believe that if a facility wanted to 24 improve their scores, they would engage with the 25 consultant or the boot camp to try to elevate their
Page 123 1 MS. MALONEY: Objection. 2 A. I believe it called it a boot camp, but we 3 could go back. I'm sure we could find the emails. 4 BY MS. BLAIR: 5 Q. Okay. And you understand that there are 6 allegations in this Complaint that hospitals that 7 participate in the hospital survey pay Leapfrog for 8 better grades. Do you understand that's an allegation 9 in the Complaint you filed? 10 A. Yes. 11 Q. What -- and as the corporate representative 12 of St. Mary's, what facts is that allegation based on? 13 A. So I believe that because you can pay for 14 consultive boot camp advice and guidance, I believe 15 that they are -- you pay -- I think that there is an 16 incentive because you pay to use your grade, that that 17 is an inducement or an attraction for a facility to 18 engage with those services of Leapfrog in an effort to 19 get a better grade. 20 Q. Okay. And so you started that answer with, 21 "I believe." 22 A. Um-hum. 23 Q. So my question is, what facts do you have 24 that, in fact, Leapfrog exchanges money for better 25 grades with hospitals that pay them for a coaching fee?	Page 125 1 scores. 2 BY MS. BLAIR: 3 Q. And I understand that's what you believe. 4 A. Right. 5 Q. I'm just asking about facts. 6 MS. MALONEY: Objection. 7 A. If -- do I believe that's written? No, I do 8 not believe that it's written. 9 BY MS. BLAIR: 10 Q. And have you ever looked at the boot camp 11 materials to make a decision, an educated decision 12 about whether that's actually what's happening, that 13 Leapfrog is taking consulting fees in exchange for a 14 better grade? 15 A. I have read the boot camp descriptions which 16 appear to go through the survey and speak to completing 17 the survey. 18 Q. Other than the descriptions that you 19 received in the emails, no other documents that you've 20 seen support the position that Leapfrog charges 21 consulting fees to hospitals for better grades, 22 correct? 23 A. Correct. 24 Q. In terms of when your hospital -- 25 A. Can I ask a question?

Page 126 1 Q. Oh, no, I can't answer questions. 2 A. Can I clarify my answer? 3 Q. Oh, yes, of course. 4 A. Okay. Thank you. 5 I do know that for the hospitals that do 6 participate in Leapfrog, as we used to, that when I 7 provide my data to Leapfrog, I sign off saying that all 8 my data can be used by Leapfrog basically for whatever 9 commercial purposes they want, which could include 10 monetizing, increasing the financial performance of 11 Leapfrog, so there's like an attestation, you agree, 12 I'm going to give you all this data over to you and 13 use -- and you can use it however and for whatever you 14 want. And it does say that they -- they can -- they 15 can do with it as they want and they can monetize that. 16 Q. And the other thing that the attestation 17 says is that the information that you're providing to 18 the Leapfrog survey is true and correct, correct? 19 A. Correct. 20 Q. And at any time that you as St. Mary's 21 participated in the Leapfrog Hospital Survey, did you 22 ever provide incorrect data to Leapfrog? 23 A. We never provide incorrect data. But that 24 being said, the Leapfrog score imputes -- the Leapfrog 25 grade imputes scores, which I can say factually are	Page 128 1 pay Leapfrog for accolades? 2 MS. MALONEY: Objection to form. 3 A. No, that is an optional program that 4 Leapfrog offers that if you want to pay for any 5 licensing, marketing fee, then you can use your grade 6 for your marketing purposes. 7 BY MS. BLAIR: 8 Q. So other than these consulting services that 9 you believe hospitals pay for in exchange for better 10 grades and this sentence in the attestation that 11 Leapfrog may use data for commercial purposes, are 12 there any other payments that you believe Leapfrog 13 takes in exchange for grades? 14 MS. MALONEY: Objection. 15 A. In exchange for grades? As I mentioned, you 16 can pay to utilize the grade to market it, and you can 17 pay to do a boot camp with, I would say, a Leapfrog 18 consultant to assist you. 19 BY MS. BLAIR: 20 Q. And the allegation in this Complaint is that 21 Leapfrog engages in a brazen pay-to-play scheme. What 22 do you understand the word "brazen" to mean as you 23 allege it in the Complaint? 24 A. Brazen is, to me, means bold, and it is -- 25 it's a bold, aggressive tactic to incentivize hospitals
Page 127 1 incorrect. Particularly for the four measures, we 2 scored 60 out of 400 points when if Leapfrog were to 3 come verify my hand washing, my CPOE, my BCMA and my 4 intensive care staffing, I would get full credit for 5 those. So I, if I were to complete the survey, would 6 complete it honestly and truthfully, but I don't know 7 that that's reciprocated by Leapfrog, particularly 8 since the fall of 2024, because they are creating a 9 fiction about how I scored on certain metrics without 10 having knowledge. 11 Q. Okay. And I appreciate that and we'll get 12 into that, but that was not my question. My question 13 was about the attestation that you were just 14 discussing. One of the attestations says is that the 15 information you're providing to Leapfrog is true and 16 correct, correct? 17 A. Yes. 18 Q. It's not just about monetizing information, 19 is it? 20 A. It's not solely about that, but you are, you 21 have to validate that, attest that your data is 22 correct. 23 Q. Correct. And in all the time that you were 24 the CEO of St. Mary's and St. Mary's participated in 25 the Leapfrog program, was your hospital ever forced to	Page 129 1 to pay to take the survey, engage in a boot camp by 2 their consultants and, in turn, pay to market their 3 grades. 4 You could pay, I think there's a leader 5 award you can pay to nominate your person, a person in 6 your facility to get a leadership award. You can pay 7 to sit on an advisory council -- to consult with 8 advisory council panel members four times a year. So 9 there's other opportunities that are pretty bold for 10 Leapfrog to earn revenues by a facility participating 11 in a voluntary unvalidated, you know, survey. 12 Q. Do you understand that HCA sits on -- you 13 refer to the advisory panel. Do you understand that 14 HCA sits on the advisory panel? 15 MS. MALONEY: Objection to form. Lacks 16 foundation. 17 A. And that's -- is -- is -- 18 BY MS. BLAIR: 19 Q. Do you know that? 20 A. I don't know the members of the panel. 21 Q. Oh, okay. Okay. 22 Do you know how many hospitals sit on the 23 advisory, patient advisory committee for Leapfrog? 24 A. No. 25 Q. Do you know how much money Leapfrog makes

Page 130 1 from hospitals that sit on the patient advisory 2 committee? 3 A. No. 4 Q. Do you know what the hospital safety grades 5 are of any of the hospitals that sit on the patient 6 advisory committee of Leapfrog? 7 A. No. 8 Q. Do you believe that only A hospitals would 9 pay to sit on the patient advisory committee of 10 Leapfrog? 11 A. I can't speak to what any other hospital 12 would do. 13 Q. And I think you told me just a minute ago 14 that during the time in which St. Mary's participated 15 in the Leapfrog Hospital Survey, St. Mary's did not 16 inflate its responses to the hospital survey, correct? 17 A. Absolutely not. 18 Q. Do you believe that your -- that your 19 competitors inflate their grades or their -- I'm 20 sorry -- their survey response to Leapfrog? 21 A. I can't speak to what a competitor does. 22 MS. BLAIR: I'll mark this as 4. 23 (Defendant's Exhibit Number 4 for i.d.) 24 BY MS. BLAIR: 25 Q. Ms. McCauley, I've handed you now what we've	Page 132 1 A. Yes. 2 Q. And so is it your position in this 3 litigation that hospitals that do participate in the 4 survey inflate their performance? 5 A. It's my opinion that without a trust but 6 verify, someone coming to validate what I say, that you 7 can't -- you can't state that everyone is of the same 8 ethical beliefs as myself or my team that would report 9 our data accurately. I can't -- I can't speak. I do 10 believe when you take a self-test that no one is 11 checking, that it is subject to manipulation. 12 Q. This says, "Median responses for hospitals 13 that report their own scores show that these hospitals 14 inflate their performance." 15 And my question is, what facts do you have 16 that hospitals that participate in the Leapfrog survey 17 inflate their performance? 18 A. And my response to you is without a trust 19 but verify, an onsite validation, you can't validate 20 the inverse that they don't. 21 I believe that in a self-test people 22 typically will score themselves better generically than 23 perhaps the data would show. 24 Q. Okay. But you have no facts that hospitals 25 that report their own scores inflate their performance,
Page 131 1 marked as Exhibit 4. And this is the Amended Complaint 2 in this matter. Have you seen this before? 3 A. Yes. 4 Q. And you'll see at the very top here it was 5 filed on August 28th, 2025. Do you see that at the 6 top? It's like in this weird docket. It says docket 7 8-28-25 at the top. 8 A. Yes. 9 Q. And did you see this document before it was 10 filed? 11 A. Yes. 12 Q. And did you approve its filing as one of the 13 plaintiffs in this case? 14 A. Yes. 15 Q. And if we turn to paragraph 27 of this 16 Complaint, the second sentence, it says, "The data 17 provided by hospitals that do participate in the 18 TLG hospital survey is self-reported, biased and 19 subject to manipulation." 20 Do you see that? 21 A. Yes. 22 Q. And then it goes on, "Median responses for 23 hospitals that report their own scores show that those 24 hospitals inflate their performance." 25 Do you see that?	Page 133 1 correct? 2 MS. MALONEY: Objection. 3 A. I cannot say hospital X definitively did Y 4 because it's never been validated. 5 BY MS. BLAIR: 6 Q. And the only hospital that you can be sure 7 of is your own hospital, and you did not inflate your 8 numbers when you participated in the survey, correct? 9 A. That is correct. 10 Q. And do you understand that the previous 11 methodology, the spring 2024 methodology, this is 12 before the methodology changed, did you understand that 13 the imputation model at that time gave St. Mary's the 14 median score of self-reporting hospitals for the four 15 measures that are at issue in this litigation? 16 A. Yes. 17 Q. So did you understand in the spring of 2024 18 for CPOE, BCMA, ICU physician staffing and hand 19 hygiene, St. Mary's received 100 out of 100, 400 points 20 for all of those measures, based on how the 21 self-reported hospitals who are participating in the 22 survey were doing, correct? 23 A. Yes. 24 Q. And so if your statement is true that these 25 hospitals were inflating their performance, then also

Page 134 1 is it your position that the 400 out of 400 points that 2 St. Mary's was getting previously was overinflated as 3 well? 4 A. I would have to pull my data for those times 5 to respond. 6 But, for example, critical care staffing, I 7 know definitively we've had a critical care contract 8 with physicians for 24/7 coverage, so I can validate 9 factually that we should have gotten full credit for 10 that. I can't speak to the other three metrics off the 11 top of my head. 12 Q. Is it your position that to get 100 out of 13 100 points on ICU physician staffing on the Leapfrog 14 survey, you just have to have a contract in place? 15 MS. MALONEY: Objection. 16 A. We would have -- 17 MS. MALONEY: Misstates her testimony. 18 A. We would have to go through the entire 19 manual on that section and see and add up every 20 question. 21 BY MS. BLAIR: 22 Q. And in order to provide information in this 23 litigation that your counsel refers to as "sufficient 24 to simulate," did you do that with respect to the ICU 25 physician staffing measure?	Page 136 1 MS. MALONEY: Objection. Misstates 2 testimony. Lacks foundation. 3 A. When I read, when I read through the myriad 4 of documents, what I saw was there, I believe, were 5 four categories that you could get. The lowest one was 6 limited. 7 BY MS. BLAIR: 8 Q. Correct. 9 A. Correct. 10 Q. But you could get a zero, would you not 11 agree with that? 12 MS. MALONEY: Objection. 13 A. I -- I don't know. What I saw in the 14 documents I read showed "limited." 15 BY MS. BLAIR: 16 Q. Okay. Do you know how, based on the 17 documents that you saw, that limited achievement score 18 is arrived at in terms of points assigned to it? 19 MS. MALONEY: Objection. 20 A. No. 21 BY MS. BLAIR: 22 Q. In the years that St. Mary's participated in 23 the Leapfrog Hospital Survey, did it -- 24 And just the survey. I don't want to talk 25 about the hospital safety grade. Just the survey.
Page 135 1 A. Did I do what? 2 Q. Did you go through the survey and add up how 3 you did on each one of the survey questions? 4 A. I did review those survey questions. I did 5 not go and recalculate each score, no. 6 Q. And do you understand that in the fall 2024 7 methodology, we'll just stick with ICU physician 8 staffing, that hospitals that didn't participate were 9 now being given limited achievement scores for the four 10 measures that are at issue in this litigation? 11 A. Yes. 12 Q. And do you under -- 13 MS. MALONEY: Objection. You. 14 Need to give me a second to object. 15 THE WITNESS: Yes, ma'am. 16 BY MS. BLAIR: 17 Q. Do you understand, do you have any 18 understanding of what "limited achievement" means in 19 the 2024 Leapfrog methodology? 20 A. Limited achievement is the lowest score 21 possible. 22 Q. Do you know -- so you don't know whether or 23 not limited achievement actually refers to the lowest 24 score that a participating hospital received for that 25 measure?	Page 137 1 -- did St. Mary's derive any benefit from 2 participating in the survey? 3 A. Hard for me to -- hard for me to assess, 4 especially during our COVID years which were the large 5 part of my early career. 6 Q. Prior to 2019 when you were the chief 7 administrative officer at St. Mary's, was St. Mary's 8 participating in Leapfrog Hospital Survey? 9 A. I believe so. 10 Q. Did you have any involvement with the 11 hospital survey, the Leapfrog Hospital Survey prior to 12 2019? 13 A. Not tangibly that I recall. 14 Q. What about intangibly? 15 A. I don't -- I don't recall it. 16 Q. Okay. Do you know whether or not at any 17 time that St. Mary's was participating in the Leapfrog 18 Hospital Survey it used the Leapfrog Hospital Survey to 19 benchmark itself? 20 MS. MALONEY: Objection. Asked and 21 answered. 22 A. Not that I'm aware of. 23 BY MS. BLAIR: 24 Q. Do you know whether or not St. Mary's' 25 decision to stop participating in the Leapfrog Hospital

Page 138 1 Survey was a directive from Tenet home office? 2 A. It's my understanding it was not a directive 3 from the Tenet home office. 4 Q. Do you understand that -- well, strike that. 5 Did you have any discussions between 2019 6 and 2021 with anyone at Tenet home office about 7 St. Mary's' participation in the Leapfrog Hospital 8 Survey? 9 A. Not that I recall. 10 MS. MALONEY: Objection to form. 11 THE WITNESS: Sorry. 12 BY MS. BLAIR: 13 Q. During the time in which St. Mary's 14 participated in the Leapfrog Hospital Survey, how many 15 hours were spent in completing the survey annually? 16 A. In my understanding from my quality director 17 at the time, it took her more than a full calendar week 18 to complete the survey. 19 Q. Did she do it alone? 20 A. I can't validate that. 21 Q. Do you know how many FTE's worked on 22 completing the Leapfrog Hospital Survey during that 23 time? 24 A. I can't factually tell you that. 25 Q. When the decision was made in 2021 to stop	Page 140 1 BY MS. BLAIR: 2 Q. Okay. So when you say "validated," you mean 3 that there's no onsite review? 4 A. Correct. 5 MS. MALONEY: You want to take a break? 6 BY MS. BLAIR: 7 Q. You okay? 8 A. I'm okay. 9 Q. We'll get through it. 10 MS. MALONEY: Maybe at an appropriate time 11 we should take a lunch break. 12 MS. BLAIR: Yeah, do you -- yeah, maybe -- 13 MS. MALONEY: So whenever you're ready in 14 terms of where you're going... 15 MS. BLAIR: We can do it now. Okay? 16 MS. MALONEY: Okay. 17 THE WITNESS: Yeah. 18 THE VIDEOGRAPHER: Off the record, 12:56. 19 (A recess was taken from 12:56 p.m. to 1:42 p.m.) 20 THE VIDEOGRAPHER: This is media unit number 21 three. The time is 1:43. We're back on the 22 record. 23 BY MS. BLAIR: 24 Q. Ms. McCauley, when you stopped, when 25 St. Mary's stopped participating in the Leapfrog
Page 139 1 participating in the Leapfrog Hospital Survey, were 2 there any discussions with the St. Mary's' executive 3 team about the decision to stop participating? 4 Are you okay? 5 A. Um-hum. 6 Amongst -- did you say amongst the 7 St. Mary's. 8 Q. The St. Mary's team. 9 A. So amongst our team? 10 Q. Yes. 11 A. A limited amount of discussion, yes. 12 Q. And what do you recall about those 13 discussions? 14 A. I recall discussing, this was post COVID. 15 And as we were assessing the limited resources we have 16 and participating in a survey that's not required, not 17 regulated and not validated that we could better use 18 our staff's time towards other responsibilities. 19 Q. And when you say "not validated," what do 20 you mean by that? 21 MS. MALONEY: Objection. 22 A. Not validated is that no one comes on site, 23 like I said earlier, like in a CARF survey or ACS 24 survey to look at the survey and validate that what you 25 responded is true and accurate.	Page 141 1 hospital survey, did anybody at St. Mary's, to your 2 knowledge, reach out to Leapfrog about whether or not 3 they would continue to be graded now that they've 4 stopped participating in the survey? 5 A. I'm unsure. 6 Q. Did you understand when you stopped 7 participating in 2021 that Leapfrog graded all adult 8 acute care hospitals across the country regardless of 9 participation in the survey? 10 A. I actually believe that when we stopped 11 participating, we would no longer receive a letter 12 grade. 13 Q. Okay. And what was that belief based on? 14 A. It was based on my understanding that if you 15 don't take a survey, somebody can't say how did you on 16 the survey. 17 Q. Okay. But you didn't read any literature 18 from Leapfrog that said if you don't participate in the 19 survey, we don't grade you, correct? 20 A. Not that I recall, no. 21 Q. In the last year that St. Mary's 22 participated in the Leapfrog Hospital Survey how was 23 compliance handled? 24 A. What's the question? 25 Q. Yes. So was there somebody that was in

Page 142 1 charge of doing the survey and they would delegate 2 tasks to others underneath them? How was it 3 coordinated to respond to the survey? 4 A. So the survey was typically coordinated by 5 the director of quality. I can't speak to how she or 6 who she would have engaged or how she would have gotten 7 that task done. 8 Q. Okay. And then the last year that you 9 participated was 2021, correct? 10 A. Correct. 11 Q. Would that have been Gina West who was the 12 director of quality at that time? 13 A. No. 14 Q. Who would that have been? 15 A. It may have been Carola Kuret, but I'm not 16 positive if that's who was in the role at that time. 17 Q. And what year did Regina West become the 18 director of quality? 19 A. At St. Mary's, I believe Gina's been there a 20 year and a half. 21 Q. To date, she's been there a year and a half? 22 A. At St. Mary's. 23 Q. Okay. What about with Palm Beach Health 24 Network? 25 A. I'm not sure.	Page 144 1 participating in the Leapfrog survey, was the number of 2 staff in the quality department reduced? 3 A. I do not believe so. 4 Q. Do you know if there was a number one, two, 5 three of staff that were dedicated to complying with 6 the Leapfrog survey? 7 MS. MALONEY: Objection. Asked and 8 answered. 9 Objection. Lacks foundation and vague. 10 A. I said before I don't -- I know who 11 ultimately was responsible, but I don't know who 12 completed the survey. 13 BY MS. BLAIR: 14 Q. Okay. So as you sit here today, you're 15 unaware of whether there was a dedicated FTE to 16 completing the Leapfrog survey in 2024? 17 MS. MALONEY: Objection. Asked and 18 answered. 19 A. A FTE would imply 2,080 hours, so there was 20 not a 2,080-person -- 80-hour person designated for 21 this one task. 22 BY MS. BLAIR: 23 Q. Between when you stopped participating in 24 the survey in 2021 through fall of 2024, did St. Mary's 25 have any discussions with the governing board about
Page 143 1 Q. Do you know what hospital she was at before 2 she came to St. Mary's? 3 A. I believe Gina was at -- I'm not positive, 4 but if I venture a guess, she may have been at 5 Good Sam. 6 Q. But would you agree with me based on 7 documents that have been produced in this litigation 8 that Gina West was the director of quality in 2024? 9 MS. MALONEY: Objection. Lacks foundation. 10 A. If Gina has been there for a year and a 11 half, she should have been there in 2024. I don't 12 recall when she started. 13 BY MS. BLAIR: 14 Q. Do you recall how much St. Mary's budgeted 15 towards the Leapfrog completing the Leapfrog survey in 16 2021? 17 A. That's not how budgets are completed. 18 Q. Do you know how much -- well, how are 19 budgets completed, then? 20 MS. MALONEY: Objection. 21 A. So when you're completing a budget for a 22 department, you would budget for number of staff, not 23 for number of tasks. 24 BY MS. BLAIR: 25 Q. Was there -- after St. Mary's stopped	Page 145 1 participation in the Leapfrog Hospital Survey? 2 A. I can't recall. 3 Q. You have no recollection of a discussion? 4 A. I can't recall without looking at minutes. 5 Q. Between 2020 and the fall of 2024, what 6 discussions do you recall St. Mary's having -- and I'm 7 asking you this in your corporate capacity -- 8 A. Um-hum. 9 Q. I'll ask this question as a corporate 10 representative. Between 2020 and 2024, what 11 conversations were had between St. Mary's and 12 Palm Beach Health Network regarding participating in 13 the Leapfrog Hospital Survey? 14 A. It's difficult to sit here and recount any 15 specific conversation from a year or five years ago. 16 Q. Okay. Are you aware that every safety -- 17 every Leapfrog Safety Grade cycle, the Palm Beach 18 Health Network would ask each of the five hospitals for 19 their Leapfrog Hospital Safety Grades? 20 MS. MALONEY: Objection. Lacks foundation. 21 A. I'm not certain if I'm aware or not aware of 22 that. 23 BY MS. BLAIR: 24 Q. Okay. 25 MS. BLAIR: I'm going to hand you what we're

Page 146 1 going to mark as Exhibit 4. I think this is 4, 2 right, Barbie? 3 THE STENOGRAPHER: This is 5. 4 MS. BLAIR: 5. Apologize. 5 (Defendant's Exhibit Number 5 for i.d.) 6 BY MS. BLAIR: 7 Q. Have you seen this document before today, 8 Ms. McCauley? 9 A. I am copied on the email, so I would say, 10 yes. 11 Q. Who is Carola Kuret? 12 A. Carola Kuret was the quality director at 13 that time. 14 Q. And that time, according to this email which 15 is Bates numbered PBHN 6927 through 6930, was April of 16 2023, correct? 17 A. Yes. 18 Q. And do you see that she's sharing the 19 subject is "Spring forward, spring 2023 letter grade 20 embargo period opens today," do you see that? 21 A. Yes. 22 Q. Does this refresh your recollection that 23 St. Mary's was keeping track of its Leapfrog Safety 24 Grades in 2023 at least? 25 A. This indicates that Carola was monitoring	Page 148 1 fact, if we turn to the next page, that is, in fact, 2 the St. Mary's Leapfrog grade from 2023, correct? 3 A. Correct. 4 Q. And who is Bonnie Nukala, if I'm saying that 5 correctly? 6 A. I do not know. 7 Q. You don't know who she is? 8 A. No. 9 Q. Okay. And you see it's here it says below 10 her signature she's a biostatistician of clinical 11 operations at Tenet Healthcare, correct? 12 A. That's what it says. 13 Q. But you don't know who that is? 14 A. No. 15 MS. MALONEY: Objection. 16 (Defendant's Exhibit Number 7 for i.d.) 17 BY MS. BLAIR: 18 Q. Mrs. McCauley, I'm handing you now what 19 we've marked as Exhibit 7 to your deposition Bates 20 labeled PBHN 6838 through 6840. 21 That top email in the first page is from 22 Jessica Miller to Regina West and yourself. 23 Do you see that? 24 A. Yes. 25 Q. The subject is "Leapfrog Preview Reports,"
Page 147 1 the safety grade. 2 Q. Do you have any recollection that Tenet 3 health home office was asking that these safety grades 4 be monitored? 5 A. I don't have any knowledge -- any 6 recollection. 7 Q. Okay. We'll look at the next one, then. 8 This will be 6. 9 (Defendant's Exhibit Number 6 for i.d.) 10 BY MS. BLAIR: 11 Q. I'm now handing you what we've marked as 12 Exhibit 6 to the McCauley deposition. Do you see this 13 is an email from Satyavani Nukala to several people, 14 including yourself. The subject is spring 2023 letter 15 grade. Do you see that? 16 A. Yes. 17 Q. And if we look underneath, it's 18 Jennifer Hugh is sending an email to Bonnie, correct? 19 A. It appears that way. 20 Q. And she says "FYI"? 21 A. Yes. 22 Q. Who is Jennifer Hugh? 23 A. I have no idea. 24 Q. And Bonnie says to everybody, "Thank you for 25 forwarding the email, Jennifer." And the email is, in	Page 149 1 correct? 2 A. Yes. 3 Q. And it's dated October of 2023, correct? 4 A. Yes. 5 Q. And if you turn to the second page, you'll 6 see that there is score calculators from the Leapfrog 7 calculator attached, correct? 8 A. Yes. 9 Q. Did you ask Regina West to provide these 10 reports to you related to the Leapfrog Hospital Safety 11 Grade? 12 A. I don't recall asking Gina to do that. 13 Q. Okay. Did you look at these reports for any 14 particular purpose? 15 A. Not that I recall. 16 Q. If you see, who is Jessica Miller? 17 A. She was our CNO at the time. 18 Q. Okay. And the time being, again, October of 19 2023, correct? 20 A. Correct. 21 Q. And she's not the current CNO, correct? 22 A. She is not. 23 Q. And she -- if we look at Gina's email on the 24 bottom of the first page here, she says to Jessica and 25 yourself, "The Leapfrog fall 2023 preview reports are

Page 150 1 available. We won't know our letter grade until closer 2 to November. Based on the spring 2023 distribution 3 we'll likely land in the C category." 4 Do you see that? 5 A. Yes. 6 Q. Do you have any recollection of any 7 discussions you would have had with Ms. West and/or 8 Ms. Miller in or around October 2023 regarding the 9 Leapfrog Hospital Safety Grade? 10 A. I do not recall. 11 Q. And you don't recall, again, why you would 12 have been asking for these -- this information -- or 13 I'm sorry. You don't recall if you were asking for 14 this information, correct? 15 A. That's correct. 16 Q. And if we look at Jessica's email back she 17 says, "Thank you, Gina. We have the directors getting 18 their teams and processes geared to a renewed focus on 19 patient experience as we have plenty of opportunity." 20 Do you see that? 21 A. I do. 22 Q. Do you know what she's referring to when she 23 refers to patient experience? 24 A. I didn't write the email so I can't opine as 25 to what Jes thinking at the time.	Page 152 1 BY MS. BLAIR: 2 Q. And if we look at, again, that same chart we 3 were looking at in the middle of page 2, that first 4 line, computerized first order entry, CPOE, do you see 5 that? 6 A. Yes. 7 Q. Would you agree with me that's one of the 8 four measures that is at issue in this litigation? 9 A. Yes. 10 Q. And do you see right next to it, St. Mary's 11 was receiving 100 out of 100 points for that measure? 12 A. Yes. 13 Q. And you were receiving that perfect score 14 even though you were not completing the survey, 15 correct? 16 A. Yes. 17 Q. And that would be the same if we go to the 18 second row for BCMA right below, correct? 19 A. Yes. 20 Q. And the same for physician ICU staffing 21 right below that, correct? 22 A. Yes. 23 Q. And then if we look at hand hygiene, which 24 is like four rows down, again, St. Mary's is getting 25 100 out of 100 points on the Leapfrog Safety Grade in
Page 151 1 Q. Would you agree with me that HCAHPS are 2 patient experience scores. 3 MS. MALONEY: Objection. Asked and 4 answered. 5 A. Yes. 6 BY MS. BLAIR: 7 Q. And if we turn to the second page, when you 8 look at the measures that are listed, at least we'll 9 take that, the middle of the second page, do you see 10 where it says H-COMP 1, H-Comp 2, H-Comp 3, 5 and 6? 11 A. Yes. 12 Q. Is it your understanding that those are 13 HCAHPS scores? 14 A. Yes. 15 Q. Do you recall in or around October 2023 any 16 discussions you would have had with your quality staff 17 related to the need to improve patient experience 18 scores? 19 A. Not specifically, no. 20 Q. And if we look again, you were not 21 participating in or around this time, October 2023, you 22 were not participating in the Leapfrog Hospital Survey, 23 correct? 24 A. Correct. 25 MS. MALONEY: Objection.	Page 153 1 the fall of 2023 even though it's not participating in 2 the survey, correct? 3 A. Yes. 4 Q. And I asked you this earlier, but you don't 5 know as you sit here today how Leapfrog was calculating 6 that perfect score for St. Mary's in or around fall of 7 2023, correct? 8 A. That's correct. 9 MS. BLAIR: 8? 10 THE STENOGRAPHER: Yes. 11 (Defendant's Exhibit Number 8 for i.d.) 12 BY MS. BLAIR: 13 Q. Ms. McCauley, I'm now handing you what we 14 marked McCauley Exhibit 8. This is an email stream 15 with the Bates label PBHN 6765 through 6770. The first 16 email on the top is from Regina West to yourself dated 17 February 22nd of 2024. Do you see that? 18 A. Yes. 19 Q. And Regina says, the preview -- oh, I'm 20 sorry. The subject is "Hospital Safety Grade 21 Announcements." Do you see that? 22 A. Yes. 23 Q. And if you review this, does this document 24 reflect on page 6766 that she's referring to the 25 Leapfrog Hospital Safety Grade announcement?

Page 154 1 A. Yes. 2 Q. And if you look at the middle email from you 3 to Regina West, you say, "What do we estimate our grade 4 will be? Are we still a C or have we reclaimed our B?" 5 Do you see that? 6 A. Yes. 7 Q. Does this refresh your recollection that at 8 least in February of '24 you were monitoring your 9 Leapfrog Hospital Survey? 10 A. It indicates that I was curious what our 11 grade was. 12 Q. And then Gina responds to you in the first 13 email in this chain, correct, "Hi there. The preview 14 opens on the 26th, and we can see how we compare to the 15 current national averages to get an idea." 16 Do you see that? 17 A. Yes. 18 Q. And so does this refresh your recollection 19 that at least Gina was benchmarking St. Mary's' 20 performance against the current national averages? 21 A. I don't want to weigh in on what -- 22 MS. MALONEY: Objection. 23 A. -- Gina may or may not have been focused on. 24 BY MS. BLAIR: 25 Q. Okay. Do you recall any conversation was	Page 156 1 Q. And Gina says, "We can't get too excited 2 about this. But if Leapfrog uses the same scoring as 3 fall 2023, SMMC is set to get an A this spring." 4 And then she says "What?!?" et cetera. 5 Do you recall receiving this email in or 6 around March of 2024? 7 A. It's difficult to recall an email from a 8 year and a half ago. 9 Q. Does it refresh your recollection in any way 10 that St. Mary's was, in fact, monitoring the Leapfrog 11 Hospital Safety Grade? 12 MS. MALONEY: Objection -- 13 A. No. 14 MS. MALONEY: -- to form. Lacks foundation. 15 BY MS. BLAIR: 16 Q. And then if we look at the email that starts 17 on the bottom of page PBHN 12735 and goes on to 12736, 18 this is an email, again, from Bonnie Nukala to several 19 people. And she says, "Hello, everyone. Good morning. 20 Leapfrog has released the hospital's preliminary 21 numerical score for 2024 spring safety grades. Please 22 share your preliminary score." 23 Do you see that? 24 A. I see that. 25 Q. Does that refresh your recollection in any
Page 155 1 Gina West in or around this time about using Leapfrog's 2 hospital safety grade to benchmark St. Mary's against 3 other hospitals in the nation? 4 MS. MALONEY: Objection. Lacks foundation. 5 Misstates the document and misstates testimony. 6 A. No. 7 BY MS. BLAIR: 8 Q. Thank you. 9 (Defendant's Exhibit Number 9 for i.d.) 10 BY MS. BLAIR: 11 Q. Ms. McCauley, I'm handing you what the court 12 reporter has now marked as McCauley Exhibit 9, which is 13 a document Bates labeled PBHN 12734 through 12736. Is 14 that the document you have in front of you? 15 A. Yes. 16 Q. And it is an email, the first page is an 17 email from Gina West to Jessica Miller and yourself 18 dated March 7th, 2024, correct? 19 A. The front page has an email from -- 20 Q. Yes. 21 A. -- from Gina to Jes and myself, yes. 22 Q. Correct. And, again, the subject is "Spring 23 2024 Leapfrog Hospital Safety Grade review period now 24 open," correct? 25 A. Yes.	Page 157 1 way that, in fact, Tenet home office was asking 2 hospitals to share their Leapfrog scores with home 3 office in or around this time? 4 A. No. 5 Q. So I take it regardless of all of the emails 6 that I may show you, you just don't have a recollection 7 that in or around 2023 through the -- well, prior to 8 the fall of 2024 that St. Mary's was in any way 9 monitoring its Leapfrog Safety Grade? 10 MS. MALONEY: Objection. Lacks foundation. 11 Mischaracterizes her testimony. 12 A. So I can't say personally that I was 13 monitoring it, but there are emails evidencing that it 14 was shared with me. 15 Q. Right. But did you, as the CEO of God -- of 16 St. Mary's in or around this time, '23 and '24, was it 17 important to you at all what the Leapfrog Hospital 18 Safety Grade was for St. Mary's? 19 A. I know that Leapfrog was not a survey we 20 participated in, so I would imagine I still was curious 21 that we were getting a score, so it would not seem 22 unusual for me to be curious how they were scoring us 23 on a survey we didn't participate in. 24 Q. Okay. But it was your position in or around 25 that time that the score that was being generated would

Page 158 1 not have been accurate in terms of St. Mary's' actual 2 patient safety, correct? 3 MS. MALONEY: Objection. 4 A. At the time of this score, they were not 5 using imputed scores, so they were -- after the change 6 in methodology in the fall, the scores became grossly 7 inaccurate. 8 BY MS. BLAIR: 9 Q. Well, they were using imputed scores. They 10 were giving you 100 out of 100 for certain data, 11 correct? 12 MS. MALONEY: Objection. 13 A. They gave us 100 out of 100, but they did 14 not use a limited achievement for metrics that we are 15 achieving. 16 BY MS. BLAIR: 17 Q. Right. You got full achievement for those 18 measures that we're in litigation for before fall of 19 2024, correct? 20 A. It appears that way, yes. 21 Q. If we go back to the interrogatory answers 22 that I marked previously as an Exhibit, I think it's 23 number 2 perhaps, do you have that in front of you, 24 Ms. McCauley? 25 A. Yes.	Page 160 1 on page, starts on page 21, my apologies. And the 2 question is, "Describe any steps taken by your hospital 3 to improve any and all the patient safety measures 4 considered by Leapfrog's Hospital Safety Grade." 5 Do you see that? 6 A. Yes. 7 Q. And if I look at your answer, and I just had 8 a question about your answer, the amended answer, 9 excuse me, with after the objection starts, the last 10 paragraph on page 22, it says, "Plaintiff tracks three 11 of these metrics through its safety" -- "patient safety 12 plan or as part of its quality improvement." 13 Which three is that referring to? 14 A. It is referring to hand washing, barcode 15 administration and CPOE. 16 Q. Okay. And it's not referring to ICU 17 coverage because the last sentence says, "Plaintiff has 18 24/7 ICU coverage for its intensivists unit and has had 19 that coverage for several years," correct? 20 A. Correct. 21 Q. And so you still track that, though, right, 22 the ICU coverage? 23 MS. MALONEY: Objection. 24 A. Define what you mean "track that." 25
Page 159 1 Q. Before we get to that, in 2023, was 2 St. Mary's measuring its CPOE compliance? 3 MS. MALONEY: Objection to form. Vague. 4 Lacks foundation. 5 A. I can't attest yes. I can surmise that 6 we've been tracking and trending for quite sometime. 7 BY MS. BLAIR: 8 Q. Okay. And CPOE is one of four measures that 9 is at issue in this litigation, correct? 10 A. Correct. 11 Q. And barcode medication administration prior 12 to the fall of 2024, was St. Mary's tracking its 13 compliance with barcode administration internally? 14 MS. MALONEY: Objection. 15 A. To -- to the best of my knowledge, that is a 16 metrics that's tracked. 17 BY MS. BLAIR: 18 Q. And in 2020 -- or prior to the fall of 2024, 19 was St. Mary's measuring its compliance with its hand 20 hygiene policy? 21 MS. MALONEY: Objection. 22 A. To the best of my knowledge, yes. 23 BY MS. BLAIR: 24 Q. And if we turn to that Exhibit and 25 particularly the answer to interrogatory 13, which is	Page 161 1 BY MS. BLAIR: 2 Q. Well, this says that there's a contract -- 3 let's lay some foundation. 4 You have a contract in place, St. Mary's 5 does for 24/7 coverage for the ICU, correct? 6 A. Correct. 7 MS. MALONEY: Objection. You need to slow 8 down. 9 THE WITNESS: I'm sorry. 10 MS. MALONEY: Okay? 11 THE WITNESS: Thank you. 12 MS. MALONEY: Thank you. 13 BY MS. BLAIR: 14 Q. And I understand that. But is there some 15 way in which St. Mary's measures that, in fact, there 16 is a specialty intensivist at the unit 24/7? 17 A. So there is a calendar that identifies which 18 intensivist is on which day. 19 Q. Okay. And so there's some tracking that 20 that person is on and did come to work and was covering 21 the shift, correct? 22 MS. MALONEY: Objection. Asked and 23 answered. 24 A. It's a calendar that would say Dr. McCauley 25 is here on Thursday, right, 7:00 A or I forget if they

Page 162 1 start 7:00 A or 8:00 A. 2 BY MS. BLAIR: 3 Q. So in terms of, so I want to start with 4 CPOE. How were you monitoring CPOE? And I'm asking 5 you this as the corporate representative of St. Mary's. 6 How was St. Mary's monitoring CPOE in -- or prior to 7 the fall of 2024? 8 A. The facility has a clinical informaticist, I 9 think is the title, that can run reports to track that 10 data. 11 Q. And who is the clinical informaticist of 12 St. Mary's, let's just say, from 2023 to present? 13 A. In 2023, it would have been 14 Barbara Greathouse, and mid 2023 to present is 15 Emily Fuentes. 16 Q. Do you know whether or not the informaticist 17 runs tests on the CPOE system to make sure that the 18 alerts are functioning properly? 19 A. I can't speak to that. 20 Q. Have you seen reports from your 21 informaticist regarding how many errors, if any, in 22 CPOE occur on a regular basis? 23 A. I can't recall reading that. 24 Q. Have you produced all documents in this case 25 to substantiate that St. Mary's was in compliance with	Page 164 1 that done at St. Mary's? 2 A. We have a computerized system, Omnicell, 3 where medications are secured. 4 Q. Is the BCMA system at St. Mary's linked such 5 that a nurse would scan a barcode on a medication, then 6 scan the wristband of a patient to make sure that they 7 were getting the right medicine at the right time? 8 MS. MALONEY: Objection. Lacks foundation. 9 Compound. 10 A. So I can speak higher level since I don't 11 perform that function, but, yes, there would be a 12 scanning of the patient's arm band and the scanning of 13 the drug. My understanding is when they scan the drug, 14 it speaks to the computer system that identifies that 15 that's a match. And then when they've identified that 16 that is the patient, the nurse would administer the 17 drug. 18 BY MS. BLAIR: 19 Q. Are there reports issued by St. Mary's that 20 set forth the rate of errors for BCMA at St. Mary's? 21 MS. MALONEY: Objection. Lacks foundation. 22 A. I am sure there are drugs [sic] that are 23 produced that monitor the safe administration of drugs. 24 BY MS. BLAIR: 25 Q. You said "drugs." I just want to clean that
Page 163 1 Leapfrog's CPOE standard? 2 MS. MALONEY: Objection. 3 A. We complied with all the requests for 4 documents to the best of my knowledge. 5 BY MS. BLAIR: 6 Q. And there is an agreement that the hospitals 7 that are plaintiffs in this litigation would produce 8 documents sufficient to simulate how they would score 9 on the Leapfrog survey from fall of 2024 had they 10 completed that survey. And my question is specific to 11 that. Do you -- have you produced all of the documents 12 in this case that are sufficient to simulate how 13 St. Mary's would have done on Leapfrog's CPOE standard? 14 A. I would have to go through all the document 15 production. 16 Q. But you're confident that the documents were 17 compiled by your office? 18 A. I'm confident that if the document exists 19 that we would have complied. 20 Q. Would you agree with me that CPOE is 21 important to patient safety? 22 MS. MALONEY: Objection. 23 A. Yes. 24 BY MS. BLAIR: 25 Q. Barcode medication administration, how is	Page 165 1 up. 2 A. Medications, pharmaceuticals. 3 Q. Yeah, and I just want you to be able -- you 4 said, "I'm sure there are drugs that monitor the safe 5 administration of drugs." 6 A. Oh. Okay. 7 Q. And I assume you meant there are "reports," 8 correct? 9 A. Correct. 10 Q. Okay. I just want to make sure that we're 11 clear. 12 Do you know what the names of any of those 13 reports are? 14 A. I do not. 15 Q. Do you know if those are reports that have 16 been produced in this litigation? 17 A. If those reports were requested, I'm 18 confident the team would have produced them. 19 Q. As you sit here today, do you know what the 20 percentage of errors are, let's just say, for the year 21 2024 for BCMA for St. Mary's? 22 MS. MALONEY: Objection. 23 A. If -- if I knew that number, I can't recall 24 it. 25

Page 166 1 BY MS. BLAIR: 2 Q. Do you know whether or not St. Mary's 3 regularly runs tests on its BCMA system to make sure 4 that it is functioning appropriately? 5 A. I am confident that there are routine 6 protocols on how to ensure that our systems are working 7 appropriately. 8 Q. Do you know who runs those routine 9 protocols? 10 A. I could make a guesstimate. 11 Q. I don't want you to guess. Do you know how 12 often those routine protocols are run? 13 A. I do not know factually. 14 Q. Would you agree with me that proper barcode 15 medication administration is important to patient 16 safety? 17 A. Yes. 18 Q. Can you describe for me what St. Mary's' 19 hand hygiene policy was in 2024? 20 A. We don't have a unique hand hygiene policy. 21 Q. Okay. How was hand hygiene monitored in 22 2024? 23 A. In 2024, hand hygiene was monitored by 24 direct observation. 25 Q. And who's observing whom in that situation?	Page 168 1 St. Mary's? 2 A. The report is produced monthly. 3 Q. And you said earlier that St. Mary's does 4 not have a unique hand hygiene policy. What did you 5 mean by that? 6 A. They are -- it's not a policy called hand 7 hygiene. 8 Q. Okay. Is there a policy called something 9 else that covers hand hygiene? 10 A. There's a patient safety plan. 11 Q. And the hand hygiene policy is within the 12 patient safety plan? 13 MS. MALONEY: Objection. 14 A. The standards would be nested in there. 15 BY MS. BLAIR: 16 Q. And is the patient safety plan unique to 17 St. Mary's or is it a patient safety plan for Palm 18 Beach Health Network? 19 A. It is a St. Mary's plan. 20 Q. Would you agree with me that hand hygiene is 21 important for patient safety? 22 A. Yes. 23 Q. We talked a little bit about ICU physician 24 staffing. And I know that you have, I've seen it, a 25 contract, correct, for ICU physician staffing for 24/7
Page 167 1 A. A department director, a nurse leader can 2 observe. Members from infection control or quality 3 management can be involved in the team that's making 4 the observations. 5 Q. And how are those observations catalogued, 6 if at all? 7 A. They observe, and then they create there's a 8 paper where they mark if the individual followed the 9 World Health Organization procedure for hand washing 10 fully. 11 Q. And where are those logs stored? 12 A. I believe they're stored in a system called 13 AMP@. 14 Q. A-m-p? 15 A. I believe. 16 Q. Are there reports produced to you as the CEO 17 of St. Mary's regarding the outcome of those hand 18 hygiene observations? 19 A. I have seen a summarized report of 20 compliance. 21 Q. Do you know if that summarized report of 22 compliance has a name? 23 A. A specific name, no. 24 Q. How often do you get the summarized report 25 of compliance with hand hygiene as the CEO of	Page 169 1 coverage, correct? 2 A. Yes. 3 Q. And we talked about how you monitor, that, 4 in fact, there is actually a person on site, correct? 5 A. Yes. 6 Q. Have you produced that calendar that you 7 discussed that confirms that there is, in fact, an ICU 8 intensivist on staff 24/7 at St. Mary's in this 9 litigation? 10 A. I would have to check to see if that was a 11 document requested. 12 Q. What was your understanding of how the 13 prefall 2024 Leapfrog methodology scored 14 nonparticipating hospitals with respect to the four 15 measures that are at issue in this litigation? 16 A. Based on what I just reviewed with you, 17 they -- it appears that we received 100 in each of 18 those four categories. 19 Q. And I think we've already established this, 20 but you don't know how that 100 was calculated; is that 21 correct? 22 A. That's correct. 23 Q. And do you understand that three measures on 24 the Leapfrog Hospital Safety Grade nonparticipating 25 hospitals were not being graded on, they were just

Page 170 1 declined to respond? 2 A. There are three that, right, we, are 3 reallocated to other questions. 4 Q. Did you have an understanding that prior to 5 fall of 2024, the ICU physician standard measure was 6 already -- well, strike that. 7 What is your understanding of how the ICU 8 physician staffing measure was applied to 9 nonparticipating hospitals in the spring of 2024? 10 A. Based on what I've seen in the documents, we 11 were given 100 points. 12 Q. Do you have any understanding that even in 13 the spring of 2024 for a hospital that did not have 14 four, a survey within four rounds, they were being 15 given a 5 for ICU physician staffing even in the fall 16 of 2024? 17 MS. MALONEY: Objection. 18 A. I'm unaware. 19 BY MS. BLAIR: 20 Q. What was St. Mary's' Leapfrog grade in the 21 spring of 2024? 22 A. I'd have to go back and see. I believe it 23 was a C. 24 Q. Did you believe the grades that St. Mary's 25 was receiving -- well, strike that.	Page 172 1 you've seen in discovery in this case, correct? 2 A. Correct. 3 Q. So let me ask the question a little 4 differently. 5 Prior to filing the Complaint against 6 Leapfrog, what did you base your belief that the change 7 Leapfrog made in its methodology for the fall of 2024 8 was to increase participation by nonparticipating 9 hospitals? 10 A. Can you repeat that? 11 Q. Yeah. So your answer to me earlier was 12 based on documents you've seen in discovery in this 13 litigation, correct? 14 A. Yes. 15 Q. Did you hold that -- let me ask this. Did 16 you hold the same belief before you filed the 17 Complaint, that the reason for the change in the 18 Leapfrog methodology in fall of 2024 was to force 19 nonparticipating hospitals to participate in the 20 survey? 21 A. So prior to the fall of 2024 when we were a 22 C and prior to that a B, that was not -- would not have 23 the same perception of being viewed negatively by the 24 public as the majority of the hospitals in the market 25 were a C, so I didn't have to have as much concern
Page 171 1 Did you believe, yeah, did you believe the 2 grades that St. Mary's was receiving prior to the fall 3 of 2024 accurately reflected the hospital's patient 4 safety? 5 A. I didn't put any credence in the score 6 because it was a survey we weren't participating in. 7 Q. Okay. So you didn't have a -- 8 A. Didn't have sentiment. 9 Q. Okay. Do you have any understanding as to 10 why Leapfrog changed its methodology for the fall of 11 2024? 12 A. I'm not -- I'm not certain, but I believe 13 that there was a motivation to have nonparticipating 14 facilities receive a lower score to try to encourage or 15 increase participation by all facilities across the 16 United States. 17 Q. And what is your belief based on? 18 A. My belief is based on some of the discovery 19 documents that I have read, and I do believe 20 Ms. Binder (phonetic) had indicated that in one of her 21 communications that it would be beneficial to Leapfrog 22 to increase participation in the survey to have 23 nonparticipating facilities not receive full credit for 24 the four scores that we've been discussing. 25 Q. Okay. And you refer to documents that	Page 173 1 about a survey that we weren't participating in and, 2 you know, getting a B or a C for. 3 Q. Okay. So prior to filing the Complaint 4 against Leapfrog, prior to filing the Complaint against 5 Leapfrog what was your understanding as to why Leapfrog 6 changed its methodology for fall of 2024? 7 A. My understanding is that Leapfrog changed 8 its methodology to be punitive to nonparticipating 9 hospitals. 10 Q. And what is that based on? 11 A. That is based on my understanding and based 12 on something that I read, be it online, that there was 13 a move by Leapfrog to increase participation and 14 changing the score, changing the grading methodology, 15 they could get more hospitals to want to electively 16 participate. 17 Q. Do you know prior to the fall of 2024 how 18 many hospitals across the country were voluntarily 19 participating in the Leapfrog survey? 20 A. No. I believe 20 percent are 21 nonparticipating, about 20 percent are 22 nonparticipating, so math would say 80 percent. 23 Q. Okay. And do you recall, you said, "That is 24 based on my understanding and based on something that I 25 read, be it online, that there was a move by Leapfrog

Page 174 1 to increase participation and changing the score..." 2 Do you recall what it was you read online? 3 A. I have read so many documents, I can't 4 recall specifically at this time. 5 Q. And I'm talking obviously prior to filing 6 the Complaint. 7 A. Um-hum. 8 Q. You read this prior to filing the Complaint? 9 A. Perhaps. I have read so many documents, 10 both in my role generically as the CEO. I read and 11 consume a lot of material, so it's very hard for me to 12 pinpoint a date on anything for you. 13 Q. Do you understand that in the summer of 2024 14 Leapfrog put out for public comment the changes it was 15 making -- it was going to be making to its methodology? 16 A. I don't recall that specifically. 17 Q. So you don't recall reading that prior to 18 filing the Complaint in this matter, correct? 19 A. I can't say if I do or I don't. 20 Q. But that isn't what you read that informs 21 your belief that there was a move by Leapfrog to 22 increase participation and changing the score, changing 23 the grading methodology they could get more hospitals 24 to want to electively participate? 25 A. I believe I said I can't remember tangibly	Page 176 1 A. I believe there is two different surveys, 2 one more pediatrics and one for adults. 3 Q. So the CMS data is, in your view, the CMS 4 data is divided between pediatrics and adults? 5 A. Yes. 6 Q. In 2024, did you have any discussions with 7 your governing board regarding St. Mary's' CMS ratings? 8 A. I can't recall. 9 Q. Do you recall if, as we sit here today, 10 whether or not St. Mary's' CMS ratings are important to 11 the governing board? 12 A. You can ask the governing board. They -- I 13 don't know that I've specifically asked that question 14 to them, but I could surmise for them. 15 Q. Has anybody ever raised it at a board 16 meeting, to your knowledge? 17 A. Not that I recall. 18 Q. Would you agree with -- would you agree with 19 me that patient experience scores are something that 20 St. Mary's could improve upon? 21 A. Yes. 22 Q. Do you recall if you had any discussions at 23 the med exec level about St. Mary's' CMS rating? 24 A. I don't recall having a specific 25 conversation about CMS ratings.
Page 175 1 where I gleaned that from. 2 Q. And I want to make sure. I'm trying to 3 refresh your recollection. Was that based on the 4 request for public comment by Leapfrog, that is, 5 informing your belief as to the reasoning why the score 6 was being, the methodology was being changed? Excuse 7 me. 8 MS. MALONEY: Objection to form. 9 A. I can't say that it was. 10 BY MS. BLAIR: 11 Q. Have you heard -- well, strike that. 12 In '20 -- in fall of 2024 what was 13 St. Mary's' CMS star rating, overall star rating? 14 A. 1. 15 Q. And what was its perception -- I'm sorry -- 16 patient experience CMS rating? 17 A. A 1. 18 Q. And when we talk about the CMS patient 19 experience star rating, do you understand that that's 20 based on HCAHPS? 21 A. Yes. 22 Q. Do you know whether or not the information 23 that St. Mary's submits to CMS is for the adult acute 24 care center or for both the adult acute care and 25 pediatric center?	Page 177 1 Q. Do you recall anybody on the med exec ever 2 asking questions about St. Mary's CMS' star ratings? 3 A. I don't recall that. 4 Q. Do you share information with the med exec 5 regarding the St. Mary's' CMS star ratings? 6 A. We share information with the med exec. I 7 just cannot recall if I've shared our CMS star ratings. 8 Q. Do you recall whether you've shared the CMS 9 star ratings with the governing board? 10 A. I can't recall. 11 Q. Do you recall whether you've had any 12 discussions about patient experience scores with the 13 governing board? 14 A. Yes. 15 Q. What do you recall about the discussions 16 you've had about patient experience with the governing 17 board? 18 A. We have had a lot of education with the 19 governing board about patient experience. We have our 20 children's hospital has a 4.5 or 4.6 Google star rating 21 indicating strong satisfaction with the facility. And 22 the main campus has a 3.6 overall Google score. 23 Q. And so you as a hospital look more at the 24 Google ratings than the CMS patient experience scores? 25 A. I have focused on the Google scores because

Page 178 1 they are live real time every day available. If I 2 could expand -- 3 Q. Of course. 4 A. -- the Press Ganey HCAHPS, we also 5 experience, it's sent to all inpatients within two days 6 of discharge. And unfortunately, we have a -- it's 7 done by mail in English or Spanish depending on the 8 patient's language. But we have an extremely high 9 return rate of undirected or misdirected mail because 10 many of our patients do not give us their correct 11 address. 12 Q. Okay. Do you know what percentage of 13 patient experience responses St. Mary's gets back? 14 A. Somewhere between 7, 8, 9 percent. 15 Q. And do you know what percentage of patients, 16 what percent of St. Mary's' patients leave Google 17 reviews? 18 A. I don't know if I could calculate -- I've 19 never attempted to calculate a percentage. 20 Q. So you don't know if it's higher or lower 21 than the percentage you're getting from CMS? 22 A. No, but I -- 23 MS. MALONEY: Objection. 24 A. Yeah. 25 And I do think that the children's hospital,	Page 180 1 A. I believe our greatest area of opportunity, 2 especially where we've seen marked improvement, has 3 been in our CAUTI rate. 4 Q. And for the record, CAUTI, what does CAUTI 5 stand for? 6 A. It's a UTI infection. 7 Q. And do you know -- and that is a rate that 8 CMS measures, correct? 9 A. Correct. 10 Q. And the publicly available data related to 11 the CAUTI rate is lagging; isn't that correct? 12 A. Correct. 13 Q. And so the data that you have is -- I 14 already asked the question about in 2024, correct? 15 A. I don't recall. 16 Q. I don't recall either. 17 Okay. Let me ask it again. 18 Prior to -- prior to the fall of 2024 what 19 area or areas did St. Mary's consider to be in need of 20 most improvement? 21 A. Correct. Our CAUTI rate needed improvement. 22 Q. Okay. And that was true whether we were 23 looking at the publicly available CMS data that was 24 lagging as well as the current data that you had in 25 your hands?
Page 179 1 they get a different survey. I'm going through my 2 mind. It may be encapsulated in that score. They 3 don't get a separate score. It is a different survey, 4 though, but I'm trying to think of the results I've 5 gotten. The children's hospital scores may be nested 6 in the aggregate score, it's just a different survey 7 tool. 8 BY MS. BLAIR: 9 Q. Okay. 10 A. Which is, I -- I would -- I believe that's 11 the case, but I will need to trust but verify. I think 12 I said -- I think I said the opposite earlier, and I 13 don't know that that's correct. 14 Q. Would the best place be to confirm that with 15 CMS itself? 16 A. Well -- 17 MS. MALONEY: Objection. 18 A. I -- I could confirm that either with my 19 patient experience manager, or there's probably many 20 ways I could confirm that. 21 BY MS. BLAIR: 22 Q. Prior to the fall of 2024 as the CEO of 23 St. Mary's what area or areas would you have considered 24 to be in the most need of improvement in terms of 25 patient safety or quality?	Page 181 1 A. So the data certainly from the publicly 2 reported data, which is a year and a half old, since 3 that time we have seen an improvement between 50 -- a 4 reduction between 50 and 60 percent in our CAUTI rate. 5 Q. And what do you attribute that to? 6 A. Our reduction in device days, so catheters. 7 Our reduction in device days, additional reeducation 8 and training of the nurses about how to insert and pull 9 out a catheter. We are working with our physicians. 10 Again, we can be assisting in education, observation, 11 validating that the device is needed. 12 Q. Do you recall any discussions at the 13 Palm Beach Health Network level regarding St. Mary's' 14 CMS ratings? 15 MS. MALONEY: Objection. Lacks foundation. 16 Vague. 17 A. Not specifically focused on CMS star 18 ratings. 19 BY MS. BLAIR: 20 Q. Do you recall whether there was ever any 21 meetings regarding the five hospitals that make up 22 Palm Beach Health Network related to steps that could 23 be taken to improve CMS star ratings? 24 A. Not that I recall attending. 25 Q. Do you think the CMS rating for patient

Page 182 1 safety is fair? 2 A. I mean, the patients -- the patient score, 3 it's based on our data, so it's not a -- it's not a 4 judgment. It's not subjective. 5 Q. But it's lagging, correct? 6 A. It is, at least for that time period. 7 Q. When is the first time that you learned that 8 the Leapfrog was changing its methodology related to 9 how it was going to score the four measures at issue in 10 this litigation? 11 A. I can't say when the first time was that I 12 learned about it. However, I'm sure I became more 13 acutely aware of it after our grades were published. 14 Q. After your grades were published? 15 A. After our grades were published. 16 Q. And are you aware that the fall, Leapfrog 17 fall safety grades for 2024 were published on 18 November 20th, 2024? 19 A. On or about. 20 Q. Were you involved in any -- were you, 21 Cynthia McCauley, involved in any discussions in or 22 around September of 2024 related to requests by 23 Gina West that the hospitals that make up the Palm 24 Beach Health Network be allowed by home office to 25 participate in the Leapfrog Hospital Survey for the	Page 184 1 have seen it. 2 Q. Yeah, and I'm just asking if you have any 3 recollection of conversations. 4 A. It was a year ago. 5 Q. Was there any -- 6 MS. BLAIR: We'll mark this as -- 7 THE STENOGRAPHER: This will be 10. 8 (Defendant's Exhibit Number 10 for i.d.) 9 BY MS. BLAIR: 10 Q. Ms. McCauley, I'm now handing you 11 Exhibit Number 10, which is an email from Regina West, 12 where the top email is from Regina West to 13 Ricardo Ramirez dated September 7, 2024. Do you see 14 that? 15 A. Yes. 16 Q. And if we go to the last, we'll go all the 17 way to the back as to how it starts, so the second to 18 the last page is where the first email in this string 19 starts from August 23rd, and it's from Anna Gunod, 20 G-u-n-o-d. 21 Do you see that? 22 A. Yes. 23 Q. Do you know who Anna Gunod is? 24 A. She's the national director for infection 25 prevention.
Page 183 1 fall of 2024 grading period? 2 MS. MALONEY: Objection to form. 3 A. I am aware that Gina has made that request, 4 had made that request. 5 BY MS. BLAIR: 6 Q. Were you aware of the request at the time it 7 was being made? 8 A. I'm not sure if I was aware at the time it 9 was made. 10 Q. So, and I'm just trying to -- if the first 11 time you came to understand that the methodology was 12 changed for fall of 2024 was after the grade came out, 13 what involvement did you have, if any, related to the 14 potential participation in the Leapfrog survey for fall 15 of 2024? 16 A. I don't believe that the participation or 17 nonparticipation in that was something that I said, 18 yes, participate or don't participate in that. 19 Q. Okay. Do you recall any conversations you 20 had with Gina West in or around September, October of 21 2024 about the fact that due to the change in 22 methodology St. Mary's' hospital safety grade would 23 more likely than not be lowered? 24 A. I don't recall any conversations, but if 25 there was email communication, then clearly I would	Page 185 1 Q. Okay. So she works for Tenet home office? 2 A. She does. 3 MS. MALONEY: Objection. 4 BY MS. BLAIR: 5 Q. And this email says, "Good morning, quality 6 leaders, I am doing an annual check-in on Leapfrog 7 participation. Please respond to this email with 8 answers to the following questions." 9 Do you see that? 10 A. Yes. 11 Q. And there is the "to" line is only to 12 DL-DCQI only. Do you see that? 13 A. Yes. 14 Q. Do you know if Regina West falls into the 15 DL-DCQI only email? 16 A. Gina is a DCQI, so she should, but I can't 17 say that she -- you know, DLs change all the time. 18 Q. And if we look one email up from that email, 19 Regina West responds and she says, "The hospital and 20 PBHN are not participating," correct? 21 A. Correct. 22 Q. And her signature line here is both as 23 St. Mary's CMS and PBHN market quality director, 24 correct? 25 A. Correct.

Page 186 1 Q. And then if we go to the next page, there's 2 another email at the top from Regina West dated 3 September 25th. You are not on this email so I'm not 4 suggesting you are. 5 But you see here Gina West is asking 6 Anna Gunod -- if I'm pronouncing that correctly -- "If 7 we would like to participate in the next survey, are we 8 able?" 9 Do you see that? 10 A. Yes. 11 Q. And then she says, "We have done this in the 12 past so it would not be new participation. Because we 13 aren't participating, we default to imputed scoring." 14 Do you see that? 15 A. Yes. 16 Q. Do you -- does this refresh your 17 recollection in any way -- and I know you're not on the 18 email -- about whether or not you had any conversation 19 was Gina West in or around the September 25th time 20 frame about your Leapfrog Hospital Safety Grade? 21 MS. MALONEY: Objection. 22 A. Not -- not tremendously, no. 23 BY MS. BLAIR: 24 Q. Okay. And if we go to the page before that 25 Anna Gunod writes back to Regina CC'ing others, "Hi,	Page 188 1 A. It's my understanding that it says, unless 2 it's tied to a payment contract or local regulatory 3 requirement, we are not participating. 4 BY MS. BLAIR: 5 Q. Okay. And then Regina West says to 6 Ricardo Ramirez, "Moving you in, HO is not allowing 7 participation in Leapfrog, but they continue to ask for 8 our scores." 9 Do you see that? 10 A. Yes. 11 Q. At any time did you have any conversations 12 with Ricky Ramirez regarding St. Mary's' request to 13 participate in the fall 2024 Leapfrog Hospital Survey? 14 A. Not that I recall. 15 Q. Do you know whether or not anyone on behalf 16 of St. Mary's or Palm Beach Health Network commented in 17 any way to the requests for public comment by Leapfrog 18 regarding the fall 2024 methodology change? 19 A. I do not believe anyone made public comment. 20 Q. So in light of fact that your memory as you 21 first came to understand the change in the fall 2024 22 methodology after the scores were issued, what is the 23 first conversation you recall having about the change 24 in the Leapfrog methodology? 25 MS. MALONEY: Objection.
Page 187 1 Gina, Leapfrog participation is not supported unless it 2 is directly tied to a payment/contract or local 3 regulatory requirement." 4 Do you see that? 5 A. Yes. 6 Q. Do you know, have you ever been told by 7 Tenet that participation in certain things is not 8 supported unless it is directly tied to 9 payment/contract or local regulatory requirement? 10 A. I don't know that I would ever be in a 11 position to have a conversation to ask that question. 12 That doesn't fall directly under my purview. 13 Q. Okay. And then if we go to the -- well, 14 then the next email at the top of that page Gina says, 15 back to Anna, "Although not supported, is it left up to 16 the lead" -- "to the local markets to decide or a 17 strict "'no' from HO?" 18 Do you see that? 19 A. Yes. 20 Q. And then on the front page Anna says, "It is 21 a no from home office." 22 Again, is it your understanding that whether 23 or not your hospital can participate in the Leapfrog 24 Hospital Survey is governed by Tenet home office? 25 MS. MALONEY: Objection.	Page 189 1 A. I apologize. It's very difficult for me to 2 recall specific conversations that are over a -- over a 3 year old. 4 BY MS. BLAIR: 5 Q. Okay. Then tell me generally what do you 6 recall about the discussions you had after the fall 7 2024 Leapfrog Hospital Safety Grade was released 8 regarding the Leapfrog change in methodology? 9 MS. MALONEY: Objection. 10 A. So I can't recall a specific -- 11 BY MS. BLAIR: 12 Q. Understood. 13 A. -- conversation, but if it -- I would 14 imagine, and it would just be truly like this is not a 15 good place to to be, because I don't recall sitting 16 down and having a meeting to discuss Leapfrog grades. 17 Q. Okay. 18 A. Okay. So that's probably my -- my most 19 truthful answer to you. 20 Q. When was the first time someone from the 21 med exec brought to your attention the Leapfrog 22 Hospital Safety Grade from fall of 2024? 23 MS. MALONEY: Objection. Lacks foundation. 24 A. I don't know if it was somebody from 25 med exec that brought that to my attention.

Page 190 1 BY MS. BLAIR: 2 Q. Did anyone from the St. Mary's governing 3 board bring to your attention that St. Mary's was now 4 receiving a D in the fall of 2024 Leapfrog Hospital 5 Safety Grade? 6 A. I don't recall. 7 Q. Do you recall if anybody from med exec 8 brought to your attention that St. Mary's was now 9 receiving a D in the fall 2024 Leapfrog Hospital Safety 10 Grade? 11 A. Again, it's so long ago I do not recall. 12 Q. Do you recall who the first person was that 13 brought to your attention that St. Mary's was now 14 receiving a D for the fall of 2024 Leapfrog Hospital 15 Safety Grade? 16 A. Factually, I do not recall. 17 Q. So is it fair to say you never had -- prior 18 to the fall of 2024 safety grade being issued, you had 19 no discussions that you can recall about St. Mary's 20 participating in the Leapfrog Hospital Survey for fall 21 of 2024? 22 MS. MALONEY: Objection. 23 A. What I said is I don't -- I can't recall 24 specific conversations. 25	Page 192 1 A. Correct. 2 Q. And I'm just trying to get a generalized 3 time frame. Do you recall whether you had any 4 conversations prior to seeing that D grade about 5 potentially -- with anyone about potentially 6 participating in the Leapfrog Hospital Survey for the 7 fall 2024 grading period? 8 MS. MALONEY: Objection. 9 BY MS. BLAIR: 10 Q. Just generally. 11 MS. MALONEY: Objection. 12 A. And my response was, do I specifically 13 recall? No. 14 BY MS. BLAIR: 15 Q. Okay. So no recollection as we sit here 16 today? 17 MS. MALONEY: Objection. Asked and 18 answered. 19 A. No recollection that I can specifically 20 recall in my mind from a year ago a specific 21 conversation or a specific encounter. 22 BY MS. BLAIR: 23 Q. Okay. And then after the D grade comes out 24 in the fall of 2024 what is the first conversation you 25 recall having about the fact that St. Mary's received a
Page 191 1 BY MS. BLAIR: 2 Q. Right. 3 A. Right. I can't -- I cannot recall specific 4 conversations from a year ago. 5 Q. And I don't want to know about specific 6 conversations. I'm just asking time frame. 7 A. Um-hum. 8 Q. You don't recall any conversations with 9 anyone about participating in the Leapfrog Hospital 10 Survey for fall of 2024 prior to the fall 2024 grade 11 being issued, correct? 12 MS. MALONEY: Objection. 13 A. Your question is asking me to say, Cynthia, 14 did you and when was it, and I cannot in my mind, as I 15 sit here today, go back and say in August, in 16 September, in October, in whatever month I recall a 17 specific conversation. 18 BY MS. BLAIR: 19 Q. So we know that your grade fell to a D in or 20 around November 20th of 2024, correct? 21 A. Correct. 22 Q. We know that at least from the Exhibit we 23 just saw that Gina in September of 2024 was asking to 24 participate in the Leapfrog Hospital Safety -- Hospital 25 Survey for the fall 2024 grade, correct?	Page 193 1 D on the 2024 Leapfrog Hospital Safety Grade? 2 A. My challenge with your question and 3 answering it honestly is that I can't -- I can't 4 factually say X was the first conversation after 5 anything that happened a year ago, so I apologize for 6 not being able to give you a granular response. There 7 is too much that goes on on a daily basis in the world 8 to recall, at least for me, specific conversation and 9 timeline off the top of my head. 10 Q. And I'm not asking for granular. 11 A. Okay. 12 Q. I'm just saying what is the first time you 13 remember talking about, not a date, just what's -- I 14 mean, somebody called me. Just in the most general 15 terms, when do you first remember hearing about the 16 fact that your hospital got a D? You filed a lawsuit 17 about that day. 18 A. Right. 19 MS. MALONEY: Objection. Argumentative. 20 Objection. You are being specific. This is not 21 generalized. You're asking for the first time. 22 Objection. She has answered this multiple times 23 now. 24 MS. BLAIR: There's been no answer. 25 MS. MALONEY: At this point this is and

Page 194 1 argumentative to the witness. 2 BY MS. BLAIR: 3 Q. What is the first conversation? I don't 4 need to know granular. 5 MS. MALONEY: That is inherently a granular 6 question. 7 BY MS. BLAIR: 8 Q. You're here as a 30(b)(6) witness on this 9 topic, Ms. McCauley. 10 MS. MALONEY: Are you asking her as a 11 30(b)(6)? 12 MS. BLAIR: Yes. 13 MS. MALONEY: You certainly didn't establish 14 that either. 15 BY MS. BLAIR: 16 Q. As a 30(b)(6) witness when is the first time 17 St. Mary's had a conversation with anyone regarding the 18 D grade that they received in the Leapfrog fall 2024 19 hospital safety grade? 20 MS. MALONEY: Objection. Asked and 21 answered. 22 Objection. Argumentative. 23 BY MS. BLAIR: 24 Q. The answer is you don't know, right? 25 MS. MALONEY: Objection. Argumentative.	Page 196 1 other survey, accredited regulatory survey body. So I 2 explained to our governing board the difference between 3 the elective Leapfrog survey that imputes scores as 4 compared to a Joint Commission survey, which many of 5 them participated in because they sat on the 6 leadership, or the American College of Surgery 7 Pediatric Verification or the DNV neuro stroke 8 certification or the CARF accreditation. 9 So it was my job as the CEO to educate them 10 why this survey that we don't participate what the 11 grade means. 12 Q. When did that meeting occur? 13 A. Oh, we'd have to look at which month that 14 was. I don't recall. 15 Q. How often does the governing board meet? 16 A. They meet monthly. 17 Q. Would you have told them in the first 18 meeting after the D grade came out? 19 A. We'd have to go back to the minutes. 20 Q. What was the reaction of the governing board 21 once you had that conversation with them regarding the 22 D grade that St. Mary's received for fall of 2024? 23 MS. MALONEY: Objection. 24 A. My opinion is that the board was surprised, 25 and many of them were uneducated about how Leapfrog
Page 195 1 A. I cannot factually tell you when, no. 2 There have been -- there has been a lot of 3 information, and I can't -- I can't factually recall 4 when and with whom, at what time, where. I don't have 5 that recall. 6 BY MS. BLAIR: 7 Q. Have you ever talked to your board about the 8 fact that Leapfrog -- that St. Mary's received a 9 D grade in fall of 2024 from Leapfrog? 10 A. Yes. 11 Q. Okay. What do you recall about the 12 conversations you had with your governing board about 13 the fact that St. Mary's received a D grade for the 14 fall of 2024? 15 A. So I recall presenting that we were scored a 16 D by Leapfrog. 17 I further went to educate them that this was 18 not a survey that we participated in, that 19 20 percent of the hospitals that across the states do 20 not participate in the Leapfrog survey. 21 I further educated the governing board that 22 it is a self-test. You complete it on your own, that 23 there is no validation, that there's no correlation to 24 the survey that we had in January by Joint Commission 25 or earlier in the year by ACF or by CARF or by any	Page 197 1 imputes its scores. 2 BY MS. BLAIR: 3 Q. Did your governing board, to your knowledge, 4 did your governing board have an understanding of what 5 Leapfrog was prior to the meeting you had with them 6 educating them about the D grade that St. Mary's had 7 received? 8 A. I can't speak to individually what they know 9 or don't know. 10 Q. Prior to that meeting that you had with your 11 governing board where you explained to them the D grade 12 that St. Mary's had received, had you ever had any 13 other conversations at a governing board meeting about 14 Leapfrog Safety Grades? 15 A. In my six years, I would give you a definite 16 maybe. 17 Q. Do you have any specific recollection of any 18 conversations about Leapfrog? 19 A. No. 20 Q. Did you also have a meeting with your 21 med exec to talk about the D grade that St. Mary's had 22 received for fall of 2024? 23 A. Yes. 24 Q. Do you know when that meeting occurred? 25 A. I don't recall which month.

Page 198 1 Q. Do you recall what you told the med exec 2 about that? 3 A. I would have told the med exec similar to 4 what I just recounted that I would have told the 5 governing board. 6 Q. Do you recall whether you had any slides, a 7 slide deck prepared on this issue? 8 A. I would not have had a slide deck prepared 9 on Leapfrog. 10 Q. For either the med exec or the governing 11 board? 12 A. Correct. 13 Q. Do you need to take a break? 14 A. No. It's just a burp. 15 Q. Okay. And do you recall any meetings that 16 you would have had at the Palm Beach Health Network 17 level regarding the D grade that St. Mary's received 18 for the 2024 safety grade period? 19 A. I don't recall a meeting specifically 20 discussing St. Mary's' D grade. 21 Q. Did you ever have any telephone calls or 22 meetings with any of the CEOs of the other Palm Beach 23 Health Network hospitals to discuss the fall 2024 24 Leapfrog hospital safety grades? 25 MS. MALONEY: Objection to form.	Page 200 1 THE VIDEOGRAPHER: Off the record at 2:59. 2 (A recess was taken from 2:59 p.m. to 3:42 p.m.) 3 THE VIDEOGRAPHER: Back on the record 3:43. 4 BY MS. BLAIR: 5 Q. Ms. McCauley, at some point in time are you 6 aware that these five hospitals sent a cease and desist 7 letter to Leapfrog? 8 A. Yes. 9 Q. And do you recall before that cease and 10 desist letter was sent there was some publicity about 11 the Leapfrog grades and these five hospitals? 12 A. I remember publicity by the news. I can't 13 recall the timing on both. 14 Q. Sure. 15 11. 16 (Defendant's Exhibit Number 11 for i.d.) 17 BY MS. BLAIR: 18 Q. Ms. McCauley, I'm handing you what we marked 19 McCauley Exhibit 11. It's Bates labeled PBHN 5141 20 through 5145. 21 Do you have that document in front of you? 22 A. Yes. 23 Q. And if you look at the first page of this 24 document, there's a letter -- or, I'm sorry -- an email 25 from Andrew Lofholm, do you see that?
Page 199 1 A. There may have been. 2 BY MS. BLAIR: 3 Q. Do you recall any? 4 A. Not factually. 5 Q. What do you mean when you say "not 6 factually"? 7 A. Because if you ask me that question, you 8 would then -- I would then say "When did that happen?" 9 And I would say, "I don't recall things from a year ago 10 without going back to my calendar and looking it up." 11 So -- so do I think it could have happened? 12 Yeah, I'm fairly confident. I'm fairly confident, not 13 maybe 100 percent but 99. I'm fairly confident there 14 must have been a conversation with the group where we 15 might have discussed it. But I can't recall 16 specifically that there was a meeting and an agenda 17 item and dialogue. 18 Q. Okay. So fairly confident there would have 19 been some discussions but no recollection of when, 20 where or with whom? 21 A. Right. 22 MS. MALONEY: Can we take a break pretty 23 soon at an appropriate time? 24 MS. BLAIR: Absolutely. We can take a break 25 now.	Page 201 1 A. Yes. 2 Q. And for the record, again, who is 3 Andrew Lofholm? 4 A. He is the, let's see, the communications and 5 community relations manager. 6 Q. For the Palm Beach Health Network? 7 A. For the Palm Beach Health Network. 8 Q. Do you know is he associated with any 9 individual hospital as well? 10 A. Not uniquely, no. 11 Q. And his email is advising you and others 12 about a piece that was published in Stet news on the 13 Leapfrog rankings, correct? 14 A. Correct. 15 Q. And the date of this email is December 10th, 16 2024. Do you see that? 17 A. Correct. 18 Q. And the hospital safety grade was released 19 at the end of November of 2024, correct? 20 A. Correct. 21 Q. Does this refresh your recollection in any 22 way about any discussions you may have had with members 23 of the -- other members of the Palm Beach Health 24 Network regarding the Leapfrog Hospital Safety Grade in 25 or around this time?

Page 202 1 A. No. 2 Q. Do you recall any discussions specifically 3 about this Stet news article? 4 A. No. 5 Q. Do you recall any discussions you may have 6 had with the governing board of St. Mary's regarding 7 this Stet news article? 8 A. I don't recall raising this article 9 specifically to the governing board. 10 Q. Okay. Do you recall having any discussion 11 specifically about this article with the med exec of 12 St. Mary's? 13 A. I don't recall specifically presenting this 14 article. 15 Q. Okay. As you sit here today -- well, is 16 this one of the documents you reviewed prior to your 17 deposition to prepare for today? 18 A. There were a lot of documents. It could 19 have been in the binder. 20 Q. Do you recall seeing this article which is 21 entitled "Tenet Hospitals At Bottom of Local Safety 22 Grades" in or around December of 2024? 23 A. Not specifically. 24 Q. Okay. And I mentioned earlier the cease and 25 desist letter. Do you recall that that letter was	Page 204 1 January of 2025? 2 MS. MALONEY: Objection. 3 A. No, I believe my conversations, as I said, 4 with the governing board were more educational and 5 informative. 6 BY MS. BLAIR: 7 Q. Do you have -- do you recall having any 8 conversations with the med exec in or around January of 9 2025 regarding a decision to send a cease and desist 10 letter to Leapfrog? 11 A. No. 12 MS. MALONEY: Objection. 13 BY MS. BLAIR: 14 Q. Did you personally write this cease and 15 desist letter that was sent to Leapfrog? 16 A. No. 17 Q. Do you know if you made any edits to the 18 cease and desist letter that was written to Leapfrog? 19 MS. MALONEY: Objection. I think this is 20 getting into attorney-client privilege, this 21 question. 22 A. I don't -- 23 MS. MALONEY: Before you answer, do you want 24 to recharacterize the question? 25 MS. BLAIR: Yes.
Page 203 1 September in January of 2025? 2 A. Yes. 3 Q. Were you involved with the decision in 4 sending that cease and desist letter? 5 A. Yes. 6 Q. And I don't want to know about any 7 conversations you had with your attorneys, but I'm 8 going to ask you, do you recall any conversations 9 outside the presence of your attorneys that you had 10 with anyone regarding your decision to send a cease and 11 desist letter to Leapfrog? 12 A. Not that I recall. 13 Q. Okay. You have no recollection of 14 conversations with the other CEOs of the Palm Beach 15 Health Network regarding the cease and desist letter? 16 A. No. 17 Q. Did you ever have any personal conversations 18 with Maggie Gill regarding the decision to send the 19 cease and desist letter? 20 MS. MALONEY: Objection. 21 A. Not specifically that I recall. 22 BY MS. BLAIR: 23 Q. Okay. Do you recall having any 24 conversations with your governing board about sending a 25 cease and desist letter to Leapfrog in or around	Page 205 1 BY MS. BLAIR: 2 Q. Do you recall outside the presence of your 3 attorneys and without the input of your attorneys, did 4 you provide any personal, did you, Ms. McCauley, 5 personally provide any edits to the cease and desist 6 letter that was sent to Leapfrog in or around January 7 of 2025? 8 MS. MALONEY: Objection. 9 A. I -- 10 MS. MALONEY: Objection. That calls for 11 privileged information to the extent those edits 12 were seeking legal advice. If they were only 13 factual in nature, you may answer to the extent 14 you know. 15 A. I don't recall the specific letter and 16 whether I made any factual edits or not. 17 BY MS. BLAIR: 18 Q. Okay. Did your governing board vote, have 19 to vote to agree to send a cease and desist letter to 20 Leapfrog? 21 A. No. 22 Q. What was your -- what was the expectation of 23 St. Mary's as the corporate representative of 24 St. Mary's about sending a cease and desist letter, the 25 effect of sending a cease and desist letter to

Page 206 1 Leapfrog? 2 A. The goal of the cease and desist letter 3 is -- was to have Leapfrog remove the hospitals in the 4 Palm Beach Health Network from their published grades 5 because we didn't participate in the survey. And we 6 didn't feel that it was an appropriate reflection of 7 our score given the imputed methodology that was 8 changed in the fall of 2024. 9 Q. Was it to remove just the fall 2024 hospital 10 safety grade or all previous hospital safety grades? 11 A. I believe -- I would have to refresh my 12 memory specifically, but I thought it was to remove us 13 from the times that we did not participate. 14 Q. And was the expectation that you would not 15 be graded going forward as well? 16 A. Yes. 17 Q. When did St. Mary's make the decision to 18 file a lawsuit against Leapfrog? 19 A. Timing wise, I can't recall specifically, 20 but it was after the response from Leapfrog that they 21 disagreed with the cease and desist. 22 Q. So after Leapfrog's response to the cease 23 and desist letter, correct? 24 A. Correct. 25 Q. Did the governing board of St. Mary's vote	Page 208 1 marked as Exhibit 12, which is an email from 2 Maggie Gill dated December 13th, 2024 to you and, it 3 appears to be, the other CEOs of the four hospitals 4 that are plaintiffs in this litigation as well as 5 Tyler Sherrill, Ricky -- Ricardo Ramirez, and then 6 CC'ing Shelly Weiss, Lisa Cook, Derek Collins, 7 Maria Morales and Michelle Cartwright, and the subject 8 is "Leapfrog." 9 Do you have that in front of you? 10 A. Yes. 11 Q. Do you have any recollection of seeing this 12 document in or around December 13th of 2024? 13 A. I am on the email so I'm certain I received 14 it. 15 Q. But do you have any specific recollection of 16 this email in or around December of 2024? 17 A. Honestly, I get 200 emails a day. It's hard 18 to remember any specific. 19 Q. Understood. 20 And if you look at Maggie's email, the 21 second email on the first page, which is December 11th, 22 2024, at 3:34 p.m., and she says "CEOs, we have gotten 23 several media inquiries about Leapfrog." 24 Do you see that? 25 A. Yes.
Page 207 1 to file a lawsuit against Leapfrog? 2 A. No. 3 Q. Is there a requirement that the governing 4 board vote to file a lawsuit against someone like 5 Leapfrog? 6 A. No. 7 MS. MALONEY: Objection. 8 BY MS. BLAIR: 9 Q. Was the governing board advised prior to the 10 filing of the lawsuit that the lawsuit was being filed? 11 Advised by you. I don't want to know about your 12 attorneys. Did you as the CEO of St. Mary's advise the 13 governing board of St. Mary's that the lawsuit was 14 going to be filed outside the presence of your 15 attorneys? 16 A. No. 17 Q. Why not? 18 MS. MALONEY: Objection. 19 A. There was no need for them to be advised in 20 advance. 21 MS. BLAIR: Am I on 12? 22 THE STENOGRAPHER: Yes. 23 (Defendant's Exhibit Number 12 for i.d.) 24 BY MS. BLAIR: 25 Q. Ms. McCauley, I'm now handing you what we've	Page 209 1 Q. Had you in or around this time, December of 2 2024, you as the CEO of St. Mary's, had you received 3 several media inquiries about Leapfrog? 4 A. No. 5 Q. And if we look at the first email in this 6 string -- I'm sorry -- I guess it's the last email in 7 the string on PBHN 4565 she says, Maggie Gill says to 8 all of you, "All, I have spoken with several members of 9 ELT about this issue." 10 Do you see that? 11 A. Yes. 12 Q. Who is ELT? 13 A. Executive leadership team. 14 Q. And who do you understand makes up the 15 executive leadership team that she's referring to in 16 this email? 17 A. I would think Maggie would have to ask [sic] 18 who she spoke to. 19 Q. Okay. 20 A. Answer who she spoke to. 21 Q. Let me ask it another way. 22 Is ELT an acronym that you all use regularly 23 in Palm Beach Health Network? 24 A. I personally don't use ELT, but I can 25 translate what it means.

Page 210 1 Q. Okay. And I guess my question is ELT 2 referring to you as the executive leadership team or do 3 you know? 4 A. I'm not sure. 5 Q. Okay. And do you see the next sentence 6 says, "There are efforts underway to address Leapfrog's 7 ability to score us even though we don't participate." 8 Do you see that? 9 A. Yes. 10 Q. Do you know or have any recollection of what 11 Maggie Gill was referring to about the efforts underway 12 to address Leapfrog's ability to score us even though 13 we don't participate? 14 A. Specifically at that time, no. 15 Q. Okay. Do you recall asking her? 16 A. No. 17 Q. Do you recall if anyone that was on this 18 email responded to Maggie Gill's email? 19 A. I would imagine if anyone did, it would be 20 in the discovery. I'm sure I didn't. 21 Q. And do you see below again in the middle of 22 this page Maggie Gill, the email that's addressed to 23 CEOs, she says, "This is our statement. Feel free to 24 use it." And then it's in italicized. Do you see 25 that?	Page 212 1 have had with any of the other CEOs that make up 2 Palm Beach Health Network regarding the filing of the 3 lawsuit? 4 A. No. 5 Q. And you don't recall any conversations you 6 may have had with Maggie Gill outside the presence of 7 your lawyers about the filing of the lawsuit on 8 April 30th, 2025? 9 A. Not that I recall. 10 Q. Do you recall any conversations you had with 11 Regina West outside the presence of your attorneys 12 about the filing of the lawsuit which occurred on 13 April 30th, 2025? 14 A. Not specifically. 15 Q. What about generally? 16 A. I can't say I did or I can't say I didn't. 17 Q. Are you aware that Palm Beach Health Network 18 issued a press release related to the filing of the 19 lawsuit in this matter? 20 A. Yes. 21 Q. Did you review the press release before it 22 was sent out? 23 A. I don't believe I did. 24 Q. Did you have any -- I might have just 25 answered my own question. But did you have any
Page 211 1 A. Yes. 2 Q. Do you recall in or around December of 2024 3 whether you ever had occasion to use this statement 4 with respect to the publication of Leapfrog's 2024 5 hospital safety grades as it related to St. Mary's? 6 A. I can't recall if I ever had to use this. 7 Q. Do you know whether or not Regina West ever 8 had to use this statement with respect to inquiries 9 St. Mary's was receiving about its fall 2024 Leapfrog 10 Hospital Safety Grade? 11 A. I wouldn't know if Gina had to use it. 12 Q. If she had to use it, would she have CC'd 13 you on the email? 14 A. I don't know. 15 Q. Who is Heidi Zosiak? 16 A. Zosiak. She was my executive assistant. 17 Q. Okay. Outside the presence of your 18 attorneys, I don't want to know about any 19 communications you had with your attorneys or anything 20 they've done or shown you, but did you provide -- did 21 you have any discussions outside presence of your 22 attorneys with respect to the decision to ultimately 23 file the lawsuit on April 30th, 2025? 24 A. No. 25 Q. You don't recall any conversations you may	Page 213 1 involvement in drafting the press release that was sent 2 out? 3 A. No. 4 Q. Do you recall whether you had any inquiries 5 from anyone regarding the contents of the press release 6 after it was sent? 7 A. I don't recall. 8 Q. Do you recall if there was anything in the 9 press release that you disagreed with after you read 10 it? 11 A. Not that I recall. 12 Q. Do you know who drafted the press release? 13 A. Not specifically, no. 14 (Defendant's Exhibit Number 13 for i.d.) 15 BY MS. BLAIR: 16 Q. 13. 17 Ms. McCauley, I'm handing you what we've now 18 marked as Exhibit 13. And I'll submit to you that this 19 is a subpoena response from Boca News Now to a subpoena 20 that we issued in this litigation. And on the second 21 page of this Exhibit you'll see the heading "Palm Beach 22 Health Network Hospitals File Legal Complaint against 23 the Leapfrog Group." 24 Do you see that? 25 A. Yes.

Page 214 1 Q. Do you know who Rebecka Henrikson is? 2 A. No. 3 Q. Do you know what Scales Strategy is? 4 A. No. 5 Q. And do you see she says, "Hi, Andrew, I'm 6 reaching out on behalf of Palm Beach Health Network." 7 Do you see that, the first sentence in her 8 email? 9 A. I see that in the first sentence. 10 Q. But as you sit here today you have no idea 11 what her affiliation is with Palm Beach Health Network, 12 if any. 13 A. No. 14 Q. She goes on to say that "The five hospitals 15 filed a legal Complaint against The Leapfrog Group 16 alleging its patient safety ratings are inaccurate." 17 Do you see that? 18 A. Yes. 19 Q. And we've talked a lot today about your 20 thoughts on how the methodology is inaccurate, correct? 21 A. Yes. 22 Q. And then next word is "corrupt," do you see 23 that? 24 A. Yes. 25 Q. In what way do you believe that The Leapfrog	Page 216 1 Rebecka," it says, "You can read more about the filing 2 in the press release below." 3 Do you see that? 4 A. Yes. 5 Q. And do you understand that the press release 6 was issued on behalf of your hospital and the other 7 four plaintiffs in this litigation? 8 A. Yes. 9 Q. And is it your testimony that this press 10 release was authorized by St. Mary's and the other four 11 members of Palm Beach Health Network when it was 12 issued? 13 A. I believe it was authorized by the market on 14 behalf of the five hospitals, yes. 15 Q. Okay. And so we'll talk about the use of 16 the word "corrupt" down below in the actual press 17 release. It says -- where it starts "Palm Beach, 18 Florida April 30th, 2025," do you see that, bottom? 19 A. April 30th, yes. 20 Q. And the very last sentence on this page, 21 again, it says, "The organization's hospital patient 22 safety ratings are inaccurate, corrupt and misleading." 23 Do you see that? 24 A. Yes. 25 Q. Okay. So in your own press release it uses
Page 215 1 Group is corrupt? 2 A. I believe it states that the Leapfrog safety 3 ratings are corrupt. I don't think it says that 4 Leapfrog is corrupt. But I think -- I believe that 5 what this statement says is that the patient safety 6 ratings are inaccurate, the patient safety ratings are 7 corrupt. The patient safety ratings are misleading. 8 Q. And in which way, in what ways are the 9 patient safety ratings corrupt? 10 A. The patient safety ratings, as we have 11 referenced, due to their imputed -- due to 12 nonparticipation, due to the assigning of scores to the 13 survey you haven't taken, I think they're corrupt 14 because they present a very fictitious representation 15 of hospital safety. 16 Q. So is that different than being inaccurate 17 or misleading? 18 A. I didn't -- I didn't write this article. 19 Ms. Rebecka did, so I guess you could ask Ms. Rebecka. 20 Q. And you think Ms. Rebecka wrote this? 21 A. Well, it says, "Hi, Andrew." "Best, 22 Rebecka." 23 Q. That's a good point. 24 But if we look down, though, it says, "You 25 can read" -- let's go right before it says "Best,	Page 217 1 the word "corrupt." And you made a good point that up 2 above it is Rebecka's email, but here this is your 3 press release. So is "corrupt" different than 4 "inaccurate and misleading" in this sentence that's 5 contained in the please release your hospital issued? 6 A. I think each word individually has a 7 slightly different connotation. 8 Q. Okay. And "corrupt" has the connotation 9 that you described above with respect to 10 Ms. Henrikson's email, correct? 11 A. Yes. 12 Q. And then if we go to the second page, I want 13 to talk about the first full paragraph, the last 14 sentence, it says, "Leapfrog did not punish the 15 plaintiff" -- 16 Are you there? Right here, this, the first 17 full paragraph at the top of the last sentence? 18 A. Okay. Yes. 19 Q. It says, "Leapfrog did not punish the 20 plaintiff hospitals for the past four years that they 21 did not respond to its voluntary data request until 22 last year when they changed their criteria to 23 deliberately fail nonparticipating hospitals." 24 Do you see that? 25 A. Yes.

Page 218 1 Q. Is it your position that all 2 nonparticipating hospitals get a failing hospital 3 safety grade? 4 A. I believe that all nonparticipating 5 facilities get imputed score which ultimately makes it 6 very difficult, if not impossible, to score an A 7 grading. 8 Q. But this says that "Leapfrog deliberately 9 fails nonparticipating hospitals." 10 Do you see that language? 11 A. Yes. 12 Q. Do you believe that nonparticipating 13 hospitals all receive failing grades? 14 A. I have not personally reviewed the grade for 15 every hospital in the United States, but I do believe 16 that the large preponderance of nonparticipating 17 facilities are unable to score an A. 18 Q. Okay. Are you aware that there are 19 nonparticipating hospitals that do receive an A? 20 A. I believe there could be, but I do not 21 believe that that is the norm. 22 Q. Okay. So the fact that this says that 23 Leapfrog deliberately failed nonparticipating 24 hospitals, that's not true, right? 25 MS. MALONEY: Objection.	Page 220 1 trying to promote their safety grades and adding 2 credibility to them. 3 Q. Okay. And so that's basis for the statement 4 that the methodology is not based on any credible 5 science or independent analysis? 6 MS. MALONEY: Objection. 7 A. That is my belief. 8 BY MS. BLAIR: 9 Q. Okay. Are you aware of the fact that 10 Leapfrog has an independent expert panel for its 11 hospital safety grade? 12 A. Yes. 13 Q. Have you ever looked at who the members are 14 of that independent expert panel? 15 A. Not recently, no. 16 Q. You go on to say in this sentence, "They are 17 riddled with falsehoods, distorted by undisclosed 18 financial incentives." 19 What are the undisclosed financial 20 incentives you're referring to here? 21 A. So the undisclosed financial incentives for 22 Leapfrog is the greater the participation, as we 23 discussed earlier, if I am participating and get a good 24 grade, I can pay a licensing fee to Leapfrog, so 25 there's a financial incentive to Leapfrog to get me to
Page 219 1 A. It doesn't say "deliberately failed all 2 nonparticipating hospitals." 3 BY MS. BLAIR: 4 Q. Okay. So the missing word is here, it 5 doesn't say "all"? 6 MS. MALONEY: Objection. Mischaracterizes 7 her testimony. Argumentative. 8 BY MS. BLAIR: 9 Q. If we go down to the fourth full paragraph, 10 it says, "Leapfrog's so-called grades are not grounded 11 in credible science or independent analysis." 12 Do you see that? 13 A. Yes. 14 Q. What is St. Mary's -- as the corporate 15 representative of St. Mary's, what are you referring to 16 regarding the methodology of Leapfrog and its not being 17 grounded in credible science or independent analysis? 18 A. I believe it's arbitrary. I believe there 19 was a statement from American Hospital Association that 20 indicated that people should not rely on Leapfrog's 21 safety grade to choose a facility, that there is no 22 strong correlation between that safety grade and a 23 high-performing facility. There have been several 24 different organizations that have reviewed and made 25 statements disputing the methodology of Leapfrog for	Page 221 1 participate, score, you know, perhaps take the boot 2 camp, get a good grade, and publish that. 3 There's incentives from Leapfrog to get me 4 to nominate one of my leaders for one of their leader 5 awards. There are financial incentives for -- by 6 Leapfrog for me to attend their quarterly advisory 7 chats. 8 So I don't think the public understands that 9 Leapfrog, although a not-for-profit, is a 10 revenue-generating organization that is certainly 11 motivated to increase revenues, generate revenues and 12 is not just a true credible science on what a safety 13 score for a hospital is. 14 Q. You worked at a not-for-profit at one point 15 in your career, did you not? 16 A. I did. 17 Q. Did that not-for-profit generate revenue? 18 A. They certainly did. 19 Q. So you don't have an issue with 20 not-for-profits generating revenue to keep their 21 mission going, do you? 22 A. No. 23 Q. And you keep talking about nominating 24 leaders for awards. What are you referring to there, 25 again?

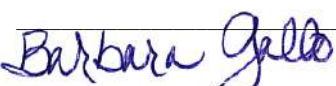
Page 222 1 A. In some of the Leapfrog communications, in 2 one of the emails, they're very standard emails, they 3 talk about an award that you can nominate your -- a 4 team member for to get, I don't know if they call it -- 5 I don't think it was called leader of the year, but I'd 6 have to go through the Leapfrog collateral. But they 7 have leader awards. 8 Q. And you believe you pay for those? 9 A. Um-hum. 10 Q. Are you aware of hospitals that receive A's 11 that don't do the boot camp that aren't on the advisory 12 council, that don't do these things and still receive 13 A's? 14 A. I, as I said earlier, have not looked at the 15 scores and investigated every hospital across the 16 country. 17 Q. You go on in this next paragraph, you say, 18 "Leapfrog aggressively pushes hospitals to pay for its 19 consulting services." 20 Do you see that? 21 A. Yes. 22 Q. How does it aggressively push hospitals to 23 pay for consulting services? 24 A. I believe on every quarterly information 25 that comes out, it encourages you to participate in one	Page 224 1 that come -- that comes from Leapfrog throughout the 2 year. 3 Q. Do you get calls from Leapfrog? Does 4 St. Mary's get calls from Leapfrog? 5 A. I personally don't, that I'm aware of. 6 Q. Do you know if anybody in your organization 7 gets calls from Leapfrog pushing these consulting 8 services for pay? 9 A. I'm unaware. 10 Q. And then you say here, this whole sentence 11 says, "Leapfrog aggressively pushes hospitals to pay 12 for its consulting fees and promotional licenses," and 13 then it says "in exchange for better grades." Do you 14 see that? 15 A. Yes. 16 Q. Is it your position in this litigation that 17 hospitals that participate in this boot camp get better 18 grades? 19 A. It is my belief if I attended one, two three 20 boot camps at \$395 a camp that ultimately the goal 21 would be to get a better grade. 22 Q. Well, isn't always the goal to improve your 23 patient safety? 24 A. Yes, but I believe that by learning how to 25 take the survey and answer it in a way that could drive
Page 223 1 of those boot camps or speak with one of, engage with 2 one of their consultants about the scores, you know, 3 about their programs. 4 Q. So let's put that boot camp aside. Are 5 there any other consulting services that you believe 6 Leapfrog is offering to hospitals? 7 A. Those are the ones I'm most familiar with. 8 Q. The ones or the one? 9 A. Well, there's at least three boot camps. 10 Q. Okay. Are they the same boot camp? 11 A. There was three distinct ones. 12 Q. Oh. Because there's three distinct 13 programs, correct? 14 A. We could probably go through and find it. 15 Q. No, we'll find it. I'm just trying to 16 understand what you're referring to. 17 Okay. So these boot camps, other than the 18 three boot camps, anything else that you characterize 19 as consulting services? 20 A. That's my primary recollection. 21 Q. And the aggressive nature of that, as 22 referred to here, is the fact that there are emails 23 that come out during safety grade time about the boot 24 camps? 25 A. I would say there's other communications	Page 225 1 your grade up. 2 Q. Oh, okay. So you believe these boot camps 3 are kind of giving the hospitals a cheat sheet that 4 helps them get better grades? 5 A. I have not attended a boot camp so I can't 6 speak to it. But I believe that if you were to go and 7 take one of the boot camps, it specifically says that 8 it will teach you about the scoring and the survey. 9 Q. And the scoring is free to access on the 10 website for anyone, correct? 11 A. Correct. 12 Q. And the survey is also free to access for 13 anyone on the website, correct? 14 A. Correct. But it's 300 plus pages that 15 they -- that the average person is not going to glean 16 through. 17 Q. Okay. And that's what I'm trying to say. 18 This says in exchange for better grades. So is it a 19 quid pro quo if you go to the boot camp, Leapfrog gives 20 you a better grade? 21 A. Do I think that it's automatic guaranteed? 22 I don't think it's automatic guaranteed. 23 Q. But in your mind Leapfrog is pushing, 24 Leapfrog aggressively pushes hospitals to pay for its 25 consulting services and promotional licenses, and you

Page 226 1 stand by that statement, right? 2 A. I believe there's a correlation. 3 Q. You believe there's a correlation. 4 So going to the next paragraph, it says 5 here, "The hospitals are taking legal action to expose 6 this scheme, protect patients and restore integrity to 7 the way healthcare information is shared in this 8 country," correct? 9 A. Correct. 10 Q. How is information related to patient safety 11 shared in this country? 12 A. The average consumer, educated consumer 13 could no to Medicare.gov. 14 Q. Does Medicare.gov have any statistics for 15 hospital's CPOE system? 16 A. I'm not certain. 17 Q. What about BCMA, does CMS have any 18 information on CMS? 19 A. I'm not certain. 20 Q. Do you know whether or not CMS shares any 21 information related to hand hygiene? 22 A. I'm not certain. 23 Q. Do you know whether or not CMS shares any 24 information related to ICU physician staffing? 25 A. I am sure it doesn't.	Page 228 1 A. I can assure you they don't come on site to 2 trust but verify. 3 Q. And neither does Healthgrades®, right? 4 A. But Healthgrades® is getting publicly -- 5 public information from CMS. 6 Q. Correct. And -- 7 A. They are not imputing any scores. And they 8 are not going to defame our facility. 9 Q. Oh. So you believe this is a defamation 10 case? 11 MS. MALONEY: Objection. Calls for a legal 12 conclusion, mischaracterizes her testimony and 13 is argumentative. 14 BY MS. BLAIR: 15 Q. You used the word "defame." What did you 16 mean by "defame"? 17 A. Leapfrog is by saying that St. Mary's earned 18 a D is not a safe facility. That is the -- that is 19 what Leapfrog is promoting. And that is what other 20 hospitals who are participating when they use their 21 marketing license collateral to hold out that because 22 they're an A, they are better than a St. Mary's' D. 23 Q. And is there anywhere that you've seen on 24 the Leapfrog website where Leapfrog promotes that you 25 are a -- I want to use your word -- not a safe
Page 227 1 Q. And so with respect to at least the four 2 measures that we're in this litigation about, how is -- 3 how are we restoring integrity to the way we are 4 sharing patient safety information? 5 A. So Leapfrog holds itself out with a safety 6 score with imputed methods, imputed scores for 7 hospitals that do not participate, and it expressly 8 holds out that safety grade as a solid measure of a 9 hospital's safety. 10 So patients, the generic public, I believe, 11 is unaware, albeit the information could be buried 12 somewhere in the Leapfrog website, they are unaware of 13 what the metrics mean on the survey. They would be 14 unaware of the time frames. They would be unaware that 15 it's elective, that it's self-reported, that there's no 16 trust but verify and that somebody can complete the 17 survey, but no representative from Leapfrog comes to 18 validate that what the hospital has submitted or in the 19 case of a nonparticipating hospital what the true facts 20 are. 21 Q. In -- 22 A. So there's not integrity. If you don't 23 trust but verify, there is no integrity. 24 Q. Are you aware of Leapfrog's verification 25 process?	Page 229 1 hospital, unsafe hospital? 2 A. I would say by virtue of Leapfrog scoring us 3 a D, a D is not a high performance grade, so it would 4 give the false impression that we do not have the same 5 level or high quality. 6 Q. Would you agree with me that St. Mary's' 7 HCAHPS scores are below both the national average and 8 the Florida average? 9 A. Our patient safety satisfaction score? 10 Q. Correct. 11 A. Yes. 12 Q. Would you agree with me that your CMS score 13 is a 1 star which is the lowest available? 14 A. Yes, it is. 15 Q. Do you believe that consumers look at the 16 CMS star ratings when deciding what hospital to go to? 17 A. I'm not certain with a consumers look at. 18 Q. But do you believe they look at a Leapfrog 19 hospital grade? 20 A. I believe the Leapfrog hospital grade 21 because they are marketed and licensed are aggressively 22 marketed by competitor facilities. 23 Q. And you don't believe that your competitor 24 facilities aggressively market their five-star CMS 25 ratings?

Page 230 1 A. I have not seen that as much now. 2 Q. And when you're talking about your 3 competitors, you're talking about Jupiter specifically? 4 A. Correct. 5 Q. And Jupiter, is Jupiter the only A-rated, 6 Leapfrog A-rated hospital in your geographic area? 7 A. Yes. 8 Q. Do you know how Jupiter's admissions rates 9 compare to those of St. Mary's? 10 A. No. 11 THE VIDEOGRAPHER: I'm sorry to interrupt, 12 Counsel. 13 MS. BLAIR: Yes. You need to change? 14 THE VIDEOGRAPHER: Yes. This is the end of 15 media unit three. We're going off the record 16 for a media change. 17 (A recess was taken from 4:20 p.m. to 4:22 p.m.) 18 THE VIDEOGRAPHER: This is media unit number 19 four. The time is 4:22. We are back on the 20 record. 21 BY MS. BLAIR: 22 Q. Ms. McCauley, in terms of the reputational 23 damage that's been allegedly suffered by St. Mary's in 24 connection with the Leapfrog Hospital Safety Grade that 25 it received in the fall of 2022 [sic], in your capacity	Page 232 1 Q. Okay. And when did you -- you personally 2 spoke to this patient? 3 A. It was a Google review, yes. 4 Q. It was a Google review. 5 And do you recall when the date of that 6 Google review? 7 A. I don't recall the date. 8 Q. You said it was relatively recently? 9 A. It's relatively recent. 10 Q. Was it after the filing of this lawsuit? 11 A. It was past couple months. 12 Q. And you spoke with him directly? 13 A. He posted it on social media. 14 Q. So it was a social media post, correct? 15 A. Correct. 16 Q. Does he specifically refer to Leapfrog in 17 the social media post? 18 A. Not that I recall. 19 Q. Have you produced that social media post in 20 this litigation? 21 A. I'm not certain. 22 Q. Other than this one social media post, 23 Google review that you just told me about, what -- how 24 are you making the connection to the decrease in 25 elective admissions at St. Mary's to the grade
Page 231 1 as a corporate representative can you describe for me 2 the reputational damage that has occurred? 3 A. So you did mean fall of 2024. 4 Q. Did I say it wrong? Probably. 5 A. Yes. 6 Q. Fall of 2024. 7 A. As indicated earlier, we have had a decline 8 in number of births delivered at our facility. We have 9 had a decline in outpatient pediatrician physical 10 therapy. We have had a decline in elective outpatient 11 surgeries. We have had a decline in volume in our 12 emergency department. 13 Q. And that you attribute all to the Leapfrog 14 grade? 15 A. I do attribute it to the Leapfrog grade. 16 And I can give an example where a patient 17 who came to the facility indicated to me that he was 18 nervous that his wife was brought to St. Mary's because 19 of what he has heard. This is fairly recent. But he 20 was pleasantly surprised at what an amazing experience 21 and outcome his spouse had at the facility. But that 22 reputation that's been developed because of the 23 Leapfrog grade has resulted in patients not selecting 24 St. Mary's as evidenced by our decreased elective 25 volumes.	Page 233 1 St. Mary's received in the fall of 2024? 2 A. So heretofore prior to the fall of 2024 3 St. Mary's was successful in growing its volume. And 4 since the fall of 2024 and the published grades, we 5 have seen a degradation in elective volume. 6 Q. What documents do you look at in order to 7 determine that you've had a decrease in elective 8 volume? 9 A. So I recount telling you earlier today that 10 we on a monthly basis look at financials which include 11 volume data. 12 MS. BLAIR: Mark this as 14. 13 (Defendant's Exhibit Number 14 for i.d.) 14 BY MS. BLAIR: 15 Q. Ms. McCauley, I'm handing you now what we've 16 marked as Exhibit 14. And I'll submit to you this is 17 your declaration, but attached to it is only Exhibit 4 18 to your declaration for purposes of my Exhibit here 19 today. 20 If you could take a look at this document 21 and specifically turn to the last page of the 22 declaration. And my question will be, is this your 23 signature? 24 A. We're looking at -- 25 Q. No, we're looking at --

Page 234 1 A. Is this a different? 2 Q. Yes. They're a group Exhibit, and I only 3 attached Exhibit 4, not the whole thing. 4 A. So on 2234, that is my signature. 5 Q. Okay. And do you recall drafting this 6 declaration and signing it in or around May of 2025? 7 A. I wouldn't have personally drafted it. 8 Q. Fair enough. 9 Do you recall reviewing it and signing it in 10 or around May 13th of 2025 as indicated by the 11 signature and date line? 12 A. Yes. 13 Q. And when is the last time you have reviewed 14 this declaration? 15 A. I reviewed this over the past few days. 16 Q. And having reviewed it over just the past 17 few days, is everything in it still true and correct to 18 the best of your knowledge? 19 A. To the best of my knowledge. 20 Q. And I want to direct your attention to 21 Exhibit 4, this is Exhibit 4 to your declaration which 22 is a document. Well, you tell me what this document 23 is. 24 A. So this document shows key indicators fiscal 25 year '24 and year to date March '25 for each of the	Page 236 1 to make the determination that your Leapfrog Hospital 2 Safety Grade had a negative impact on the reputational 3 harm of St. Mary's? 4 MS. MALONEY: Objection. 5 A. So this is -- so this is the data for the 6 February 20 -- fiscal year '24 compared to the first 7 quarter of '25. 8 BY MS. BLAIR: 9 Q. Do you have this data for the second 10 quarter? 11 A. I'm sure it can -- do I have it? This 12 actually -- this data actually has all the market. I 13 wouldn't have all the market. 14 Q. Okay. That's a great point. 15 Does St. Mary's have the capability of 16 providing its numbers for these categories, admits, 17 total outpatient visits, total surgeries, 18 I/P surgeries, inpatient surgeries, outpatient 19 surgeries, total emergent encounters and total elective 20 encounters? Does St. Mary's have the ability to run 21 these numbers for Q2 of 2025? 22 A. Yes. 23 Q. And do they have the ability to run it in a 24 comparison type of table? 25 A. For 2024 to 2025, yes.
Page 235 1 facilities on different metrics. 2 Q. Okay. And so if we look at the top kind of 3 box, and it looks like the total lines is "Admits Palm 4 Beach Market," do you see that? 5 A. Yes. 6 Q. Does that mean everything above this box is 7 all of the admissions at each of the individual 8 hospitals? 9 A. So is the first box -- correct, they're 10 summary, admits, Palm Beach Health, Palm Beach market. 11 Q. Okay. And is this the -- this would not be 12 just the electives, correct? 13 A. No, this would be everything. 14 Q. Okay. Is there somewhere on this page where 15 the electives show up? 16 A. I don't see that. 17 Q. Okay. 18 A. Well, at the bottom, total -- well, one up 19 from the bottom, total elective encounters, Palm Beach 20 market. 21 Q. Okay. Got it. And it looks like it's 22 shaded. But is it shaded because it's in the negative? 23 A. That's what it appears. 24 Q. Okay. And is this what you were talking 25 about, then? These are the electives that you look at	Page 237 1 Q. Correct. Yes. 2 And I suspect since next week will be end of 3 Q3, you will have Q3 numbers at that time, correct? 4 A. Mid October. 5 Q. Okay. Do you know -- when you told me 6 earlier about electives being down, were you referring 7 to these numbers, or were you referring to Q2 numbers? 8 A. I was referring to more year-to-date numbers 9 that I'm familiar with from participating in reviewing 10 month-end financials. 11 Q. Okay. So you're reviewing financials on a 12 monthly basis? 13 A. Correct. 14 Q. Okay. Have you ever looked at these -- 15 other than what's in Exhibit 4 to your declaration, 16 have you ever looked at the quarterly, the June 17 quarterly comparisons for St. Mary's of these types of 18 numbers? 19 A. I'm not certain that I have or haven't 20 because I review our financials monthly. 21 Q. Okay. And when you're reviewing the 22 financials monthly, you can just tell by looking that 23 they're down from last year? 24 A. Correct. 25 Q. Okay. Does it show you that? I guess

Page 238 1 that's what I'm saying. 2 A. It would have -- it could have fiscal year 3 '24 or prior year to current year. 4 Q. Okay. And you get those every month? 5 A. Correct. 6 Q. Now, you told me about -- so the way that 7 you are connecting the Leapfrog Hospital Safety Grade 8 from fall of 2024 to an effect of your reputational 9 harm is directly related to volume, correct? 10 A. To elective volume. 11 Q. Elective volume, which is the bottom box on 12 Exhibit D, correct? 13 A. One up from employees, yes. 14 Q. Yes. 15 Is there any other way that you are 16 measuring the reputational harm to St. Mary's as a 17 result of the Leapfrog fall 2024 Hospital Safety Grade? 18 A. The way a hospital would measure would be 19 based on volume and patients coming to a facility. 20 Q. Other than the Google review that you told 21 me about where the husband posted that he was nervous 22 to bring his wife to St. Mary's, are there any other 23 patient reviews that you're aware of that you believe 24 substantiate that the Leapfrog fall 2024 Hospital 25 Safety Grade was the cause of the downward trend in	Page 240 1 Q. Okay. So any -- so we have the Google 2 review, the rounding. How many patients would you say 3 since fall of 2024 have you talked to that have had 4 concerns about the reputation of St. Mary's? 5 A. It's hard to quantify. 6 Q. Prior to the fall of 2024 had you had any 7 conversations like that with any patients? 8 A. I don't recall specific conversation where 9 patients voiced concerns. 10 Q. In all your years as either a chief 11 administrative officer or chief executive officer of a 12 hospital, do you recall any conversations you had with 13 patients or patients' families regarding Leapfrog? 14 A. Not -- no, not specifically, no. 15 Q. So in the rounding with patients and the 16 Google reviews, are there any other discussions you've 17 had about that you feel establish that the cause of the 18 decrease in elective admissions -- 19 A. Volume. 20 Q. -- volume, sorry, is directly linked to the 21 Leapfrog Hospital Safety Grade? 22 A. I mean, I recently received a letter from a 23 patient referring to our Leapfrog grade D, and the 24 patient advised me that we should no longer vaccinate 25 children because we were a Leapfrog D.
Page 239 1 elective volume at St. Mary's? 2 A. On a daily basis, I round and visit a lot of 3 patients, and in conversations with patients or 4 patient's family, there -- there have been concerns 5 mentioned about what they might have heard or a 6 sentiment from the media. 7 Q. Do they ever mention Leapfrog in those 8 conversations with you? 9 A. Not specifically that I recall. 10 Q. Do they ever tell you what specific media 11 they refer to, what specific media they're relying on? 12 A. I don't know that I -- that I pushed the 13 question. 14 Q. Prior to -- well, okay. So in your rounding 15 you'll talk to patients and patients' families about 16 their concerns about the reputation of what? 17 A. So I round on patients to find out how their 18 care is, how their nurse is, is there anything we can 19 do better. I thank them, if it was elective, for 20 choosing St. Mary's and try to understand, just to try 21 to get better sense for our patients. 22 Q. Okay. And it's during those conversations 23 that you've had conversations with patients and/or 24 patient's families about their concerns? 25 A. Correct.	Page 241 1 Q. Have you produced that document in this 2 litigation? 3 A. I'm not sure. It's a very recent letter so 4 I sent it to counsel. 5 Q. Did you reach out to that patient? 6 A. No, I didn't. 7 Q. Other than that letter, anything else that 8 you can think of? 9 A. That is the most recent and -- the most 10 recent one that comes to mind. 11 Q. And so have you told me, then, about all of 12 the discussions you've had with patients or anyone 13 else -- not discussions but reviews you've seen, 14 letters you've received, discussions you've had with 15 patients or patients' families or anyone else that of 16 inform your belief that the Leapfrog fall 2024 Hospital 17 Safety Grade is the cause of the down turn in elective 18 volume? 19 A. I believe based on declining volumes, which 20 is a new event for St. Mary's, that that is the 21 attributing factor. 22 Q. Right. And I'm just trying to make sure 23 I've covered all my bases. 24 A. Right. 25 Q. Like have you told me about all the

Page 242 1 different categories of patients and Google reviews and 2 letters from patients? Is that everything you can 3 think of that informs your belief that Leapfrog is the 4 cause of the decline in elective volume? 5 A. At this moment, those are the things that 6 come to my mind. 7 MS. BLAIR: Can we take a quick break? I 8 think I'm almost finished if you don't mind. 9 THE VIDEOGRAPHER: Off the record. 4:38. 10 (A recess was taken from 4:38 p.m. to 4:57 p.m.) 11 THE VIDEOGRAPHER: Back on the record 4:57. 12 MS. BLAIR: Ms. McCauley, I have no further 13 questions for you? 14 THE WITNESS: Perfect. Thank you. 15 MS. BLAIR: Sorry you had to take that long 16 of a break. 17 MS. MALONEY: I'll designate the transcript 18 as confidential, please. 19 MS. BLAIR: And we'll reserve our rights to 20 dispute the confidential nature of certain parts 21 of that deposition. 22 I will order the usual, rough draft and an 23 eTran regular delivery with Exhibits. 24 MS. DABANKA: Same. 25 THE VIDEOGRAPHER: This marks the end of	Page 244 CERTIFICATE OF OATH THE STATE OF FLORIDA) COUNTY OF PALM BEACH COUNTY) I, the undersigned authority, certify that remotely appeared before me and was duly sworn on the 24th day of September 2025. Signed this 5th day of October 2025.  BARBIE GALLO, RMR-CRR Notary Public - State of Florida My Commission No. GG939757 My Commission Expires: December 18, 2027
Page 243 1 today's deposition. The time is 4:57. We're 2 going off the record. 3 (Thereupon, the proceedings concluded at 4 4:57 p.m.) 5 (The witness did not waive signature.) 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25	Page 245 CERTIFICATE OF REPORTER THE STATE OF FLORIDA) COUNTY OF PALM BEACH) I, Barbie Gallo, RMR-CRR, Registered Merit Reporter-Certified Realtime Reporter, certify that I was authorized to and did stenographically report the deposition of CYNTHIA MCCAULEY, pages 1 through 247; that a review of the transcript was requested; and that the transcript is a true and complete record of my stenographic notes. I further certify that I am not a relative, employee, attorney, or counsel of any of the parties, nor am I a relative or employee of any of the parties' attorney or counsel connected with the action, nor am I financially interested in the action. DATED this 5th day of October 2025.  Barbie Gallo, RMR-CRR

Job No.: 421987

CYNTHIA MCCAULEY

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EXHIBIT 23

UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF FLORIDA
WEST PALM BEACH DIVISION
CASE NO.: 9:25-CV-80526-DMM

GOOD SAMARITAN MEDICAL CENTER, INC.,
DELRAY MEDICAL CENTER, INC.,
PALM BEACH GARDENS COMMUNITY
HOSPITAL, INC. d/b/a PALM BEACH
GARDENS MEDICAL CENTER,
ST. MARY'S MEDICAL CENTER, INC.,
AND WEST BOCA MEDICAL CENTER, INC., et al.,

Plaintiffs,

v.

THE LEAPFROG GROUP,

Defendant.

VIDEOTAPED DEPOSITION OF HEATHER HAVERICAK
(CONFIDENTIAL)

DATE TAKEN: Friday, September 19, 2025
TIME: 9:08 a.m. - 3:51 p.m.
PLACE: Quest Workspaces West Palm Beach
515 North Flagler Drive
Suite 350
West Palm Beach, Florida 33401

Stenographically Reported By:
Barbie Gallo, RMR-CRR
www.lexitaslegal.com
888-811-3408

Job No.: 421986

Page 2 1 APPEARANCES: 2 On behalf of the Plaintiffs: 3 MARCUS, NEIMAN, RASHBAUM & PINEIRO, LLP 4 2 South Biscayne Boulevard 5 Suite 2530 6 Miami, Florida 33131 7 (305) 400-4268 8 BY: JEFFREY E. MARCUS, ESQUIRE 9 jmarcus@mnrlawfirm.com 10 11 AND 12 13 GIBSON, DUNN & CRUTCHER, LLP 14 811 Main Street 15 Suite 3000 16 Houston, Texas 77002-6117 17 (346) 718-6706 18 BY: KEVIN SIMMONS, ESQUIRE 19 ALEXANDER M. FISCHER, ESQUIRE (via realtime) 20 kmsimmons@gibsondunn.com 21 afischer@gibsondunn.com 22 AND 23 GIBSON, DUNN & CRUTCHER, LLP 24 200 Park Avenue 25 New York, NY 10166 26 (212) 351-4000 27 BY: MARC AARON TAKAGAKI, ESQUIRE 28 mtakagaki@gibsondunn.com 29 (via realtime streaming) 30 On behalf of the Defendant: 31 WILSON, ELSE, MOSKOWITZ, EDELMAN & DICKER LLP 32 161 North Clark 33 Suite 4500 34 Chicago, Illinois 60601 35 (312) 821-6139 36 BY: KIMBERLY E. BLAIR, ESQUIRE 37 kimberly.blair@wilsonelser.com 38 39 ALSO PRESENT: 40 DANIEL RAGLAND, videographer 41 42 43 44 45	Page 4 1 Exhibit 10 EMAIL TO REGINA WEST FROM 149 2 MONICA STILLMAN-VORMITTAG 3 SUBJECT: SIR BENCHMARKS 4 PBHN000012206 5 Exhibit 11 EMAIL CHAIN SUBJECT: RE: 153 6 LEAPFROG MARKET ANALYSIS 7 PBHN000012145 - PBHN000012146 8 Exhibit 12 EMAIL TO DL-PBG-EXECTEAM, ET 183 9 AL. FROM ANDREW LOFHOLM CHAIN 10 SUBJECT: FYI LEAPFROG "F" 11 RANKINGS STORY FROM BECKER'S 12 PBHN000010789 13 Exhibit 13 DELRAY MEDICAL CENTER LEAPFROG 189 14 KEY MESSAGES 15 PBHN000004921 16 Exhibit 14 12/17/24 EMAIL CHAIN SUBJECT: 198 17 LARRY E 18 PBHN000004887 & PBHN000004923 19 Exhibit 15 EMAIL FROM STEVE SALTZMAN TO 204 20 LARRY EDELSON SUBJECT: RECENT 21 POST 22 PBHN000004888 23 Exhibit 16 12/11/24 EMAIL FROM HEATHER 207 24 HAVERICAK TO JENNIFER 25 SHOEMAKER, ET AL. SUBJECT: LEAPFROG STANDARDS PBHN000004823 Exhibit 17 9/27/24 EMAIL CHAIN 212 SUBJECT: RE: LEAPFROG PBHN000005133 Exhibit 18 12/13/24 EMAIL CHAIN SUBJECT: 220 RE: LEAPFROG PBHN000002618 Exhibit 19 METRODESK MEDIA, LLC 8/12/25 229 RE: GOOD SAMARITAN MEDICAL CENTER, INC., ET AL. VS THE LEAPFROG GROUP SUBPOENA RESPONSE: BOCANNEWSNOW_000001 - BOCANNEWSNOW_000004 Exhibit 20 PLAINTIFF DELRAY MEDICAL 265 CENTER, INC.'S AMENDED AND SUPPLEMENTED RESPONSES AND OBJECTIONS TO DEFENDANT THE LEAPFROG GROUP'S FIRST SET OF INTERROGATORIES TO DELRAY MEDICAL CENTER, INC. (36 PAGES) 25
Page 3 1 INDEX OF PROCEEDINGS 2 E X A M I N A T I O N S 3 4 WITNESS: PAGE: 5 HEATHER HAVERICAK 6 DIRECT EXAMINATION 6 7 BY MS. BLAIR 8 CERTIFICATE OF OATH 269 9 CERTIFICATE OF REPORTER 270 10 READ & SIGN LETTER TO WITNESS 271 11 ERRATA SHEET 272 12 13 E X H I B I T S 14 NUMBER DESCRIPTION PAGE 15 Exhibit 1 AMENDED NOTICE OF TAKING 6 16 IN-PERSON VIDEOTAPED 17 DEPOSITION OF HEATHER 18 HAVERICAK, INDIVIDUALLY, AND 19 PURSUANT TO RULE 30(b)(6) TO 20 DELRAY MEDICAL CENTER, INC. (8 21 PAGES) 22 Exhibit 2 DECLARATION OF HEATHER 16 23 HAVERICAK 24 PBHN000002114 - PBHN000002127 25 Exhibit 3 DELRAY MEDICAL CENTER AWARDS & 69 DISTINCTIONS BY SERVICE LINE PBHN000008916 -PBHN000008917 Exhibit 4 EMAIL CHAIN SUBJECT: RE: 96 LEAPFROG SCORE UPDATE PBHN000002072 - PBHN000002075 Exhibit 5 EMAIL CHAIN SUBJECT: RE: FALL 96 2024 LEAPFROG HOSPITAL SAFETY GRADE EMBARGO PERIOD PBHN000011845 - PBHN000011849 Exhibit 6 LEAPFROG HOSPITAL SURVEY HARD 120 COPY VERSION 9.1 FIRST RELEASE: APRIL 1, 2025/UPDATED RELEASE: MAY 2, 2025 Exhibit 7 DELRAY MEDICAL CENTER POLICY 126 AND PROCEDURES SUBJECT: MEDICATION ADMINISTRATION PBHN000010852 - PBHN000010590 Exhibit 8 DELRAY MEDICAL CENTER POLICY 133 AND PROCEDURES SUBJECT: INFECTION PREVENTION & CONTROL: CLINICAL SAFETY: HAND HYGIENE POLICY PBHN000010530 - PBHN000010547 Exhibit 9 EMAIL CHAIN SUBJECT: RE: FALL 145 2024 LEAPFROG HOSPITAL SAFETY GRADE REVIEW PERIOD NOW OPEN PBHN000013590 - PBHN0000113593 25	Page 5 1 Thereupon, 2 the following proceedings began at 9:08 a.m.: 3 * * * 4 THE VIDEOGRAPHER: We are now on the record. 5 Today's date is September 19th, 2025. The time 6 is 9:08 a.m. This is the video-recorded 7 deposition of Heather Havericak taken in the 8 matter of Good Samaritan Medical Center, 9 Incorporated versus The Leapfrog Group. 10 This deposition is being held at 515 North 11 Flagler Drive, Suite 350, West Palm Beach, 12 Florida 33401. 13 My name is Daniel Ragland. I am the 14 videographer with Lexitas. The stenographer is 15 Barbie Gallo with Lexitas. 16 Will counsel please announce their 17 appearances for the record after which the 18 stenographer will swear in the witness. 19 MS. BLAIR: Kim Blair for The Leapfrog 20 Group. 21 MR. MARCUS: Jeff Marcus on behalf of the 22 plaintiffs. I'm joined by Kevin Simmons of 23 Gibson Dunn. 24 THEREUPON, 25 HEATHER HAVERICAK,

Page 6 1 Being by me first duly sworn to tell the whole truth, 2 as hereinafter certified, testified as follows: 3 DIRECT EXAMINATION 4 BY MS. BLAIR: 5 Q. Ms. Havericak, as you know, I'm Kim Blair. 6 I represent The Leapfrog Group in connection with this 7 matter. I want to just start by showing you what we're 8 going to mark as Exhibit 1. 9 (Defendant's Exhibit Number 1 for i.d.) 10 BY MS. BLAIR: 11 Q. Ms. Havericak, I will submit to you this is 12 the Amended Notice of the Taking In-Person Videotaped 13 Deposition of Heather Havericak Individually and 14 Pursuant to Rule 30(B)(6) to Delray Medical Center, 15 Inc. 16 Have you seen this document before? 17 A. Yes. 18 Q. And so you understand that you've been 19 summoned here today to testify not only as in your 20 individual capacity but also as the corporate 21 representative for Delray Medical Center? 22 A. That's correct. 23 Q. And have you -- if we turn to page 6 of this 24 document, these are the matters, the topics upon which 25 you are to be giving testimony in your capacity as the	Page 8 1 Delray Medical Center. 2 Q. Okay. Were they in connection with Broward? 3 A. They were. 4 Q. And approximately how long ago were those 5 depositions? 6 A. I can't recall the years of those. 7 Somewhere in the early 2020s. 8 Q. Is it fair to say this is the first 9 deposition that you're giving in a corporate capacity 10 for Delray Medical Center? 11 A. Yes. 12 Q. I just want to go over a few ground rules, 13 but you're probably familiar. The court reporter is 14 taking down everything that I say and everything you 15 say, and so I'm going to attempt to not talk over your 16 answers today, and I ask that you try to into the talk 17 over my questions so that Barbie can get down 18 everything that we're saying. 19 Is that fine? 20 A. Yes. 21 Q. She's also taking down words, and so she 22 can't record a shrug of the shoulders, an "uh-huh," 23 "huh-uh," so all of your answers must be verbal. 24 Is that fair? 25 A. Yes.
Page 7 1 corporate representative for Delray Medical Center, 2 correct? 3 A. That's correct. 4 Q. And you've seen this document before, and 5 you're prepared to testify on these topics that we see 6 on page 6, 7 and 8 today? 7 A. That is correct. 8 Q. And to the extent I ask questions today that 9 cover the topics that are on pages 6 through 8, I will 10 assume that your testimony is on behalf of 11 Delray Medical Center if they relate to these topics 12 unless you tell me otherwise. 13 Is that fair? 14 A. That's correct. 15 Q. Have you been deposed before? 16 A. I have. 17 Q. How many times? 18 A. Three. 19 Q. And were they in a personal capacity or in 20 your capacity, your professional capacity? 21 A. In my professional capacity. 22 Q. Were any of those depositions with respect 23 to Delray Medical Center as opposed to Broward where 24 you used to work? 25 A. They were not in connection with	Page 9 1 Q. At any time -- this is not an endurance 2 test, so if at any time you need to take a break, just 3 let me know, and at that point in time we will take a 4 break. The only caveat being that if there is a 5 question pending, I ask that you answer that question 6 before we steak a break. 7 Is that fine? 8 A. Yes. 9 Q. From time to time your lawyers may lodge an 10 objection to one of my questions. Unless your lawyer 11 instructs you not to answer, you need to answer that 12 question. 13 Is that fair? 14 A. Yes. 15 Q. I will from time to time ask bad questions. 16 If at any time you don't understand a question that 17 I've asked you, please ask me to rephrase it and I will 18 do my best. To the extent you answer that question, 19 we're going to assume you understood it for purposes of 20 the record. 21 Is that fine? 22 A. Yes. 23 Q. What did you do to prepare for your 24 deposition here today? 25 A. I worked with my counsel and reviewed

Page 10 1 relevant documents to the case. 2 Q. How many times did you meet with your 3 counsel? 4 A. I would have to pull up my calendar and have 5 that to give an accurate number to quantify. 6 Q. More than five? 7 A. I can't quantify that number. 8 Q. Do you know how many hours approximately you 9 spent preparing for your deposition? 10 A. Again, I would need to look at my calendar. 11 Q. Do you recall any of documents you reviewed 12 in preparation for your deposition? 13 A. There were many documents we reviewed. 14 Q. Can you tell me any general categories of 15 documents that you reviewed? 16 A. We looked at quality documents, patient 17 experience scores. We looked at some of our other 18 regulatory accreditations and previous Leapfrog scores. 19 Q. Did you review any emails? 20 A. We did. 21 Q. Do you recall any specific emails you 22 reviewed in preparation for your deposition? 23 A. I would need the documents in front of me to 24 be able to tell you all the emails we reviewed. 25 Q. Did you review any board meeting minutes?	Page 12 1 A. I need my calendar. I'm a CEO of a hospital 2 so I have so many meetings every day. I can't remember 3 all those off the top of my head. 4 Q. Do you know if it was within the last month? 5 A. We've had meetings in the last month, but I 6 don't know when the first one was. I need the 7 calendar. 8 THE VIDEOGRAPHER: The time is 9:17 a.m. 9 We're going off the record. 10 (A recess was taken from 9:17 a.m. to 9:18 a.m.) 11 THE VIDEOGRAPHER: The time is 9:18 a.m. We 12 are back on the record. 13 BY MS. BLAIR: 14 Q. Ms. Havericak, were you involved in 15 gathering documents to produce in this litigation? 16 A. I saw some of them. 17 Q. And I'm asking specifically about gathering 18 documents to provide to your lawyers to produce to the 19 other side. Were you involved in that process? 20 A. I was involved in some of that process. 21 Q. And what documents do you recall gathering 22 and producing to your lawyers in this litigation? 23 A. Emails that were relevant to the topic, some 24 of our committee minutes which we already talked about 25 which are med exec and governing board.
Page 11 1 A. We did. 2 Q. What about med exec meeting minutes? 3 A. Yes. 4 Q. Did you review any quality scorecards? 5 A. Yes. 6 Q. Do you know if you've produced those quality 7 scorecards in this litigation to your counsel? 8 A. I would need the documents in front of me to 9 see which quality documents we've given. 10 Q. But you can't recall as you sit here today 11 what quality documents specifically you reviewed? 12 A. No, because there was multiple documents so 13 I need them in front of me. 14 Q. Did you speak to anybody other than your 15 counsel about your deposition here today? 16 A. I did not. 17 Q. Have you reviewed the deposition transcript 18 of Sheri Montgomery in preparation of your deposition 19 here today? 20 A. I have not. 21 Q. Do you recall when the first -- I don't want 22 to know anything you talked about with your counsel. 23 I'm not allowed to know about that. But do you recall 24 when your first meeting was with your counsel to 25 prepare for your deposition?	Page 13 1 And then other members of our team gathered 2 some of the quality data, which could be quality 3 scorecards or just quality dashboards and some of the 4 patient experience scores and some of the past Leapfrog 5 data. 6 Q. When you say "emails relevant to the topic," 7 what do you consider the topic to be? 8 A. Relevant to Leapfrog scoring, relevant to 9 the Leapfrog process. 10 Q. And when you refer to the dashboards, what 11 does that refer to? 12 A. It can be a variety of things. We have 13 multiple quality dashboards that we utilize within the 14 hospital to help us gauge our performance on quality 15 and safety. 16 Q. Do you know do those dashboards have names? 17 A. There's a whole -- there's a variety of 18 dashboards, so you could have dashboards in the 19 cardiovascular space. You could have dashboards for 20 hand hygiene. You could have dashboards for the 21 unit-based measures. I mean, there's a whole variety 22 of them. 23 Q. And your understanding is that those 24 dashboards have been produced in this litigation? 25 A. Correct.

Page 14 1 Q. And is there a software that is associated 2 with those dashboards? 3 A. Most dashboards are just in an Excel file. 4 Q. Do you know what Trillient is? 5 A. I'm familiar with it. 6 Q. Does your hospital use Trillient to track 7 patient safety data? 8 A. I'm not certain that they use that to track 9 it. 10 Q. Do you know what your hospital uses 11 Trillient for? 12 A. I'm not familiar with what they use it for. 13 Q. Does your hospital engage in, do you know 14 what Vizient is? 15 A. I do know what Vizient is. 16 Q. Does your hospital engage in Vizient? 17 A. To my knowledge, we do not use Vizient. 18 Q. What about Premier, do you use premiere? 19 A. I'm not familiar that we use Premier. 20 Q. Does your hospital use any third-party 21 source like Vizient to track quality and patient safety 22 data? 23 A. We work with accrediting organizations, so 24 we are accredited by the Joint Commission. We also 25 have other accreditations with Joint Commission outside	Page 16 1 unit each month. There's a tool that's used to collect 2 that data. And then those scores are populated on the 3 unit-based quality dashboard. And then that 4 information of that performance is reported out on a 5 monthly basis at our infection control meeting and at 6 our quality monthly meeting. 7 Q. Have you produced the unit-based quality 8 dashboard in this litigation? 9 A. I believe that those have been produced. 10 Q. And so you believe there are documents that 11 have been produced in this litigation that show the 12 surveillance of hand hygiene at Delray Medical Center? 13 A. Yes. 14 Q. And you -- to your -- to the best of your 15 knowledge, you've given those documents to your 16 attorneys to be produced in this litigation? 17 A. Our quality team has produced those 18 documents. 19 Q. Yeah, my apologies. By "you," I meant 20 Delray Medical Center, correct? 21 A. Yes. 22 Q. I'm going to show you what we'll mark as 23 Exhibit 2. 24 (Defendant's Exhibit Number 2 for i.d.) 25 BY MS. BLAIR:
Page 15 1 of just our regulatory component. So we have hip, knee 2 and shoulder certification, which we voluntarily do, so 3 they come in and do validation visits with us. 4 We are a comprehensive stroke program 5 through DNV so they validate all of our data as well. 6 And then we have registries that we report 7 data to for all of our cardiovascular, so the Society 8 of Thoracic Surgeons, which is STS. 9 We have our TBT registry which is for our 10 TAVR program. 11 We have our PCI dashboards for our 12 cardiovascular programs. 13 We have our left atrial appenditure [sic] 14 closure dashboard, so all of those are through 15 different cardiology bodies. 16 And then we also have our trauma program 17 that's a level I trauma program that has a regulatory 18 component through the Department of Health, so there's 19 data that goes there. 20 And then we also are a Bariatric Center of 21 Excellence so we have data that goes through the 22 bariatric component as well. 23 Q. Okay. And earlier you mentioned a 24 hand hygiene dashboard. How is that kept? 25 A. So we do hand hygiene surveillance in each	Page 17 1 Q. Ms. Havericak, I'm providing you with what 2 we've marked Exhibit 2 in this deposition. I'm trying 3 to short-circuit a long discussion about what your 4 background is. 5 And if you look at paragraphs two, three, 6 four and five of this document which is the declaration 7 of -- you know what? Let me start over. 8 This document is entitled the Declaration of 9 Heather Havericak, correct? 10 A. That's correct. 11 Q. And if we turn to the last page of this 12 document which has a Bates number of PBHN 2127, is that 13 your signature on this document? 14 A. That is my signature. 15 Q. And this was executed on May 14th, 2025, 16 correct? 17 A. That's correct. 18 Q. And if we look back at paragraphs two 19 through five of the Declaration of Heather Havericak, 20 does this accurately reflect both your education and 21 your professional background? 22 MR. MARCUS: Object to form. 23 A. It does. 24 BY MS. BLAIR: 25 Q. And as I note here, it talks about from 2002

Page 18 1 to 2005 you worked at the Miami Children's Hospital, 2 correct? 3 A. That's correct. 4 Q. And then sometime in or around 2006 you went 5 to Broward, correct? 6 A. That's correct. 7 Q. And as I read this document, you were at 8 Broward until you took the job as the CEO at 9 Delray Medical Center in 2024? 10 A. That's correct. 11 Q. In terms of your education, you have a 12 master's degree from Indiana State University, correct? 13 A. Correct. 14 Q. Is there any other education or -- well, is 15 there any other education that's not listed in 16 paragraph three of Exhibit 2? 17 A. Well, there's the primary education that you 18 get to before you get a master's degree, yes. 19 Q. Good point. Where did you go to undergrad? 20 A. I went to College of DuPage in Glen Ellyn, 21 Illinois, and then I went to Florida International 22 University for my bachelor's of science in nursing. 23 And I did a couple years at North Central College as 24 well. 25 Q. Do you have any accreditations that are not	Page 20 1 August of 2019, correct? 2 A. That's correct. 3 Q. At any time -- well, and you were the -- you 4 were the acting CEO of Broward Health Medical Center 5 from 2019 to 2024? 6 A. No. I was acting from March of that year 7 until I became permanent in August. And then I was 8 permanent CEO from August until I left Broward actually 9 in July of 2023. 10 Q. And what did you do -- where did you go in 11 July of 2023? 12 A. I just took some time in between going to 13 Delray. 14 Q. Got it. About a year. 15 A. No, no. Just a couple of months. 16 Q. And you -- oh, you started at Delray in 17 January of 2024? 18 A. Yeah. 19 Q. When you were at -- where is Broward Health 20 Medical Center located? 21 A. It's in Fort Lauderdale, Florida. 22 Q. When you were the CEO of Broward, they 23 participated in the Leapfrog survey, correct? 24 A. That's correct. 25 Q. Did you ever in any of your time at Broward
Page 19 1 listed in this document? 2 A. No. I'm just a fellow of the American 3 College of Healthcare Executives. 4 Q. And what does that mean? 5 A. It's an advanced certification for 6 healthcare leadership that requires you to give back to 7 the community, doing community service hours, serving 8 on boards, passing a board of governors exam and then 9 doing ongoing continuing education. 10 Q. So you still are involved with that today? 11 A. Yes, it's required to be renewed every three 12 years. 13 Q. And so you take continuing education classes 14 to renew that? 15 A. I do. 16 Q. Are any of those continuing education 17 classes in patient safety? 18 A. Yes, I actually just renewed my fellowship, 19 and I did do some patient safety. 20 Q. I want to talk a little bit about your work 21 at Broward. How long -- did you start as a nurse at 22 Broward Health? 23 A. I started as a bedside nurse in pediatric 24 hematology oncology. 25 Q. And you became the permanent CEO starting in	Page 21 1 for 17 years have any involvement in the completion of 2 the Leapfrog survey for Broward Medical Center? 3 A. I did. 4 Q. And can you just briefly tell me about what 5 your involvement was in completing the Leapfrog survey 6 while at Broward? 7 A. So we would be -- I would be involved in 8 just looking at the measures, looking at where we 9 potentially needed to have improvement strategies. And 10 then before any data was actually submitted, I would 11 review that. 12 I did have one year where I was coming in as 13 an interim where data had already been submitted, and 14 there was a data error in that submission to Leapfrog. 15 So during that period of verification when we're able 16 to verify and validate data that Leapfrog allows us, we 17 noticed that one of the self-reported measures was not 18 correct. 19 And we mitigate -- we asked them to change 20 that during that embargo period or whatever it's 21 called, but we weren't able -- we were not successful 22 in getting that changed. So, you know, moving forward 23 from there when I was in a permanent role, every time 24 that data was submitted, I sat with our quality 25 director to make sure every single component had

Page 22 1 accuracy. 2 Q. Do you recall what the change was that you 3 asked Leapfrog to change during the verification 4 period? 5 A. I don't remember which measure it was. It 6 was either barcode medication scanning or CPOE. I 7 can't recall which one it was, but it did cause us to 8 get a D, as in dog. 9 Q. And do you recall the reason why they would 10 not change it? 11 A. We didn't get any rationale on why it wasn't 12 changed, from what I remember. 13 Q. Did you contact them through the help desk, 14 through the Leapfrog help desk? 15 A. Our -- the team did that was there. 16 Q. And at some point in time while you were the 17 CEO of Broward Health, Broward was an A, correct? 18 A. Broward -- Broward Health North was an A, 19 not Broward Health Medical Center, and I was at Broward 20 Health Medical Center, yes. It's part of a network of 21 hospitals. 22 Q. What is the highest grade Broward Health 23 Medical Center ever received from leapfrog while you 24 were associated with them? 25 A. I believe it was a B.	Page 24 1 A. I wouldn't agree with that. 2 BY MS. BLAIR: 3 Q. Have you seen Leap -- you've seen Leapfrog 4 survey, correct? 5 A. Yes. 6 Q. Would you agree with me that not every 7 measure on the Leapfrog survey is part of the scoring 8 methodology for the hospital safety grade? 9 A. I wouldn't agree with that. 10 Q. So it's your testimony that every answer 11 from the Leapfrog Hospital Survey gets scored into the 12 Leapfrog hospital safety grade? 13 MR. MARCUS: Object to form. 14 A. I would say that every measure in that -- 15 that survey matters, especially since 2024 when the 16 imputation model was changed. You're asking me about 17 Leapfrog, what -- and how it was before 2024, so when 18 that imputation model changed, that penalized 19 hospitals, because with us not submitting data, that 20 really takes those four measures and makes them about a 21 30 percent weight, so every measure matters in that 22 survey. 23 BY MS. BLAIR: 24 Q. And we'll talk about it in detail later on 25 today.
Page 23 1 Q. At any time that you were associated with 2 Broward Health Medical, did Broward ever purposely 3 misrepresent its survey results to Leapfrog? 4 A. Not to my knowledge. 5 Q. To your knowledge, at any time when you were 6 associated with Broward, did Broward manipulate its 7 Leapfrog survey results? 8 A. Not to my knowledge. 9 Q. At any time that you were associated with 10 Broward, do you believe that Broward's score -- that 11 Broward's scores on the Leapfrog survey were 12 overinflated because you were a participating hospital? 13 MR. MARCUS: Object to form. 14 A. I wouldn't say that -- say that, no. 15 BY MS. BLAIR: 16 Q. And as I understand your previous testimony, 17 at some point in time Broward was participating in the 18 Leapfrog survey and received a D? 19 A. That's correct. 20 Q. As a participant in the survey? 21 A. That's correct. 22 Q. And so do you have an understanding that the 23 Leapfrog survey is separate and distinct from the 24 Leapfrog hospital safety grade? 25 MR. MARCUS: Object to form.	Page 25 1 At any time that you were associated with 2 Broward Medical Center, did Broward pay Leapfrog for 3 its grades? 4 MR. MARCUS: Object to form. 5 A. Not that I'm aware of. 6 BY MS. BLAIR: 7 Q. At any time that you were associated with 8 Broward Medical Center, did Broward pay to participate 9 in the survey? 10 MR. MARCUS: Object to form. 11 A. Not that I'm aware of. 12 BY MS. BLAIR: 13 Q. At any time that you were associated with 14 Broward, did Broward pay Leapfrog consulting fees to 15 get a better grade? 16 MR. MARCUS: Object to form. 17 A. Not that I'm aware of. 18 BY MS. BLAIR: 19 Q. At any time that you were associated with 20 Broward did you receive any solicitation from Leapfrog 21 to pay for consulting services from Leapfrog? 22 A. Not that I'm aware of. 23 Q. Can you just tell me a little bit about, to 24 the extent you know, the rebranding of the five 25 plaintiff hospitals in this litigation as Palm Beach

Page 26 1 Health Network, what the purpose of that was? 2 A. That was really, from my understanding, to 3 just show how our hospitals that are all affiliated 4 with each other come together, so from a community 5 perspective and consumer perspective that all of those 6 hospitals are part of the Palm Beach Health Network. 7 Q. Do you consider any of the other four 8 hospitals that are plaintiffs in this litigation to be 9 competitors of Delray? 10 MR. MARCUS: Object to form. 11 A. No. 12 BY MS. BLAIR: 13 Q. And why not? 14 A. Because we work together as a health network 15 in a system to provide care to our community, and each 16 of us has slightly different services, and we need to 17 come together to provide those services holistically 18 for our community. 19 Q. Do you -- does Delray transfer patients to 20 the other four hospitals and vice versa? 21 A. Typically Delray does not have to transfer 22 patients because Delray typically takes more patients. 23 We're a level I adult and pediatric trauma center. We 24 have tertiary cardiovascular care and advanced 25 neuroscience, so the only thing that we typically need	Page 28 1 the hospitals but has group oversight. Our chief 2 financial officer is at our center but then has group 3 oversight. There's a variety of positions that have 4 group oversight. We have an infection prevention 5 person for the group. 6 Q. Who's the infection prevention person? 7 A. Her name is Taylor. 8 Q. Taylor Pool? 9 A. Yes. 10 MS. BLAIR: That's P-o-o-l-e [sic]. 11 BY MS. BLAIR: 12 Q. How much of the Delray budget goes into the 13 Palm Beach Health Network marketing budget? 14 MR. MARCUS: Object to form. 15 A. I would need -- I would need those numbers 16 in front of me. I can't tell you those. 17 BY MS. BLAIR: 18 Q. Am I right that Delray or all five hospitals 19 contribute money to the group marketing budget? 20 A. That would be correct. 21 Q. And do all five of these hospitals 22 contribute money to the quality budget? 23 A. We each have quality directors and quality 24 departments at our facilities, so I don't believe that 25 they're cost allocated over for the group people
Page 27 1 to transfer out are women having babies or if there's 2 pediatric patients that have come that might need to go 3 to the children's hospital within the Palm Beach Health 4 Network or burn patients because we are not a burn 5 center. 6 Q. Does Delray have -- well, strike that. 7 Do these five hospitals have different or 8 separate budgets and financial statements? 9 A. We do each have separate budgets and 10 financial statements. 11 Q. And do each of these five hospitals keep 12 separate statistics on admissions? 13 A. We do. 14 Q. Do the five plaintiff hospitals share any 15 resources at the Palm Beach Health Network level? 16 A. We do. 17 Q. And what resources do you share? 18 A. Our group chief strategy officer is a 19 resource for the network. Our public relations is a 20 resource for the network. Our marketing is at a 21 network level. Gina West who's one of our quality 22 directors has a primary focus at a hospital but also 23 has network oversight. Our chief nursing officer 24 has -- we have one from one of our facilities that has 25 oversight. Our chief operating officer is at one of	Page 29 1 because we have those locally. 2 Q. Okay. So Regina West, for example, she -- 3 is she not the group chief quality officer? 4 A. She is the group chief quality officer, but 5 she also is the quality officer for St. Mary's Medical 6 Center. 7 Q. Okay. And so her -- she gets paid through 8 St. Mary's and not through group budget? 9 A. I think so. I'd have to look at it. 10 Q. Do you have any idea how much Delray's 11 marketing budget is? 12 A. I, again, would need the financial statement 13 in front of me to tell you. 14 Q. Is it a percentage of the overall budget? 15 A. Again, I need the numbers in front of me. 16 Q. What about what is Delray's quality budget? 17 A. Again, I need the numbers in front of me. I 18 have 1,600 employees. I can't tell you the number of 19 the budget of each department off the top of my head. 20 Q. I don't have the documents or I'd give them 21 to you. 22 Do you know what percentage of Delray's 23 budget goes to the quality budget for your hospital? 24 A. Not without looking at numbers. 25 Q. What type of document would I need to look

Page 30 1 at to know -- strike that. 2 What type of document would you need to look 3 at in order to tell me the answers to what is the 4 marketing budget and what is the quality budget? 5 A. I would need the cost centers associated 6 with those budgets from the financial statements and 7 the FTE counts, the full-time equivalents from each of 8 those departments. 9 Q. Maggie Gill is the chief executive of 10 Palm Beach Health Network, correct? 11 A. She's the group president and chief 12 executive officer of the Palm Beach Health Network. 13 Q. And do the five hospitals that make up the 14 Palm Beach Health Network contribute to pay her salary? 15 A. I have not -- I'm not involved in how her 16 salary is paid. 17 Q. What is her role in the Palm Beach Health 18 Network? 19 A. She's our group president and all the CEOs 20 report directly to her. 21 Q. Do you know what her job duties are as the 22 group president? 23 A. I don't -- no, I'm not familiar with her 24 specific job duties. Those wouldn't necessarily be 25 shared with me.	Page 32 1 directors of quality as well, so they have a dotted 2 line to Regina. 3 Q. And in terms of the balanced scorecard you 4 just talked about, is that a balanced scorecard for 5 each individual hospital, or is it for the Palm Beach 6 Health Network as a whole? 7 A. So the balanced scorecard is for each 8 individual hospital, and then there's a roll-up to the 9 Palm Beach Health Network of how we're doing 10 collectively. 11 Q. And are those physical reports that you 12 receive? 13 A. We receive them, but we also have a software 14 that we can pull them out of and look at them at any 15 time. 16 Q. And what is the name of that software, if 17 you know? 18 A. Kaleidoscope. 19 Q. What is QIPSC? 20 A. QIPSC is our quality monthly meeting where 21 all of our quality data from all the different 22 departments is filtered up into, so we meet on a 23 monthly basis. We have a physician chairing that with 24 our director of quality, and that's where the leaders 25 come together looking at our outcomes and how we're
Page 31 1 Q. Does she make decisions for Delray, any 2 decisions for Delray related to quality or patient 3 safety? 4 A. We make decisions together. 5 Q. Does she report directly to Tenet Healthcare 6 home office? 7 A. She reports to one of the members in the 8 home office. 9 Q. Do you know who she reports to? 10 A. Lisa Foo. 11 Q. That's F-o-o? 12 A. Yes. 13 Q. And what is Lisa Foo's title? 14 A. She's the chief operating officer of 15 Tenet Healthcare. 16 Q. What is Regina West's role, not at 17 St. Mary's but for Palm Beach Health Network? 18 A. So Regina is the group quality director, so 19 she will facilitate our monthly quality meetings, which 20 are called QMOR, so we have a balanced scorecard that 21 we meet together with on a monthly basis. She also 22 brokers meetings to facilitate standardization of 23 quality practices among the Palm Beach Health Network 24 with all the DQIs or the directors of quality at each 25 site, so she facilitates leadership within the	Page 33 1 performing in quality, patient safety. 2 And then that information goes up to the med 3 exec and then up on to the governing board so that that 4 dissemination of information is filtered up. 5 Q. Okay. So QIPSC is at the individual 6 hospital level? 7 A. Yes, yes. 8 Q. And what types of data does Regina West 9 track for the hospitals that make up the Palm Beach 10 Health Network? 11 A. So she -- we all have the same -- we have 12 the same balanced scorecard, so there's a large 13 component in there that's looking at our 14 hospital-acquired infections, which would be 15 catheter-based infections, central-line-based 16 infections, MRSA and then C. diff infections, so she 17 has a large component on that. 18 She also is looking at our mortality rates, 19 and then also looking at readmission rates and things 20 like that. 21 Q. Does she put together a hospital safety plan 22 for the group as a whole? 23 A. She doesn't put the plan together as a 24 whole. We do those individually at each of the 25 hospitals.

Page 34 1 Q. How often do you put -- do you do a hospital 2 safety plan? 3 A. Those have to be updated annually. 4 Q. And that's a regulatory requirement, 5 correct? 6 A. Correct. 7 Q. And do you know if the hospital safety plans 8 have been produced in this litigation for '23, '24 and 9 '25? 10 MR. MARCUS: Object to form. 11 A. I would need the documents in front of me to 12 see which years, but I know the safety plan has been 13 submitted. 14 BY MS. BLAIR: 15 Q. Is Regina West in charge of putting together 16 any patient safety improvement plans for any of the 17 individual hospitals? 18 A. She could have an influence on those when 19 we're putting them together because, again, if we have 20 a best practice at one of our hospitals that's working 21 from a patient safety perspective and it's evidence 22 based, we'd want to disseminate that to the other 23 facilities, but those are also worked on at the 24 facility level as well. 25 And I'd have to say that's one area that	Page 36 1 able to get these patients tested appropriately on 2 admission. And it's just driven large improvements for 3 us in our patient safety and our outcomes for our 4 patients. 5 Q. Who is your infection control champion 6 physician? 7 A. Dr. Erritouni. 8 Q. Can you spell that? 9 A. I knew you were going to ask me that. 10 Q. Sorry. 11 A. It's -- I don't think I could spell it off 12 the top of my head. It's e-r-o-u-t-i-n-i [sic], I 13 think. 14 Q. And you talked a little bit about CAUTI, 15 right, that's UTI infections? 16 A. Yes. 17 Q. C. diff, correct? 18 A. Yes. 19 Q. MRSA, right? 20 A. Yes. 21 Q. These -- and CLABSI I think you spoke about, 22 correct? 23 A. Yes. 24 Q. And those are all infections that are 25 monitored by CMS, correct?
Page 35 1 Delray Medical Center has improved significantly on. 2 We today, as we sit here, are 270 days in our hospital 3 without a central-line-based infection. 4 We've made huge improvements in C. diff and 5 then also have made huge improvements in catheter-based 6 UTIs. 7 And those were all developed through our 8 quality teams with our physicians because we really put 9 in nurse-driven protocols to get Foleys out, which is a 10 best practice. 11 We were able to do conversions of our not 12 having PIC lines in and going to mid-lines which are 13 going to reduce the incidence of developing central 14 line-associated infections. 15 We identified that C. diff is very prominent 16 in our patient population, so getting testing done 17 early and often when the patients are coming in with 18 loose stool is very important. 19 And then because we serve a very elderly 20 population where the average age is in the 80s and some 21 are coming from skilled nursing facilities, they may be 22 living in, being at acute rehabs, there's a high 23 incidence of MRSA from the community onset, so we 24 developed protocols with our infection control champion 25 physician where we're able to do a Nozin® protocol and	Page 37 1 A. Those are monitored by CMS, yes. 2 Q. In terms of the -- you mentioned earlier the 3 group chief strategy officer at Palm Beach Health 4 Network. Is that Derek Collins? 5 A. That is Derek Collins. 6 Q. Is he involved in decisions regarding 7 marketing of the hospitals? 8 A. Marketing reports directly to Derek. 9 Q. And is there a marketing director of Delray? 10 A. Our marketing director at Delray is also the 11 group marketing director. 12 Q. And who is that? 13 A. Lisa Cook. 14 Q. Oh, yes. I see. 15 And you talked about a chief nursing officer 16 for Palm Beach Health Network. Is that 17 Ricardo Ramirez? 18 A. That is. 19 Q. What hospital does he work at? 20 A. West Boca Medical Center. 21 Q. What about Shannon Wills, is she the 22 Palm Beach Health Network chief human resource officer? 23 A. She is, and she's also my chief human 24 resource officer at Delray. 25 Q. And as I read your interrogatory answers,

Page 38 1 there's no nurse union at Delray, correct? 2 A. We do not have a union. 3 Q. Has Delray, like other hospitals, had 4 trouble recruiting nurses in the last three, four 5 years? 6 A. From what I understand, because I came to 7 Delray in 2024, they did have some significant 8 challenges in years past, but we have done a wonderful 9 job developing a nurse extern program, so we have been 10 able to really build that pool up to 100 plus nurses 11 where we're able to recruit talent right out of that 12 nurse extern program. And we've gotten our retention 13 rates for the year down to below 15 percent. And 14 there's just been really a concerted effort on 15 recruiting the best talent we can. But that nursing 16 extern program has been really important for us. 17 Q. How long has that been in place? 18 A. That's been in place, I believe, for two and 19 a half or three years. 20 Q. There's a -- I think you -- well, I want to 21 go back to the rebranding of Palm Beach Health Network. 22 I understand that occurred in April of 2022. Does that 23 comport with your understanding? 24 MR. MARCUS: Object to form. 25 A. I'm not sure the exact date because I wasn't	Page 40 1 Q. Is he a practicing physician? 2 A. He is. 3 Q. Where does he practice? 4 A. Delray Medical Center and Palm Beach 5 Gardens. 6 Q. And for the record, Palm -- 7 A. And he has privileges at West Boca Medical 8 Center. 9 Q. And all three of those hospitals are 10 hospitals in this litigation, correct? 11 A. Correct. 12 Q. Do you know who Larry Ellison [sic] is? 13 A. Larry Edelson? 14 Q. Larry Edelson. I said that wrong. 15 A. Yes. 16 Q. Is he on the board? 17 A. He was a former board member. 18 Q. When did he stop being a board member? 19 A. He was off the board before I came, so I'm 20 not clear on the date that he rolled off. 21 Q. What about Steve Saltzman, is he a board 22 member? 23 A. No. 24 Q. Do you know who Steve Saltzman is? 25 A. I don't think I'm familiar with
Page 39 1 in my capacity at the facility. 2 BY MS. BLAIR: 3 Q. Have you ever been told or come to find out 4 what the purpose or whether or not the purpose of the 5 rebranding was to compete with new hospitals or medical 6 facilities that were coming into the Palm Beach area? 7 MR. MARCUS: Object to form. 8 A. That's not my understanding of it. 9 BY MS. BLAIR: 10 Q. You've never read any newspaper articles 11 that have suggested that that was the purpose of the 12 rebranding of Palm Beach Health Network? 13 A. I have not. 14 MR. MARCUS: Object to form. 15 BY MS. BLAIR: 16 Q. You've mentioned the board at Delray. How 17 many members are on your board? 18 A. I believe right now we have seven. 19 Q. How long are their terms? 20 A. Their terms are anywhere from two to three 21 years and they can be renewed. 22 Q. Is there a chair of the board? 23 A. There is. 24 Q. Who is that? 25 A. Dr. Jeffrey Newman.	Page 41 1 Steve Saltzman. 2 Q. Does Delray Medical Center have any issues 3 recruiting for board membership? 4 A. We do not. 5 Q. Who -- how are board members recruited for 6 Delray? 7 A. We work just with our community stakeholders 8 to look at different people in the community that would 9 have good skill sets that could be of benefit for our 10 board and really just be a good addition to the board. 11 So we want a well-rounded board. We wouldn't want 12 everyone that's in the medical field. We have people 13 that are from the real estate sector, from the business 14 sector, from the government sector, from fire rescue 15 because we just want it to be well rounded. 16 Q. How many members are in your med exec? 17 A. Let me count them. So we have our chief of 18 staff. We have our vice chief of staff. We have our 19 treasurer. We have our department of medicine chair, 20 department of cardiology chair, department of surgery 21 chair. We have our two members at large. And then we 22 have our trauma director, our chief of vascular, our 23 chief of the emergency room and chief of radiology and 24 chief of pathology. 25 Q. Is there a chair of the med exec?

Page 42 1 A. There is. 2 Q. And who is that? 3 A. Dr. Lon Sadowsky. 4 Q. I'm from Chicago so these names aren't 5 making sense to me, but could you spell it for her? 6 A. Me, too. 7 S-a-d-o-w-s-k-y. 8 Q. And do the -- does the director -- well, let 9 me ask this. 10 Who is the director of quality for Delray? 11 A. Stephany Johnson. 12 Q. And who is Heather Wehmeyer? 13 A. She was the former director of quality. 14 Stephany started at or around October 3rd, 2024. She 15 transferred to us from St. Mary's. 16 Q. When did Heather Wehmeyer stop working at 17 Delray? 18 A. So she just works in a different capacity 19 now. She works in our cardiac quality team. 20 Q. Was that a demotion for her? 21 A. It was. 22 Q. Why was she demoted? 23 A. She just had been promoted into the wrong 24 role. That role was just a little too large for her. 25 Q. And when was she transitioned to the cardiac	Page 44 1 Q. Oh. 2 A. For just three months or four months. 3 Q. What about before you? 4 A. Maria Morales who is now the group COO and 5 she's at St. Mary's. 6 Q. Yes. 7 Is it common for executive leadership to go 8 from one of these five hospitals to the other? 9 A. Yeah, I think we've done a really good job 10 building a bench and identifying succession planning 11 where you're able to recruit that talent within and 12 give people opportunities. And that's common in the 13 healthcare overall. 14 Q. Who's the current CNO? 15 A. Jennifer Shoemaker. 16 Q. And when did she become the CNO? 17 A. I don't have her exact date either. It was 18 before I came. I think it was sometime in 2023. 19 Q. Who is the CFO currently? 20 A. Michelle Cartwright, and she's also the 21 group CFO. 22 Q. How long has she been the CFO? 23 A. I don't have her exact dates, but she's been 24 there as long as I've been there in my role. 25 Q. So prior to January '23 she would have been
Page 43 1 quality team? 2 A. It was sometime around when Stephany was 3 starting. I don't have the exact date. 4 Q. Does the med exec get quality reports from 5 your quality director? 6 A. They do. 7 Q. And how often do they get those? 8 A. They get quality information every month in 9 the meetings which will be given by me or by Stephany. 10 We're both in the meeting. 11 Q. And who do you consider to be executive 12 leadership at Delray? 13 A. Our chief operating officer; our chief 14 nursing officer; our chief financial officer; our CHRO; 15 our ACNO; our ACFO; and our associate administrator. 16 Q. And who is the COO of Delray? 17 A. Aganette Parks. 18 Q. And how long -- 19 Is that Mr. or Mrs.? 20 A. Mrs. 21 Q. Mrs. Parks. How long has Mrs. Parks been 22 the COO? 23 A. She was just promoted in December of 2024. 24 Q. Who was the COO before her? 25 A. I was.	Page 45 1 the CFO? 2 A. I believe so. 3 Q. What about the CHRO for Delray? 4 A. I don't have her time either, but I believe 5 she's been there a long time. 6 Q. What's her name? 7 A. Shannon Wills. I'm sorry. 8 Q. No, that's fine. And is she -- 9 A. She's group as well and ours. 10 Q. Perfect. 11 What are the job duties of the director of 12 quality at Delray? 13 A. So that person is directly responsible for 14 just the oversight of our quality and patient safety 15 programming. They also run all of our -- they have 16 oversight for all of our case review conferences, so 17 these teams report. Infection control reports up to 18 them. And really just collaboration with the 19 administrative team to ensure that that patient safety 20 plan is rolled out, adhered to and measured and 21 monitored. 22 Q. Does Delray have various quality committees? 23 A. We do. 24 Q. What quality committees do you have? 25 A. Some of them that I can think of right now,

Page 46 1 we have QIPSC. We have cardiac surgery improvement. 2 We have our STEMI work group improvement. We have a 3 monthly neuroscience for our stroke quality 4 improvement. We have monthly trauma quality 5 improvement. We have a patient experience or care 6 experience committee that meets monthly. There's a 7 variety of them. There's an EP quality improvement. I 8 mean, all the departments really have a lot. 9 Q. Well, let's talk about QIPSC. Who's on the 10 QIPSC committee for Delray? 11 A. So it's chaired, again, by our director of 12 quality and our -- one of our med exec members which is 13 Dr. Moussa, M-o-u-s-s-a. 14 Q. So that would be Stephany Johnson, correct? 15 A. Stephany Johnson and Dr. Moussa. 16 Q. Okay. 17 A. I sit on that committee. The CNO sits on 18 that committee. The COO sits on that committee. 19 And then we have our clinical directors that 20 are on that committee as well, so that would be our 21 nursing directors, our imaging director, our ED 22 director, I mean, all of those types of folks. And 23 then our infection prevention nurses are on there. 24 But I would need to give you the sign-in 25 sheet --	Page 48 1 going to be rolling some physicians into that meeting 2 next month as well. 3 Q. Have you hired a patient experience 4 champion? 5 A. So I have a care experience -- I don't 6 really use "patient experience" as a word anymore, so 7 we use "care experience." And I have a care experience 8 coordinator. And it -- she was already within the 9 health network working at Delray Medical Center so we 10 just put her in a different capacity in a different 11 role. 12 Q. When was the position of care experience 13 coordinator started? 14 A. We put her in that role in April, I believe. 15 Q. April of 2025? 16 A. Yes. 17 Q. And what is her name? 18 A. Angelica, and I'm going to spell her last 19 name, it's L-i-g-a-s, Ligas. 20 Q. What does the patient ex -- do you call it 21 the patient experience committee, or do you call it the 22 care experience committee? 23 A. I call it the care experience committee. 24 Q. What does the care experience committee do? 25 A. So we -- this was a committee, again, that
Page 47 1 Q. No -- 2 A. -- to show you, there's a lot of people that 3 are part of that committee. 4 Q. I appreciate it. It's not a memory test. I 5 appreciate that, though. 6 A. Okay. 7 Q. And how often does QIPSC meet? 8 A. Monthly. 9 Q. And what about the -- 10 A. Oh, and I'm sorry. Our governing board, 11 Lori Vinikoor, sits on our board, too. 12 Q. Vinegar like -- 13 A. No, Vinikoor, V-i-n-n-k-o-r [sic], I think. 14 Q. And what about the patient experience 15 committee, who chairs that? 16 A. I do. 17 Q. And how many members are on that committee? 18 A. Well, I just started -- I kind of 19 reinvigorated that committee in July, so I actually 20 have bedside care providers from many of the units, so 21 there's nurses, there's CNAs who are like patient care 22 techs. So I have about 20 people that sit on that 23 committee. 24 And then there's a grouping of some 25 managers, some clinical directors. And then we're	Page 49 1 was reinvigorated in July. But we are evaluating the 2 unit-based scores, the overall scores from the HCAHPS 3 for the hospital. 4 But we also are looking at our Google 5 reviews as well. So really part of that when we 6 started to look at our Google reviews back in September 7 of 2024, we were a 1.8 star-rated Google hospital. And 8 I'm happy to say that with all the process improvement 9 we've put in place we're a 4.5 so we're leading all of 10 Palm Beach County with Google reviews. So that's going 11 to be an early indicator, and then those HCAHPS will 12 start to follow. 13 So that committee is really looking at our 14 hardwired practices, looking at our scores, where we 15 can do things differently from the bedside, you know. 16 So if -- for example, we just had this 17 committee this past week, so we really were looking at 18 the bedside handoff that's happening between 19 practitioners, where we are doing well on it, where we 20 have opportunities. 21 We also developed recognition programs for 22 all the staff members as it relates to patient 23 experience so we've created a champion experience award 24 that's going to be rolled out this month. We have each 25 unit gets a care experience award if they're the

Page 50 1 champion of the month, so just developing different 2 awards and recognition programs and that they really 3 are ambassadors that are then going out into their 4 units, talking about scores, talking about best 5 practices in addition to everything that the leadership 6 team is doing to back that up. 7 Q. And those HCAHPS scores, they turn into star 8 ratings at CMS, correct? 9 A. They are a factor in the star rating. 10 Q. And what is the patient experience CMS star 11 rating currently for Delray? 12 A. It's a one-star. 13 Q. And do you anticipate that to go up as the 14 fixes -- my word -- that you put into place? 15 A. I expect them to go up, but that's going to 16 take time, because when you look at star ratings that 17 are reflective today, those -- that's data that's going 18 through, I believe, '21 to '23, so we're going to need 19 some time for those plans to mature and then that data 20 to come off so that we can start to see the fruits of 21 the labor. 22 Q. Right. And that's because the publicly 23 available CMS data lags, correct? 24 A. Correct. 25 Q. And we talked about just very briefly the	Page 52 1 different innovative technologies that we're going to 2 be launching within that given year, and we have plans 3 that go along with all of that, but it's typically by 4 service line. 5 Q. And is most of the marketing for Delray 6 individual to Delray, or is it in the Palm Beach Health 7 Network group? 8 A. The marketing can -- the marketing can be a 9 combination of both. So, for example, if it's a shared 10 service line where Delray Medical Center, for example, 11 if it's cardiovascular services that we want to 12 promote, Delray Medical Center and Palm Beach Gardens 13 are both large cardiovascular hubs and destinations so 14 there may be something that we do together. 15 Q. Would you agree with me that the brand of 16 Delray has increased under your leadership? 17 A. I would agree. 18 Q. When you came to Delray in 2024 -- 19 A. January '24. 20 Q. -- January 2024, what kind of brand 21 recognition did you believe Delray had? 22 MR. MARCUS: Object to form. 23 A. From the feedback, it's not what I believe, 24 but the feedback I received when spending time with 25 important community constituents and physicians was
Page 51 1 nurse retention improvements that you've been doing at 2 Delray. 3 Is it fair to say based on your testimony 4 that currently you don't feel as if Delray has any 5 staffing retention issues? 6 MR. MARCUS: Object to form. 7 A. I think we've made large improvements in 8 staffing and retention. I would say there's probably 9 one or two departments that are more specialty specific 10 that have more challenges that might be above that 11 average, but I think we have a good plan in place where 12 we don't need to be concerned. 13 BY MS. BLAIR: 14 Q. Can you talk to me a little bit about 15 Delray's marketing plans? Do you have a marketing plan 16 for Delray? 17 A. So we have -- we do business planning every 18 year, so really you're building in your marketing plans 19 with that, but I do go over my marketing plan, you 20 know, for the year, and then I meet on a monthly basis 21 with my marketing and then my public relations team to 22 just make sure that we're staying on track with 23 everything. So we'll identify the key service lines 24 that we are going to be promoting. It may be related 25 to new capital equipment or new capital projects or	Page 53 1 that the reputation, they didn't know all the key 2 services and the quality outcomes, the superior quality 3 outcomes that we had achieved there. It was kind of a 4 hidden secret. 5 BY MS. BLAIR: 6 Q. And when you say "they," are you referring 7 to the community at large? 8 A. The community constituents and different 9 physicians I went out to talk to. 10 Q. And when you came on as the CEO of Delray, 11 was it one of your goals to improve the brand of 12 Delray? 13 A. That's always, as a CEO, you always want to 14 improve your brand and make sure the community 15 understand the services, the physicians are comfortable 16 with the services. 17 Q. Had there ever been any studies done for 18 Delray specifically comparing its brand, let's just 19 say, in 2023 versus today? 20 A. I don't think I've seen all those studies. 21 Q. I don't... 22 And I'm just trying to figure out is there a 23 way in which -- is there a way in which Delray measures 24 whether or not you're improving your brand within the 25 Palm Beach community?

Page 54 1 A. There are these monthly reports. I don't 2 recall exactly what the name of those reports are, but 3 those come out from Lisa Cook that just talks about the 4 consumer awareness as it relates to our various 5 hospitals. 6 Q. And what is your understanding of what those 7 reports are measuring? 8 A. It's just, from what I recall -- I need them 9 in front of me -- it's looking at like consumers' 10 understanding what Delray is or what any of the 11 hospitals are. It has the positive and negatives. It 12 captures, you know, how many times we've been in the 13 media from what I remember. 14 Q. Oh, I think I've seen those. Okay. 15 Other than those types of reports, are there 16 any other reports that you're aware of that would kind 17 of measure? 18 A. Not that I'm aware of. 19 Q. Are you aware of whether Tenet Health 20 systems, like the home office, puts out any -- does any 21 analysis of individual hospitals' brand awareness? 22 MR. MARCUS: Object to form. 23 A. I'm not aware of that. 24 BY MS. BLAIR: 25 Q. Are you aware or have you ever seen any	Page 56 1 A. Sorry. 2 Q. No, no. 3 And I assume that as the CEO of a 4 hospital -- well, you tell me. 5 As the CEO of the hospital, what is like the 6 most important thing that you want to achieve for your 7 hospital? 8 A. I want it to be a quality destination that 9 is safe for patients and that consumers feel confident 10 in and physicians. 11 Q. And so would you agree with me that 12 hospitals put a high importance on patient safety? 13 A. Yes. 14 Q. And would you describe patient safety as 15 reducing the risk of preventable harm? 16 MR. MARCUS: Object to form. 17 A. I think that's part of the recipe. 18 BY MS. BLAIR: 19 Q. What are the other parts? 20 A. You want to reduce patient harm. You want 21 to be being forward thinking, making sure you're having 22 evidence-based protocols in place so that you can 23 advance the care as well. 24 Q. And I assume part of what hospitals want to 25 do is make sure that patients leave a hospital in
Page 55 1 analyses of the brand of Tenet health systems as a 2 whole? 3 A. No. 4 Q. Are you aware of whether there's any reports 5 of the brand awareness of Palm Beach Health Network as 6 a group? 7 MR. MARCUS: Object to form. 8 A. Just the report I'm telling you about there, 9 but that's more at the local, that's the local level 10 not in the Tenet Healthcare. 11 BY MS. BLAIR: 12 Q. Right. But when you say it's at the local 13 level, is it for Delray individually or is it for Palm 14 Beach Health Network? 15 A. For Palm Beach Health Network. That's the 16 reports I'm explaining. 17 Q. Oh. Is there a report like that, like the 18 one you just described, from Lisa Cook for Delray 19 individually? 20 A. Well, Delray is included. It's just, it's 21 included in that report that Lisa Cook sends. 22 Q. Okay. So it's both on a group level and 23 then kind of breaks out on an individual level? 24 A. Correct. 25 Q. I just couldn't remember.	Page 57 1 better shape than they came in; is that fair? 2 A. You always want to strive for that, but 3 depending on the kind of patients you're taking care 4 of -- and remember we are situated as a level I trauma 5 center, a comprehensive stroke center, and we have an 6 elderly population, so sometimes you're not going to be 7 able to fulfill that, but you want to do your best to 8 get them back to the level they were at, but that's 9 sometimes is impossible based on your patient 10 populations. 11 Q. That's a good point. 12 And is it important to you as the CEO of 13 Delray that patients feel cared for while they're in 14 the hospital? 15 A. It's very important to me. 16 Q. And that would be those HCAHPS scores we 17 were talking about, correct? 18 A. That's a portion of it. That's their 19 perception, but we validate that on a daily basis 20 through rounding. So our leaders are rounding. I 21 actually go and round on patients every day. And 22 that's the goal for every staff member that works in 23 our hospital that patients and families are at the 24 center every day. So that's validated through our 25 rounding every day.

Page 58 1 Q. And would you agree with me that patients 2 deserve transparency with respect to patient safety in 3 a hospital? 4 A. Yes. 5 Q. Would you agree with me that patients 6 deserve to have information related to patient 7 experiences at a hospital? 8 A. Yes. 9 Q. And that they deserve to have up-to-date 10 information with respect to hospital-acquired 11 infections at any given hospital? 12 A. Yes. 13 Q. And would you agree with me that you strive 14 to provide your board with clear and accurate data with 15 respect to patient safety at Delray Medical Center? 16 A. Yes. 17 Q. And same with the med exec, you want to make 18 sure that they have clear and transparent information 19 related to patient safety at Delray? 20 A. Yes. 21 Q. And you would agree with me that that's the 22 same for your constituents, the patients of the 23 community as well, correct? 24 A. That's correct. 25 Q. In terms of other hospitals in the area who	Page 60 1 a competitor of Delray? 2 A. Not really. 3 Q. What about Wellington Regional Medical 4 Center? 5 A. For some services they could be but not 6 really. 7 Q. And then I have had Baptist Health Boca 8 Raton Regional? 9 A. That's Boca Regional that I told you. It's 10 the same. 11 Q. It's the same? 12 A. They're all part of Baptist now. Bethesda 13 East, West and Boca. 14 Q. Sorry. I had it... 15 And what about the Broward hospitals, do you 16 consider them to be competitors? 17 A. I mean, Broward Health North that's situated 18 on Sample Road has some similar services, so we do pull 19 some of theirs, but they're not a major area of concern 20 from competition. 21 Q. Does Baptist Health Bethesda transfer 22 patients to Delray? 23 A. They do. 24 Q. Is that a regular occurrence? 25 A. Yes, especially because we're a level I
Page 59 1 do you consider the competitors of Delray hospital to 2 be? 3 A. So the Baptist Health system, which is 4 comprised of Boca Regional, Bethesda East and West, 5 JFK, those are going to be some of our more immediate 6 competitors. 7 Q. And how do you determine who your 8 competitors are? 9 A. So we look at our primary service areas that 10 we serve and just looking at where patients are going 11 within that primary service area and then hospitals 12 that are closest to us with some of same services. So 13 that's kind of how we gauge it, through those primary 14 service area maps. 15 Q. And how -- I'm not from Florida, so I 16 apologize. 17 How far is Baptist Health Bethesda east? 18 A. Bethesda East is probably, if I -- I don't 19 know, five, six miles. Bethesda West is maybe the 20 same. 21 Q. And what about Boca Raton? 22 A. Boca is probably about ten or less. 23 Q. What about HCA Florida? 24 A. That one's probably about 14, 15 miles. 25 Q. Do you consider Jupiter Medical Center to be	Page 61 1 trauma center, so those hospitals are not trauma 2 centers so they can't keep the trauma patients there. 3 Q. And have those transfers been relatively 4 consistent since you've been the president of Delray? 5 A. Yes. 6 Q. And what about Baptist Health Bethesda 7 Hospital West, do they transfer patients? 8 A. They do. 9 Q. Is that a regular occurrence? 10 A. It is, mostly for trauma patients, again. 11 Q. And have the transfer levels remained the 12 same since you've been president of Delray? 13 A. Yes. 14 Q. What about Baptist Health Boca Raton, do 15 they regularly transfer patients to you? 16 A. They will send us trauma patients. They 17 have more tertiary services, so trauma is the main 18 thing that they send us. 19 Q. And in terms of the level of transfers from 20 Baptist Health Boca Raton, have those maintained the 21 relatively same level since you've been the CEO? 22 A. Those have. 23 Q. And same questions with respect to 24 HCA Florida JFK, do they regularly transfer patients? 25 A. They do, again, mostly trauma patients

Page 62 1 because of the services that they offer and psych 2 patients. 3 Q. Trauma and psych Like psychology? 4 A. Psychiatry. We have a behavioral health 5 unit. 6 Q. And have the level of transfers from 7 HCA Florida JFK remained pretty level since you've been 8 the CEO? 9 A. They have. 10 Q. Do you consider -- well, are you aware, for 11 example, that Cleveland Clinic has come into the 12 Palm Beach area? 13 A. Yes. 14 Q. Do you consider them to be a competitor of 15 Delray? 16 A. In some limited services. 17 Q. In which limited services? 18 A. Colorectal surgery and cardiovascular 19 surgery but not to the Palm Beach hospital, like not to 20 those sites. It's pulling them down to the Weston site 21 for those services. I want to clarify that. 22 Q. Okay. And how far is Weston from Delray? 23 A. Oh, probably 30 plus miles. But they have 24 an outpost for Cleveland Clinic on the Coral 25 Springs/Parkland line where they have outpatient	Page 64 1 Q. So how long have they been admitting 2 patients -- and they, I mean, how long has NYU Langone 3 been admitting patients to Delray? 4 A. Since I've arrived they've already been 5 doing that, but we've seen a stronger collaboration. 6 Q. So those have been up since you've been a 7 CEO? 8 A. Um-hum. 9 Q. You have to say "yes." 10 A. Oh, yes, yes. Sorry. 11 Q. Do you see a decrease in patient admissions 12 at your hospital in the winter months due to the sort 13 of transient snowbird nature of the population of the 14 area? 15 MR. MARCUS: Object to form. 16 A. In the winter months, that's our season, so 17 we see them come up, so they go back to the colder 18 places in the winter -- in the summer months. 19 BY MS. BLAIR: 20 Q. Sorry. 21 A. But we actually, it's very -- we get a lot 22 more volume during those winters months. 23 Q. Okay. Yeah, I'm from Chicago so it's the 24 opposite. I apologize. 25 A. Yes.
Page 63 1 colorectal surgeons going there, so that's where that 2 feeder is. 3 Q. Okay. And do you consider Delray to be 4 losing any patients to Cleveland Clinic Weston? 5 A. Just in those two categories that I 6 described. 7 Q. And for how long have you been competing 8 with Cleveland Clinic Weston in colorectal and 9 cardiovascular? 10 A. That has really come up in 2025 we've seen 11 that. 12 Q. And do you have any understanding of why 13 that's come up in 2025? 14 A. It has to do with the providers that they 15 put out there. They put regular GI providers and the 16 colorectal surgeons in that area and did a lot of 17 marketing around it. 18 Q. What about NYU Langone Health, do you 19 consider them to be a competitor? 20 A. No, we work very closely with them. 21 Q. And how do you work closely with them? 22 A. They have large practices in cardiology and 23 primary care that are located across the street from 24 our campus, and all of their cardiology patients are 25 admitted to Delray Medical Center.	Page 65 1 Q. So, for my record, so during the summer 2 months your volume goes down; during winter months, it 3 goes up here? 4 A. That's historically what it looks like. 5 Q. Are you finding that since you've become the 6 CEO of Delray in or around January of 2024, do you see 7 that to be still the case? 8 A. We've leveled it out a lot better, so we're 9 not seeing those ups and downs, but we've been very 10 strategic in what we're doing, so really building in 11 the right physicians. We've done a lot of recruitment. 12 We've done a lot of collaboration alignment with our 13 community physicians. And then we've really worked at 14 understanding where we needed different programs. 15 So, for example, we had never had women's 16 imaging on our campus at our outpatient imaging center, 17 and we understood that women, of course, needed 18 mammograms. And talking to the physician, talking to 19 the community, we put that women's imaging in place in, 20 you know, October of 2024. 21 And then we started breast oncology surgery, 22 which had never been at Delray, in January of '25, and 23 that's just been a success where we've served 2,000 24 women in our community since putting that in place. 25 So everything has been very strategic in

Page 66 1 what we've done. 2 Q. And is that part of your strategic planning 3 as the CEO of Delray? 4 A. It is. 5 Q. And have you seen revenues go up since 6 you've become the CEO of Delray? 7 A. We have. 8 Q. Do you -- does Delray -- we just talked 9 about some of your competitors in the area, or maybe 10 all of your competitors in the area. Do you use -- do 11 you know if Delray uses Trilliant to measure your 12 competitive positions versus your competitors in the 13 area? 14 A. Our business development team has access to 15 Trilliant data. 16 Q. "Trilliant." I'm sorry. 17 A. Yes, Trilliant. And they -- they will 18 provide those reports to us. So we will sometimes look 19 at those for different service lines to understand just 20 some of referral patterns and where we need to, you 21 know, enhance our services to meet the community need. 22 Q. But, as I understand our discussion that we 23 just had, you are increasing your patient volume and 24 revenue versus your competitors' based on the strategic 25 planning that you've undertaken?	Page 68 1 Q. Do you know if they've been produced in this 2 litigation? 3 MR. MARCUS: Object to form. 4 A. I'm not aware that they were produced. 5 BY MS. BLAIR: 6 Q. Other than that Trilliant report that we 7 just discussed, do you know whether or not there's any 8 other market studies that are done for -- let's start 9 with for Delray at the individual level versus your 10 competitors? 11 MR. MARCUS: Object to form. 12 A. Not that I'm aware of. 13 BY MS. BLAIR: 14 Q. And what about on the Palm Beach Health 15 Network level, do you know whether or not, other than 16 the Trilliant we discussed, do you know whether or not 17 there are any other market studies that are done? 18 A. Not that I'm aware of. 19 Q. Are you aware of whether -- I think I might 20 have asked you this, so I apologize. 21 Are you aware of whether there's been any 22 brand analysis done for your hospital? 23 MR. MARCUS: Object to form. 24 A. Just those reports that I spoke to you 25 about.
Page 67 1 A. I don't know what the competitors' revenue 2 has looked like. I just know what ours looks like and 3 we are increasing. 4 Q. So the Trilliant platform doesn't, 5 obviously, tell you what their revenue is, correct? 6 A. No, no, it just tells you like patient, how 7 many patients have gone where and for what services. 8 It doesn't give you revenue data. 9 Q. Can you tell your patient volume versus your 10 competitors when you look at Trilliant? 11 A. You can see it to some extent, but, again, 12 it's six -- it's about six months old so it's in the 13 rear. 14 Q. And are those reports produced to you like 15 in hard copy? 16 A. They typically would be something in hard 17 copy or the business development team would just show 18 them on a screen, but they come in -- you see the 19 reports like in an Excel file, the way that it's 20 exported. 21 Q. Do you know if it has a name on the top of 22 it? 23 A. Whatever it -- whoever is running the report 24 will put like a title on it, depending on what the 25 report is.	Page 69 1 MR. MARCUS: Kim, we've been going a while. 2 Do you want to go off the record for a quick 3 break? 4 MS. BLAIR: Oh, yea. Yeah, we can go off 5 the record, absolutely. 6 THE VIDEOGRAPHER: The time is 10:26 a.m. 7 We're going off the record. 8 (A recess was taken from 10:26 a.m. to 10:43 a.m.) 9 THE VIDEOGRAPHER: This is media number two 10 in the deposition of Heather Havericak. The 11 time is 10:43 a.m. We are back on the record. 12 BY MS. BLAIR: 13 Q. Ms. Havericak, before we took a break we 14 were talking a little bit about -- well, you were 15 telling me earlier this morning about a lot of the 16 different accolades that your hospital has, correct? 17 A. Yes. 18 MS. BLAIR: And we can mark this as 19 Exhibit 3. 20 (Defendant's Exhibit Number 3 for i.d.) 21 MS. BLAIR: I have no clue where my copy is, 22 but I'll figure it out. 23 BY MS. BLAIR: 24 Q. Ms. Havericak, I've just handed you what 25 we've marked Exhibit 3 to your deposition. And if you

Page 70 1 see on the bottom right hand of these documents, they 2 have what we call a Bates number. This is PBHN 8914 3 through 8917. 4 Have you seen this document before today? 5 A. I have. 6 Q. Do you know the date in which this one, this 7 particular one would have been created? 8 A. I don't have the exact date. This gets 9 updated as we have different things that are added to 10 it. 11 Q. And if I look on the second page, a lot of 12 the awards and distinctions by service line that are 13 listed appear only to go through 2024. Would you have 14 a more up-to-date one that would list 2025 accolades as 15 well? 16 A. We do have an updated one. 17 Q. And just kind of looking at the awards and 18 distinctions on the second page of what we've now 19 marked Exhibit 3, are there any accolades here -- I'm 20 sorry. Are there any accolades that are not listed 21 here that you know of? 22 A. Yes. So our 2025 Healthgrades® awards do 23 not appear to be listed in this document. 24 Q. And do you know off the top of your head 25 what they are?	Page 72 1 it says an R and a circle. Do you see that? 2 A. I do. 3 Q. And that's, is that the accreditation mark 4 that you're referring to? 5 A. That's their trade -- trademark that you 6 have to pay to use -- 7 Q. Okay. 8 A. -- based on the quality outcomes that we've 9 earned through claims data through Medicare and private 10 payers. 11 Q. And so Healthgrades® comes from CMS data? 12 A. Part of it comes from CMS data. The other 13 part comes from private claims, too, so commercial 14 payers as well. 15 Q. And do you have to provide that for private 16 claims data to Healthgrades®? 17 A. No. 18 Q. From what platform do they receive that? 19 A. I'm not sure what platform they'd get that 20 from. 21 Q. And so if we look at the bottom of this page 22 like that first row of logos that all say 23 Healthgrades®, is that the accreditation marks you are 24 referring to that you pay for? 25 A. On the top row?
Page 71 1 A. I don't know all of them off the top of the 2 head, but there's a variety of them in cardiovascular, 3 in pulmonary care, in critical care. And then we did 4 receive Healthgrades 250 Best Hospitals™ in 2025. 5 And then we have also recently been 6 accredited through the Joint Commission for our initial 7 accreditation as a certified hip, knee and shoulder 8 replacement center. We also were just accredited 9 through the SRC, which is the Surgical Review 10 Corporation, as a Robotics Center of Excellence. 11 Q. And in terms of Healthgrades®, is that a 12 paid-for service? 13 A. That's not a paid-for service. The data is 14 not an opt in or opt out. It comes from claims data 15 that pulls from both Medicare data and private 16 insurance companies. The only time payment comes into 17 play is when you're using the actual accreditation 18 marks that you have earned through the data that's been 19 verified. 20 Q. Do you pay for the accreditation marks for 21 Healthgrades®? 22 A. We do. 23 Q. And so if I look just on this document, like 24 under cardiac and vascular where it says Healthgrades®, 25 and it is microscopic, and I apologize, it looks like	Page 73 1 Q. Yes. 2 A. Yes, those are some of them. But these are 3 not reflective of what we earned in 2025. 4 Q. Good point. 5 And if we see on that bottom row to the 6 right side there's like these U.S. News trademarks? 7 A. I see those. 8 Q. What accolades do those refer to, if you 9 know? 10 A. Can I take my glasses out for a second? 11 Q. Oh, please, yes. 12 A. Because I don't think I can see that. 13 Actually, I don't think I brought them. 14 MR. MARCUS: You want mine? 15 THE WITNESS: No, that's okay. 16 A. It appears to be from 2020 to 2023 for high 17 performing hospitals for heart attack, heart failure 18 and stroke. 19 BY MS. BLAIR: 20 Q. And to the best of your knowledge, how do 21 hospitals earn these types of awards from U.S. News? 22 A. From the best of my knowledge, and I haven't 23 looked at U.S. News & World Report in quite sometime, 24 there's also data that's pulled from Medicare, CMS data 25 and from claims data from what I remember.

Page 74 1 Q. Okay. 2 A. But we haven't been participating with 3 U.S. News & World Re -- U.S. News since I've been at 4 Delray. 5 Q. And going back to the Healthgrades®, do you 6 know whether Delray's participation in Healthgrades® is 7 approved by Tenet home office? 8 MR. MARCUS: Object to form. 9 A. It's, again, it's not an opt in or opt out, 10 so those, the data that they pull and the awards they 11 send to us, those are just there, and then we make the 12 decision to enter into the -- to use the trademark. 13 BY MS. BLAIR: 14 Q. Okay. I see. So you as a hospital don't 15 have to put any resources toward complying -- my 16 word -- complying with Healthgrades® in order to get 17 these awards out? 18 A. Can you rephrase that question? 19 Q. Sure. It was a bad question. 20 Delray hospital doesn't have to expend any 21 internal resources to provide data to Healthgrades® in 22 order for Healthgrades® to rank Delray? 23 A. Correct. 24 Q. And is that the same with respect to 25 U.S. News, to the best of your knowledge?	Page 76 1 Q. No payment to use that logo? 2 A. Correct. 3 Q. And do you know whether or not -- and is 4 that one, then, the Carotid Care Quality Champion, that 5 is one that you, Delray would use internal resources to 6 pull data to report? 7 A. They're reporting it, they're reporting that 8 monthly, like in the registry, so that is our personnel 9 pulling data. 10 Q. And what is the registry? 11 A. The registry, so in order to participate -- 12 we're part of the Vascular Quality Initiative because 13 we want to enhance our patient quality and safety for 14 quality care so we have to ept data into this platform 15 for the VQI so we have a full-time employee that does 16 that. 17 Q. Okay. And so that's like an FTE -- 18 A. Correct. 19 Q. -- full time? 20 A. Correct. 21 Q. And his or her only job is doing this? 22 A. Is vascular quality. So they will do this 23 and do other things as well -- 24 Q. Got it. 25 A. -- that relate to vascular quality.
Page 75 1 A. From what I remember from my previous 2 employer, but I can't be certain on that because I 3 haven't looked at that in sometime. 4 Q. What about -- 5 Okay. Let's just talk about this bottom row 6 of what I'm going to call -- strike that. 7 With respect to U.S. News, do you know 8 whether you have to pay to use that their logo that we 9 see on the bottom row to the right? 10 A. I'm not sure. 11 Q. Okay. And if we go to the left side of this 12 bottom row, it looks like this says -- 13 A. A carotid care champion quality [sic] 14 award. 15 Q. Yeah, what is that? 16 A. So that is based on our -- we participate in 17 submitting data through our vascular program to the 18 Vascular Quality Initiative so we have to actually take 19 our data, we have someone that works in vascular 20 quality, they have to enter all the data, abstract it 21 from the medical records. And based on outcomes of the 22 VQI data we were awarded the Carotid Care Quality 23 Champion because our data is so good and outcomes are 24 so good for our patients. And there's no payment 25 involved in that.	Page 77 1 Q. And is participating in the Vascular Quality 2 Initiative tied to any contract or payment for the 3 hospital? 4 A. Not that I'm aware of. 5 Q. What is TCAR Center of Excellence? 6 A. That's also part of our vascular program, so 7 that's a procedure that we do where you work with the 8 carotid artery, and it's minimally invasive. And we're 9 the highest -- we've done the most procedures in the 10 country at our center. And that's based on our 11 outcomes, because in order to be part of the TCAR 12 program, you also have to enter your data on the 13 outcomes of those procedures. 14 Q. And would that be same -- 15 A. Yes. 16 Q. -- person? 17 A. Yes. 18 Q. So their job is not only with the 19 Vascular Quality Initiative but also with respect to 20 TCAR, correct? 21 A. Yes, because TCAR is part of the vascular 22 program so she's responsible for all vascular items. 23 Q. Okay. And it looks like -- and I apologize. 24 I literally cannot read the next one AACVPR. Is that 25 also carotid or cardiovascular?

Page 78 1 A. No, this is cardiovascular, but it's 2 cardiovascular rehab. So we wanted to get our program 3 accredited in cardiopulmonary rehab, so that's one of 4 our outpatient departments in the hospital. So they 5 went through the accreditation process where they have 6 to meet all the standards, and then they had a 7 validation survey to show that they met all the 8 standards, their outcomes are appropriate, all the 9 staff had the appropriate proficiency training, 10 education to be able to validate that. 11 Q. And is that the same person from -- that 12 does the vascular quality? 13 A. No, that's a different -- that's a different 14 group of people. 15 Q. Okay. And then this looks like it's 16 Blue Cross/Blue Shield, the next two, Blue Distinction® 17 Center? 18 A. Yes. 19 Q. And so is -- I assume that's tied to a 20 payment program? 21 A. That's just -- that comes from the Blue 22 Cross/Blue Shield network. So they actually pull data 23 based on our outcomes. And there's a -- and I don't -- 24 without having the document in front of me of all the 25 standards, it pulls on some quality outcomes,	Page 80 1 who are experts in stroke care, and they really trace 2 through the whole journey of patients looking at open 3 records, closed records. They'll start in the 4 emergency room. They go to the operating room. They 5 go to the units and really trace everywhere where a 6 patient is. 7 And then they meet with all of the 8 stakeholders. They review all the stakeholders' files, 9 from the physicians and the staff to make sure everyone 10 meets the training and educational levels that are 11 required to be part of that. 12 Q. Okay. Okay. Thank you. I couldn't read it 13 at all. 14 So to the best of your knowledge, we at 15 least know that -- and I'm going to call them like the 16 logos or I forget what you called them, accreditation 17 marks for Healthgrades®, those are paid for, but we -- 18 you don't know for sure whether any on the bottom line 19 are paid for to use those logos, correct? 20 A. Correct. 21 Q. How do you track how Delray is doing in 22 terms of patient experience versus your competitors? 23 A. So for patient experience we use a vendor 24 called Press Ganey, so they administer our HCAHPS 25 surveys. And within there you won't be able to see,
Page 79 1 readmissions. And there's a price component in there 2 too. 3 Q. Okay. 4 A. From what I remember. 5 Q. And like legitimately I can't even read the 6 next one so I'm not going to ask. 7 A. Yeah, I was just trying. I don't -- I'm 8 sorry. 9 Q. No, no, it's totally fine. 10 And to the best of your knowledge, then, of 11 the ones we talked about -- 12 A. Oh, I know what it is. It's a comprehensive 13 stroke center it's saying. It's our DNV Comprehensive 14 Stroke Center. 15 Q. Oh. What is that? 16 A. So DNV is another accrediting organization 17 similar to the Joint Commission. So in the State of 18 Florida you do, in order to call yourself a 19 comprehensive center, you do have to either be 20 accredited through Joint Commission or through DNV. So 21 the organization at Delray before I came started that 22 through DNV. 23 So they come every year for two days to 24 validate. We just had our DNV survey and we're 25 reaccruited. So they bring three surveyors on site	Page 81 1 per se, the competitors, but it has you ranked in 2 that -- in that program. So all -- I have access to 3 Press Ganey. All the clinical managers have access, 4 the directors, the administrative team. So you can go 5 in and see how you rank at the state level and then at 6 the national level. 7 Q. And when you started at Delray, do you know 8 how Delray ranked at the state level for HCAHPS? 9 A. From what I recall, we were in a lower 10 percentile. 11 Q. And what about from a national average when 12 you started? 13 A. The same. 14 Q. But there are initiatives underway, correct? 15 A. Correct. 16 Q. Do you -- how do you track how Delray is 17 doing in hospital-acquired infections compared to 18 competitors? Is there a way to view that? 19 A. So for hospital-acquired infections we 20 report data into NHSN, so, again, it's not going to 21 tell us exactly how the competitor is doing, but it's 22 going to give us a SIR's rating, so what -- you know, 23 how many patients you have, what your expected 24 infection rate is going to be. And then it doesn't -- 25 it doesn't really rank you like that way, the same way

Page 82 1 the Press Ganey does. 2 Q. Okay. 3 A. So we really benchmark where we are like to 4 the SIR's rating, like the SIR's, and that's kind of 5 how we measure ourself. 6 Q. Okay. So -- 7 A. And then how we did to prior year like 8 continuously looking to how we improve. 9 Q. And for us lay people when you say "SIR's," 10 how do you spell that and what is it? 11 A. Sure, so it is the -- it's S-i-r-s. And 12 it's just, it is, again, just looking at the expected 13 model of how many patients you have, how many expected, 14 like what your expected infection rate should be based 15 on the patient population and the number of patients 16 you have. 17 Q. And when you started at Delray, do you 18 remember how Delray was doing on these, you know, 19 SIR's, I'm going to say ratings, but I don't know if 20 that's the right term? 21 A. Without -- without the data in front of me 22 from exactly when I started, I wouldn't be able to tell 23 you exactly where we were at. We had some 24 opportunities, but, again, I can't quote you where 25 those are.	Page 84 1 participating in Leapfrog Hospital Survey? 2 A. I don't know the date that they actually 3 started, but I do know from some of the documents that 4 I've seen, it looks like they participated in 2018, 5 2019. 6 Q. Do you know what the last year was that they 7 participated? 8 A. I think it was somewhere around 2020. 9 Q. Do you know if when Delray participated in 10 the Leapfrog Hospital Survey it was ever charged to 11 participate in the hospital survey? 12 MR. MARCUS: Object to form. 13 A. I have seen some documents that show that a 14 licensing fee was executed in a contract to use the 15 letter grade. 16 BY MS. BLAIR: 17 Q. Right. And do you understand that that 18 licensing fee was to use logos just like the logo, 19 Healthgrades® logos we looked at in Exhibit 3? 20 MR. MARCUS: Object to form. 21 A. It looks similar. 22 BY MS. BLAIR: 23 Q. And so my earlier question was, do you know 24 if Delray ever paid to complete the survey? 25 A. To my knowledge, no.
Page 83 1 Q. Okay. But that data would be available in 2 the NHSN data for that time period, correct? 3 A. Yes. 4 Q. And that would be a report would have been 5 generated in or around that time at Delray advising 6 med exec or quality directors as to what those HAI's 7 were? 8 A. Yes. 9 Q. And is that the best place for me to look at 10 what they were? 11 A. The best place to look would be in that 12 monthly quality meeting. 13 Q. But just based on your recollection when you 14 took over as the CEO of Delray, were the HAIs good? 15 Bad? Average? Do you recall? 16 MR. MARCUS: Object to form. 17 A. They were -- they were average. 18 BY MS. BLAIR: 19 Q. Do you know whether or not Delray has ever 20 participated in the Lown, L-o-w-n, survey? 21 A. I'm not familiar with that. 22 Q. Are you aware that Delray did participate in 23 the Leapfrog Hospital Survey for sometime historically? 24 A. I am. 25 Q. And do you know when they started	Page 85 1 Q. Do you know if any hospital has ever paid 2 Leapfrog to participate in a survey? 3 MR. MARCUS: Object to form. 4 A. I'm not aware of any. 5 BY MS. BLAIR: 6 Q. Are you aware of any hospital has ever paid 7 Leapfrog for better grades? 8 MR. MARCUS: Object to form. 9 A. I'm not aware that any have paid Leapfrog 10 for better grades. 11 BY MS. BLAIR: 12 Q. Do you understand that the Leapfrog Hospital 13 Survey is voluntary? 14 A. While I understand it's voluntary, with the 15 change in the imputation model in 2024, it becomes a 16 punitive measure when you don't participate because of 17 a failing grade is assigned for some of those key 18 measures that are self-reported, and those end up 19 taking up about 33 percent when you look at the 20 weighted total and average. 21 Q. Right. And we're going to look at that. 22 But you are not required as a hospital to 23 participate in the Leapfrog Hospital Survey, correct? 24 MR. MARCUS: Object to form. 25 A. We are not required.

Page 86 1 BY MS. BLAIR: 2 Q. And Delray does not currently participate in 3 the Leapfrog Hospital Survey, correct? 4 A. We do not. 5 Q. Do you know whether or not Delray has ever 6 been approached by Leapfrog to pay for consulting 7 services? 8 A. Not to my knowledge. 9 Q. Do you know whether Delray was ever forced 10 to license these trademarks that we looked at from 11 Leapfrog in exchange for better grades? 12 MR. MARCUS: Object to form. 13 A. Not to my knowledge. 14 BY MS. BLAIR: 15 Q. What is the basis for the plaintiffs' 16 allegation that Leapfrog is a "brazen pay-to-play 17 scheme"? 18 MR. MARCUS: Object to form. 19 A. We have made the decision not to participate 20 in the Leapfrog survey, and with that, we have been 21 personalized. Because of that imputation model where 22 we did not submit data, rather than giving us a 23 not applicable or not grading us, Leapfrog falsely 24 assigned an F rating, which has shaken the community's 25 confidence in our ability to provide care. It's	Page 88 1 participation in the survey? 2 MR. MARCUS: Object to form. 3 A. I, again, can repeat what I said. 4 BY MS. BLAIR: 5 Q. Right. And there was no -- in your answer 6 there was no discussion of money, correct? 7 A. There's no discussion of money. 8 Q. Do you have any reason to believe that 9 Delray's competitors that do participate in the 10 Leapfrog Hospital Survey manipulate their data? 11 A. I have no knowledge of that. 12 Q. Do you understand that's an allegation in 13 the Complaint? 14 MR. MARCUS: Object to form. 15 A. What is in the Complaint is that Leapfrog 16 does not come and do any validation of self-reporting 17 measures. That's different than saying a competitor 18 has manipulated data. 19 BY MS. BLAIR: 20 Q. Well, you say here, "Those hospitals inflate 21 their performance." 22 MR. MARCUS: Object to form. 23 BY MS. BLAIR: 24 Q. It says that in paragraph 55 of your 25 Complaint. And I'm asking do you have any evidence
Page 87 1 reckless; it's dangerous; and it's deceptive because 2 all consumers see is an F rating, and that's not the 3 full picture -- 4 BY MS. BLAIR: 5 Q. And what -- 6 A. -- of how we are providing care from a 7 patient safety and quality perspective. 8 Q. And we'll get to that. 9 I'm asking specifically the allegation in 10 the Complaint that its "brazen pay-to-play," and your 11 answer didn't have anything about paying in it. And so 12 I'm just asking, with respect -- and we'll get to all 13 of those, and I understand your theory. 14 But what is the basis for the allegations 15 that Leapfrog is a brazen play-to-pay [sic] scheme? 16 MR. MARCUS: Object to form. 17 A. Because if you choose not to participate, 18 this is the downfall of the catastrophic impact it has 19 on our community and patients. It is almost forcing to 20 you participate in Leapfrog. But when you don't 21 participate, it's causing reputational damage and harm, 22 so that's what I mean by "pay to play." 23 BY MS. BLAIR: 24 Q. Okay. So by -- what you mean by "pay to 25 play" doesn't include any actual payment. It's just	Page 89 1 that your competitors inflate their performance on the 2 Leapfrog Hospital Survey. 3 MR. MARCUS: Object to form. 4 A. I don't have evidence that they inflate, but 5 Leapfrog does not validate or verify any of the 6 self-reported measures that are submitted. 7 BY MS. BLAIR: 8 Q. And we'll get to that later, but my question 9 is about whether or not your competitors inflate their 10 performance on the Leapfrog hospital safety -- or 11 Leapfrog Hospital Survey. And you don't have any 12 evidence of that as you sit here today, correct? 13 A. I do not. 14 Q. Do you have any evidence that your 15 competitors that participate in the Leapfrog survey 16 manipulate their data on the survey? 17 MR. MARCUS: You're asking her personally, 18 right? Who's the "you"? 19 BY MS. BLAIR: 20 Q. Yes, I'm asking you personally. 21 A. I do not. 22 Q. And I think you told me earlier that when 23 Broward participated in the survey, they did not 24 manipulate their data, correct? 25 A. To my knowledge, no.

Page 90 1 Q. Do you understand that Delray has produced 2 documents in this litigation sufficient to simulate 3 what their responses would have been to the four 4 imputed measures, BCMA, CPOE, hand hygiene and 5 ICU physicians staffing? 6 A. Yes. 7 Q. And can we trust that the sufficient to 8 simulate data that has been produced by Delray in this 9 litigation was not manipulated, correct? 10 A. It was not manipulated. 11 Q. Do you know whether hospitals, and let's 12 just talk prefall of 2024. Prefall of 2024, so you -- 13 well, strike that. Let me lay some foundation. 14 You understand that the Leapfrog methodology 15 was changed for the fall 2024 hospital safety grade, 16 correct? 17 A. Correct. 18 Q. And so I want to talk about prefall 2024 the 19 hospital safety grade. Do you, Ms. Havericak, have any 20 opinion, personal opinion about whether or not there 21 was any benefit in participating in the Leapfrog 22 Hospital Survey prior to fall of 2024? 23 A. I don't think there's a lot of value in 24 participating in that survey. 25 Q. And why not?	Page 92 1 BCMA, hand hygiene and ICU physician staffing? 2 A. Yeah, I haven't seen a report that shows 3 that. 4 BY MS. BLAIR: 5 Q. Okay. And we'll look at that later. 6 If -- so I'm just making sure. Do you -- 7 would you -- is it your position that if Delray in 8 spring of 2024 as a nonparticipating hospital was 9 receiving 100 out of 100 points for the four measures 10 that come from the hospital survey and are used in the 11 hospital safety grade, that would be inaccurate? 12 MR. MARCUS: Object to form. 13 A. I can't say if it would be inaccurate 14 without putting our actual data in it. 15 BY MS. BLAIR: 16 Q. Do you know whether any of the five 17 Palm Beach hospital network's hospitals complained 18 about the Leapfrog hospital safety grade methodology 19 prior to fall of 2024 in that nonparticipating 20 hospitals were being assigned the mean grade of their 21 cohorts for those four measures? 22 MR. MARCUS: Again, you're asking the 23 witness personally? 24 MS. BLAIR: Yeah. 25 A. I'm not aware.
Page 91 1 A. I mean, just personally, there's other 2 certification and awards of quality and validations 3 that you can do where your data is actually being 4 validated, verified. And I just, I don't think that 5 this is a transparent full way of looking at quality 6 and safety. I think there's other organizations that 7 do that better. 8 Q. And when you use the word "transparent," 9 what do you mean when you use that word? 10 A. Telling the whole story and being truthful. 11 Q. And, again, I'm talking about prefall of 12 2024. What about the Leapfrog hospital safety grade 13 was not truthful? 14 A. It still was assigning in some of those 15 measures just an average grade, so it's not giving a 16 full picture of validated performance. 17 Q. And do you understand that prefall of 2024 18 for the four imputed measures, nonparticipating 19 hospitals like Delray were receiving 100 percent for 20 the four measures at issue in this litigation? 21 MR. MARCUS: Object to form. 22 A. That's not what I understand it to be. 23 BY MS. BLAIR: 24 Q. You don't understand that prior to fall of 25 2024 Delray received 100 out of 100 points for CPOE,	Page 93 1 BY MS. BLAIR: 2 Q. Are you aware as the corporate 3 representative for Delray whether that's how the 4 methodology worked prior to fall of 2024? 5 A. Can you repeat that question? 6 Q. Sure. 7 A. That sounds like a different question. 8 Q. Sure. I just, I'm trying to get an 9 understanding of whether you understand the difference 10 between how nonparticipating hospitals were graded 11 prior to the fall 2024 hospital safety grade. 12 So why don't you just tell me, for those 13 four measures, BCMA, CPOE, hand hygiene and what we 14 call IPS or ICU physician staffing, how do you 15 understand nonparticipating hospitals were graded for 16 those four measures prior to fall of 2024? 17 A. From my understanding, they were given an 18 average on -- from the cohort of what was there, not 19 100 percent. 20 Q. Well, do you understand that they were given 21 achievement scores, full achievement scores for those 22 four measures based on the median from their cohorts? 23 MR. MARCUS: Object to form. 24 A. I do understand that. 25 BY MS. BLAIR:

Page 94 1 Q. And if you look, it's 100 out of 100 for 2 achievement for those four measures. 3 MR. MARCUS: Object to form. 4 BY MS. BLAIR: 5 Q. Do you understand that to be the case? 6 A. Again, I need to see the data of what our 7 scores were for that time period. 8 Q. Okay. We'll look at that. 9 So do you have an understanding that for ICU 10 physician staffing prior to fall of 2024, a methodology 11 change had already occurred in 2023 that 12 nonparticipating hospitals would be receiving low 13 achievement for ICU physician staffing? 14 MR. MARCUS: Object to form. 15 A. I don't think I was aware of that. 16 BY MS. BLAIR: 17 Q. And what do you understand the change was 18 between spring of 2024 and fall of 2024 with respect to 19 the hospital safety grade methodology? 20 A. From what I understand, the imputation model 21 where we were not submitting data in those four 22 categories being barcode medication scanning, 23 computerized order entry, ICU physician staffing and 24 hand washing, those were now being assigned the lowest 25 possible score from the cohort if we did not submit	Page 96 1 BY MS. BLAIR: 2 Q. Any other reasons that you can think of? 3 A. Not at this time. 4 Q. Do you know whether or not the decision to 5 stop participating in the Leapfrog Hospital Survey was 6 a directive from Tenet home office? 7 MR. MARCUS: Object to form. 8 A. I'm not aware of it being a directive. 9 MS. BLAIR: What are we on, 4 and 5? 10 THE STENOGRAPHER: This will be 4 and 5, 11 yes. 12 MS. BLAIR: 4 and 5. 13 (Defendant's Exhibit Number 4 for i.d.) 14 (Defendant's Exhibit Number 5 for i.d.) 15 MS. BLAIR: Sorry. Give me one sec. 16 BY MS. BLAIR: 17 Q. I'll start with 5. 18 Ms. Havericak, I have -- I am handing you 19 what we've now marked as Exhibit 5. Do you see this is 20 an email from Satyavani Nukala to Heather Wehmeyer, 21 CC'ing Stephany Johnson on November 4th, 2024? 22 A. Yes, I see that. 23 Q. And if you -- and just for the record if I 24 look at these Bates numbers at the bottom, it's 25 PBHN 11845 through 11849. Is that what you have in
Page 95 1 data; additionally, that those categories when you look 2 at the weighted side end up representing about 3 30 percent of the total score for the Leapfrog grade 4 being assigned. 5 Q. Do you understand that the lowest possible 6 score is the lowest score assigned to a participating 7 hospital? 8 A. Yes. 9 Q. Okay. So not from the cohort, correct? 10 A. From the lowest, yes. 11 Q. And that is the change that we are all here 12 about in this litigation, to your knowledge, correct? 13 MR. MARCUS: Object to form. 14 A. That is the change that we see issue with. 15 BY MS. BLAIR: 16 Q. Do you know why the five plaintiff hospitals 17 stopped participating in the Leapfrog Hospital Survey 18 in or around 2021? 19 MR. MARCUS: Object to form. 20 A. I wasn't here in those years, but from what 21 I've been told, we wanted to use our resources in other 22 areas. That was during COVID when resources were 23 scarce, and we wanted to put our resources in driving 24 our patient safety and quality and not putting those 25 resources directly towards the Leapfrog efforts.	Page 97 1 front of you? 2 A. Yes. 3 Q. And you'll see if we go kind of to the first 4 email, all the way back on 11849, it starts on 11848. 5 This is an email from Satyavani Nukala to several 6 people. Do you see that email? 7 A. I do. 8 Q. And it says, "Good afternoon. The fall 2024 9 safety embargo period started today." 10 Who is Satyavani Nukala? "Nukala." 11 A. It appears she's a biostatistician of 12 clinical operations. I haven't worked with her. 13 Q. Okay. And she is in what we're calling the 14 Tenet Healthcare home office; is that correct? 15 A. She appears to be in the Dallas office, yes. 16 Q. Did you have an understanding in or 17 around -- well, do you have an understanding that Tenet 18 home office asked all of the hospitals in its system to 19 report their health -- their Leapfrog hospital safety 20 grades during the embargo period at each grading 21 period? 22 MR. MARCUS: Object to form. 23 A. Can you repeat that? I'm sorry. 24 BY MS. BLAIR: 25 Q. Sure. I've just seen a number of emails in

Page 98 1 this litigation, and this is not the only one, where 2 someone from home office is saying, Good afternoon. 3 You know, the safety grade embargo period started 4 today. Please review your score and letter grade and 5 share it with me. 6 Do you see how she's asking that? 7 A. I do. 8 Q. Is that something that Tenet home office 9 does regularly, asks the hospitals to share their 10 Leapfrog score with home office? 11 MR. MARCUS: Object to form. 12 A. I'm not sure because I'm not on this email 13 and would naturally be a thread in this email. I'm not 14 sure. I don't have knowledge of that. 15 BY MS. BLAIR: 16 Q. Do you have knowledge, not with this email 17 specifically but just in your role as the president of 18 Tenet Healthcare that home office asks the hospitals to 19 run their Leapfrog grade every grading period and 20 report it back to them? 21 MR. MARCUS: Object to form. 22 A. I'm not aware that home office does ask them 23 to do that. 24 BY MS. BLAIR: 25 Q. Okay. And you'll see here there's like a	Page 100 1 Q. And if we look at 11845, which is where I 2 was trying to get to when I started this, Heather says 3 to Satyavani, "It is because we have not been 4 participating in Leapfrog per Tenet corporate's 5 instruction." 6 Do you see that? 7 A. I see that. 8 Q. Does that refresh your recollection that, in 9 fact, the reason that the hospital stopped 10 participating, at least one of them, was at the 11 direction of corporate? 12 MR. MARCUS: Object to form. 13 A. It doesn't. This is an email from 14 Heather Wehmeyer, and I wouldn't know who gave her that 15 direction because I've never been given that direction 16 personally. 17 BY MS. BLAIR: 18 Q. And we'll look at what we're going to mark 19 as Exhibit 4 or I've already marked as Exhibit 4. And, 20 for the record, this is PBHN 2072 through 2075. 21 A. Yes. 22 Q. And I want to focus on the second email on 23 the first page here, which is from you to 24 Stephany Johnson and Jennifer Shoemaker as well as 25 Nicole Jackson. Do you see that like about in the
Page 99 1 follow-up if we look at page 11847. This Mr. or 2 Mrs. Nukala is asking Stephany for an update. "Please 3 share the Leapfrog fall 2024 score and grade," correct? 4 MR. MARCUS: Object to form. 5 A. So it looks like on 887 -- or I'm sorry -- 6 47 and 48, yes, it looks like there's a transition 7 between Heather and Stephany and she's asking her to 8 send the grade. 9 BY MS. BLAIR: 10 Q. And that was going to be my question. Is 11 this the transition in them in the role as quality 12 director for Delray? 13 A. It appears to be during that time frame. 14 Q. And then if we look at 11846, Heather is 15 updating home office that the Delray grade is going to 16 be an F, correct? 17 MR. MARCUS: Object to form. 18 A. It appears she sent an email to Bonnie that 19 the score is going to be an F for Delray. 20 BY MS. BLAIR: 21 Q. Okay. And then the email at the top of 22 11846 is "Thank you, Heather. I wonder why Delray's 23 grade is depriving year by year." 24 Do you see that email? 25 A. I do.	Page 101 1 middle of the page? 2 A. I do. 3 Q. Who is Nicole Jackson? 4 A. My associate chief nursing officer. 5 Q. Okay. And you say, "This is unfortunate 6 because the public still looks at this. Does the PR 7 team have something prepared that talks about not 8 participating in this?" 9 Do you see that? 10 A. I do. 11 Q. Okay. And that is in response to, if we go 12 to 2073, Stephany Johnson's email to you dated 13 November 4, 2024 where she says, the Leapfrog score for 14 Delray has fallen from a D reported in the spring 2024 15 to an F. All scores across the market have fallen as 16 we were instructed by corporate to not participate in 17 data submission for the rating." 18 Do you see that? 19 A. I do. 20 Q. Does that refresh your recollection that, in 21 fact, the hospitals were instructed by corporate to not 22 participate in data submission for rating? 23 MR. MARCUS: Object to form. 24 A. I mean, I see it here, but, again, I have 25 not been told by corporate not to participate in

Page 102 1 Leapfrog. So I get a lot of emails every day. I 2 don't... 3 BY MS. BLAIR: 4 Q. Okay. And you don't recall, and you've not 5 in preparing for your deposition today, you've not come 6 to the conclusion that part of the reason that at least 7 the five hospitals that are plaintiffs in this 8 litigation stopped participating in the Leapfrog survey 9 because it was a directive from corporate? 10 MR. MARCUS: Object to form. 11 A. Again, I haven't been given that directive 12 from corporate. 13 BY MS. BLAIR: 14 Q. Still to this day you have not? 15 A. I have not. 16 Q. Are you aware of any emails from corporate 17 that advised at least the five plaintiff hospitals in 18 this litigation that participation in Leapfrog would 19 not be supported unless it was tied to a local 20 requirement, contract compliance or reimbursement? 21 MR. MARCUS: Object to form. 22 A. I don't recall seeing that email. 23 BY MS. BLAIR: 24 Q. Were you the president of Delray in or 25 around September 27th of 2024?	Page 104 1 decision that its resources would be better utilized in 2 patient care and patient safety and not in complying 3 with or participating in, excuse me, the Leapfrog 4 Hospital Survey? 5 MR. MARCUS: Object to form. 6 A. That is correct. 7 BY MS. BLAIR: 8 Q. Do you know whether or not there was any 9 objection by Delray executive staff in or around 2021 10 about staffing participation in the Leapfrog hospital 11 safety grade? 12 MR. MARCUS: Object to form. 13 A. I don't have knowledge of that. You're 14 talking about 2021. I wasn't there. 15 BY MS. BLAIR: 16 Q. Have you had any discussions with your 17 board, your governing board regarding Delray's decision 18 to stop participating in the Leapfrog Hospital Survey? 19 A. I did. 20 Q. And when were those discussions? 21 A. I believe, but without looking at minutes, I 22 can't be certain, I believe they were around the time 23 it would have been, I think, November of '24, 24 December '24 where we talked about those letter grades 25 coming out and that we would not -- we were not
Page 103 1 A. Yes. 2 Q. Who is Anna Gunod? 3 A. She is the infection prevention lead in the 4 home office. 5 Q. I don't have a copy of this, but I'll get 6 one later. 7 So it's your understanding -- is it your 8 understanding that the decision for the five plaintiff 9 hospitals to stop participation in the 10 Leapfrog Hospital Survey was the decision of the five 11 hospitals without any input from Tenet corporate? 12 MR. MARCUS: Object to form. 13 A. Again, I wasn't here when those decisions 14 were made, so I don't know every single person that was 15 involved in that. From what I have been told 16 secondhand is that it was during the time in transition 17 of COVID and that we were going to use our efforts to 18 improve our patient safety and quality and focus on our 19 other accreditations, and that's the information that I 20 have. 21 BY MS. BLAIR: 22 Q. And as the corporate representative of 23 Delray, is it the answer of Delray that the reason 24 Delray stopped participating in the Leapfrog Hospital 25 Survey in 2021 was because Delray itself made the	Page 105 1 participating. 2 Q. And what was the reaction from the board 3 about the letter grades? 4 A. They were concerned. Again, they asked a 5 lot of questions. And we took time to go through how 6 the scores are calculated, what the measures are and 7 then really talking about what our performance and 8 quality and safety looked like. 9 But they needed to be equipped with the 10 right information so they didn't just have the 11 deceptive information that they were seeing with an F 12 and what went into that F and what it meant because it 13 could be confusing for them when they're seeing, you 14 know, data that's happening right now that looks very 15 different than that. 16 Q. And do you recall what you told the board 17 about what goes into the safety grade? 18 A. Yeah, we went through the self-reported 19 measures; we went through the CMS star rating measures 20 and just kind of talked through all of those pieces. 21 Q. Did your board come to a consensus that the 22 right decision was to for the participate in the 23 hospital -- the Leapfrog Hospital Survey? 24 MR. MARCUS: Object to form. 25 A. I don't know that they came to a consensus.

Page 106 1 BY MS. BLAIR: 2 Q. Was there a vote by your board about whether 3 or not Delray should participate in the Leapfrog 4 Hospital Survey? 5 A. There was not a vote. 6 Q. Do you know whether or not you told the 7 board that home office would not allow participation in 8 the Leapfrog Hospital Survey unless it was directly 9 tied to payment -- 10 MR. MARCUS: Object to form. 11 BY MS. BLAIR: 12 Q. -- or accreditation? 13 A. I don't remember saying that. 14 Q. Was there any discussion at the board level 15 about attempting to increase the Leapfrog hospital 16 safety grade for Delray by means other than 17 participating in the Leapfrog Hospital Survey? 18 A. We talked about enhancing our ratings, our 19 CMS ratings and some of the safety initiatives that go 20 along with that, so our hospital-acquired infections, 21 our patient experience, those are the things that we 22 talked about. 23 Q. And do you understand that there are 24 hospitals -- well, strike that. 25 Do you understand that Leapfrog grades	Page 108 1 not. 2 Q. You've never undertaken that analysis; is 3 that correct? 4 A. I have not. 5 Q. Do you know if any of the experts that 6 you've hired in this litigation have ever undertaken 7 that analysis? 8 MR. MARCUS: Object to form. 9 A. I don't know what they've done. 10 BY MS. BLAIR: 11 Q. Would you agree with statements that have 12 been made in this case that if you don't participate in 13 post fall of 2024, if you don't participate in the 14 Leapfrog Hospital Survey, you automatically receive a 15 failing grade? 16 A. Yes, I agree with that. 17 Q. So it is your position as the corporate 18 representative of Delray that if a hospital does not 19 participate in the Leapfrog Hospital Survey, they 20 receive an F? 21 MR. MARCUS: Object to form. 22 A. They have the potential to receive an F, 23 yes. 24 BY MS. BLAIR: 25 Q. Would you agree with me that any hospital
Page 107 1 approximately 2,800 acute care hospitals across the 2 United States? 3 A. Yes. 4 Q. Do you understand that 80 percent of those 5 hospitals participate in the Leapfrog Hospital Survey? 6 MR. MARCUS: Object to form. 7 A. I don't know the numbers of who participates 8 and who doesn't. 9 BY MS. BLAIR: 10 Q. That's fair. 11 Do you have -- do you know that there are 12 hospitals that do not participate in the Leapfrog 13 Hospital Survey that receive A's? 14 A. I've never seen that. 15 Q. But you are aware that there are hospitals 16 that do participate in the Leapfrog Hospital Survey 17 that, for example, receive D's, like Broward did, 18 correct? 19 A. I'm aware of that before the imputation 20 model changed, yes. 21 Q. Are you aware that there are hospitals after 22 the imputation changed that received D's even though 23 they participate in the Leapfrog Hospital Survey? 24 A. Again, I would have to see all the hospitals 25 and what their scores are and if they participate or	Page 109 1 whether they participate or not, has the potential to 2 receive an F? 3 A. Not necessarily. 4 Q. What does that mean, "not necessarily"? 5 A. It depends on what the rest of their data 6 looks like. 7 Q. Correct. 8 A. But you are going to receive an F post with 9 that imputation model if 30 percent of your scores are 10 getting assigned to the lowest number that's available 11 from the submitting hospitals. Like there's just 12 mathematically no way to overcome that with 30 to 13 33 percent of the score being a failing grade. 14 So, yes, I think if you do not participate, 15 you are going to get a failing grade. And that is 16 my... 17 BY MS. BLAIR: 18 Q. Okay. Do you know how long it takes to fill 19 out the hospital survey? I'm sorry. The Leapfrog 20 Hospital Survey? 21 A. Yes, it's very laborious because it's not 22 just about filling out the survey, but it's about 23 validating your data and ensuring it's accurate. And 24 then it takes all the time on the units doing all of 25 the hand hygiene surveillance, making sure you're

Page 110 1 validating all of those pieces. It can take upwards of 2 probably a good thousand hours to be able to do all of 3 those things appropriately. 4 Q. And so when you were the CEO of Broward, did 5 it take about a thousand hours a year to engage in the 6 Leapfrog survey? 7 A. It's about that. 8 Q. Have you -- 9 A. There's teams of people that have to devote 10 time to that. 11 Q. Have you seen studies that suggest it's 12 40 to 80 hours a year to conduct and finalize the 13 Leapfrog hospital survey? 14 MR. MARCUS: Object to form. 15 A. I have not. 16 BY MS. BLAIR: 17 Q. Are you aware that your lawyers have taken 18 the position in this litigation that it takes between 19 40 and 80 hours a year to complete the Leapfrog 20 Hospital Survey? 21 MR. MARCUS: Object to form. 22 A. I am not. 23 BY MS. BLAIR: 24 Q. Do you know how many FTE's need to be 25 assigned to complete the Leapfrog Hospital Survey in a	Page 112 1 they participated in the Leapfrog Hospital Survey? 2 A. No. 3 Q. Do you have any understanding of what the 4 budget was at Delray in 2020 to comply with the 5 Leapfrog Hospital Survey in 2020? 6 A. I don't. I'm sorry. 7 MR. MARCUS: Could we go off the record for 8 just one second? 9 THE VIDEOGRAPHER: The time is 11:48 a.m. 10 We're going off the record. 11 (A recess was taken from 11:37 a.m. to 11:39 a.m.) 12 THE VIDEOGRAPHER: The time is 11:39 a.m. 13 We're back on the record. 14 BY MS. BLAIR: 15 Q. And my follow-up question, Ms. Havericak, 16 was, do you know in the last year that Delray 17 participated in the Leapfrog Hospital Survey in 2020 18 how many FTE hours they committed to complying with the 19 Leapfrog Hospital Survey? 20 A. I'm not aware. 21 Q. And I want to start -- I want to talk just 22 about 2023 before we get to 2024 when all of the things 23 happened. 24 Do you know whether or not Delray was 25 monitoring CPOE in 2023?
Page 111 1 year? 2 A. Again, it's not just about completing the 3 survey. It's all the things that go along with the 4 survey. So in my judgment, it would be about a half of 5 an FTE. 6 Q. A year? 7 A. Yes. 8 Q. And that's about a thousand hours? 9 A. Um-hum. 10 Q. Do you know how many hours your staff has 11 spent to date in connection with this lawsuit? 12 A. I do not. 13 MR. MARCUS: Object to form. 14 BY MS. BLAIR: 15 Q. Do you know whether or not the cessation of 16 hospitals participating in the Leapfrog Hospital Survey 17 coincided with Saum Sutaria -- if I'm saying his name 18 right -- of becoming the CEO of Tenet Healthcare at 19 large? 20 MR. MARCUS: Object to form. 21 A. I'm not aware of that. 22 BY MS. BLAIR: 23 Q. Do you have any understanding of how 24 compliance with the Leapfrog Hospital Survey was 25 handled by Delray in 2020, which was the last year that	Page 113 1 A. Again, I wasn't there in 2023 so I don't 2 know what they were monitoring. 3 Q. And, for the record, do you know what I 4 mean, by CPOE? 5 A. Yes, computerized order entry. 6 Q. Okay. And can you just describe briefly 7 what computerized physician order entry is? 8 A. That's where the physicians are 9 electronically entering their order into our medical 10 records, which Cerner. You want to make sure that 11 they're entering those orders from a patient safety 12 perspective and that you're really limiting telephone 13 orders that are going in where a nurse or allied health 14 professional would be entering those orders for them. 15 Q. And you have a CPOE policy in place at 16 Delray, correct? 17 A. We do. 18 Q. Do you know if there was one in place in 19 2023? 20 A. I wasn't here in '23, but I -- from what I 21 understand in looking at our policy, it looks like it 22 was in place at that time. 23 Q. So that would be a "yes" to 2024 as well? 24 A. Yes. Yes. 25 Q. Okay. Do you know how -- and do you know

Page 114 1 how Delray was monitoring CPOE compliance prior to, 2 well, let's just say, in 2023? 3 A. I don't know how they were monitoring it in 4 '23. 5 Q. What about in '24, do you know how they were 6 monitoring CPOE compliance in 2024? 7 A. When I came, we are monitoring it through 8 the monthly meetings with all of our hospitalists. 9 That's the largest group of patients that admits 10 patients into the hospital. So on a monthly basis 11 we're pulling their CPOE compliance by provider. And 12 that's shared with the providers in a monthly meeting 13 just to ensure that they're meeting the thresholds and 14 then understanding if people are below the threshold 15 what we need to do, do they need more training, do they 16 understand how to put in the orders, do they understand 17 the CPOE policy. 18 So that's how that is monitored. 19 Q. Okay. And when you say "provider" for this 20 record, that's a physician? 21 A. Physician, yes. 22 Q. Because sometimes we say "health care 23 providers." So we're talking about physicians, 24 correct? 25 A. Physicians.	Page 116 1 A. We put those in place at the organization. 2 Q. And is that at the Palm Beach Health Network 3 level? 4 A. We all have the same within our policies. 5 Q. And do you know what the threshold is? Is 6 it a percentage? 7 A. Yeah, it's a percentage. So CPOE 8 compliance, we like the physicians to be 90 percent or 9 greater, and then barcode medication scanning, I 10 believe, is 85 or 90. I don't remember off the top of 11 my head. 12 Q. And in -- let's talk about hand hygiene. In 13 2023, do you know how Delray was monitoring hand 14 hygiene? 15 A. I do not. 16 Q. What about in 2024? 17 A. Yes. 18 Q. How was Delray monitoring hand hygiene in 19 2024? 20 A. So there are -- were unit-based tracers that 21 are done that the managers are responsible for 22 submitting to the infection control department every 23 month, and then those are shared in the infection 24 control committee and then in the quality committee. 25 We have increased those observations just
Page 115 1 Q. Do you know in 2023 whether Delray was 2 monitoring barcode medication compliance? 3 A. Again, I don't know what they were doing in 4 '23. 5 Q. What about in '24, do you know what they 6 were doing in '24? 7 A. Yes, our chief nursing officer in 8 collaboration with the directors in each of the units 9 and the divisions are looking at the barcode medication 10 scanning on a monthly basis. And then, again, if 11 there's fallouts, doing interventions to understand why 12 there's fallouts, were there issues with the computers 13 or the tools and equipment or was there user error, 14 people not following policy and procedure. 15 Q. And prior to fall of 2024 how would you 16 describe Delray's compliance with BCMA procedures? 17 A. It's excellent. 18 Q. And same question with respect to CPOE -- 19 how would you describe prior to fall of 2024, how would 20 you describe Delray's compliance with CPOE, compliance 21 with CPOE? 22 A. Correct. We're excellent, too. We're 23 meeting the thresholds. 24 Q. And when you say "we're meeting the 25 thresholds," who puts into place those thresholds?	Page 117 1 based on some of the data we were seeing. 2 Nationally you see that hand hygiene when 3 you look at the Journal of the American Medical 4 Association, you see, you know, when you're looking at 5 self-reported measures, we need to make sure people are 6 validating. So there are actually tracers that are 7 going on in all of the units when people don't know 8 they're being watched for hand hygiene, so, you know, 9 we're performing well there and identifying where the 10 gaps are. 11 So, you know, in some trends when we look at 12 the data we see, for example, maybe the food and 13 nutritional services folks that are delivering trays 14 aren't using hand hygiene every time, we're able to go 15 then and do tailored education to them, teach them 16 about hand hygiene and why it's important, and then 17 we'll do extra tracers on those units that aren't 18 meeting the targets. 19 MR. MARCUS: And, Kim, I don't want to 20 interrupt, but just we'll have a standing 21 objection if you -- to the phrasing that, "do 22 you understand your lawyers are taking 23 positions?" 24 MS. BLAIR: Oh, sure. 25 MR. MARCUS: You said that a couple times.

Page 118 1 MS. BLAIR: Yeah. Twice. I just said it 2 twice. 3 MR. MARCUS: All right. 4 MS. BLAIR: That's all right. 5 MR. MARCUS: We object to that. 6 BY MS. BLAIR: 7 Q. Ms. Havericak, when you use the word 8 "tracers," what does that mean? 9 A. It's going out and validating in realtime 10 when our clinicians are in practice, you know, what 11 they're doing. So for hand hygiene tracers we have a 12 hand hygiene tool that they look at when they're 13 tracing to see when the -- if it's a physician, if it's 14 a nurse, any bedside care provider that goes into the 15 room, are they washing their hands before they're going 16 in, after they're caring for the patient are they 17 washing their hand. We want to make sure that all of 18 those moments of hand hygiene are met. 19 Q. So is it like -- I'm sorry for -- 20 A. It's a form. 21 Q. Oh, it's a form. 22 A. It's a form that they fill out, and then we 23 just calculate the totals and the data from all of 24 those different tracer forms. 25 Q. Okay.	Page 120 1 monitoring the Leapfrog measures for all four of these 2 CPOE, BCMA hand hygiene and ICU physician staffing even 3 though it wasn't participating in the hospital survey? 4 MR. MARCUS: Object to form. 5 A. We were monitoring. You don't need to 6 monitor the ICU staffing because we have a contract in 7 place, so that wouldn't change from month to month, but 8 there are processes to monitor all three of the other 9 self-reported measures, yes. 10 MS. BLAIR: Okay. Can you mark this as 11 Exhibit 6. 12 (Defendant's Exhibit Number 6 for i.d.) 13 BY MS. BLAIR: 14 Q. I marked this as Exhibit 6. And that 15 handwritten 5 at the bottom comes from someone else's 16 deposition. 17 Ms. Havericak, I've now handed you what 18 we've marked as Exhibit 6 to your deposition, which, if 19 you look, it is entitled the Leapfrog Hospital Survey 20 Hard Copy." 21 Do you see that? 22 A. Yes. 23 Q. Have you ever seen this document before? 24 A. Yes. 25 Q. And when is the last time you saw this
Page 119 1 A. Different people are doing them at different 2 times so we can capture an accurate reflection of our 3 practices. 4 Q. Okay. So it's not electronic in some way? 5 A. No, it eventually all goes into an 6 electronic form, but they're paper form so that we can 7 have access for everyone. 8 Q. Okay. And then ICU physician staffing, do 9 you have a -- I know your interrogatory answers say you 10 have 24/7 ICU physician staffing, correct? 11 A. We do. 12 Q. And that is -- is that like pursuant to a 13 contract? 14 A. So we have two different contracts. Our 15 trauma patients are covered under the trauma contract 16 for trauma ICU, and then our cardiac ICU and neuro ICU 17 is under another contract for our intensivists so 18 they're staffed 24/7 on site. 19 Q. Is that both physicians and nurses? 20 A. So they, the trauma contract is all just 21 physicians. The other ICU contract outside of trauma 22 has physicians and then allied health professionals 23 which could be a physician assistant or an advanced 24 registered nurse practitioner. 25 Q. Do you know whether in 2024 Delray was	Page 121 1 document? 2 A. I don't recall exactly what date it was. 3 Q. Was it while you've been a CEO at Delray? 4 A. Yes. 5 Q. And for what purpose did you review this 6 document? 7 MR. MARCUS: Object to form. 8 A. I reviewed it in the case that we would 9 potentially be going back to Leapfrog reporting. I 10 wanted to understand all the measures. 11 MR. MARCUS: Kim, is there a Bates number 12 for this Exhibit? 13 MS. BLAIR: No, you used it as Exhibit 5 to 14 Karen Jupiter's deposition. I just took it from 15 what you used. 16 MR. MARCUS: Okay. 17 MS. BLAIR: I think they printed it from the 18 website, which is why it doesn't have a Bates 19 number. 20 BY MS. BLAIR: 21 Q. And so, Ms. Havericak, when you tell me 22 that -- 23 Are you okay? You want to take a break? 24 A. Yeah, I'm okay. 25 Q. I'm sorry.

Page 122 1 When you tell me that you looked at it in 2 case the hospital would go back to the Leapfrog 3 hospital's -- 4 I'm sorry. Strike all of that. 5 When you tell me that you looked at it 6 because Delray was considering potentially restarting 7 its participation in the Leapfrog Hospital Survey, was 8 that after the fall of 2024 safety grade had been 9 published? 10 A. It was. 11 Q. And did you specifically -- well, strike 12 that. 13 Do you understand that this document which 14 we've now marked as Exhibit 6 is about 350 pages long, 15 I think? 16 A. Yeah, it appears to be 353. 17 Q. And do you understand that this survey 18 contains many different areas of questions, not all of 19 which go into the hospital safety grade? 20 A. Yes, I understand that. 21 Q. And do you understand that a hospital 22 completing this survey can still complete the survey 23 without completing all nine sections of the survey? 24 MR. MARCUS: Object to form. 25 A. Yes, I understand that.	Page 124 1 are an adult or general hospital, use the take CPOE 2 tool button on the survey dashboard to access the CPOE 3 evaluation tool." 4 Do you see that? 5 MR. SIMMONS: Object to form. 6 A. I see that. 7 BY MS. BLAIR: 8 Q. Do you have any understanding what the 9 CPOE evaluation tool is in the Leapfrog Hospital 10 Survey? 11 MR. MARCUS: Object to form. 12 A. I mean, I'm not an expert in the CPOE tool, 13 no. 14 BY MS. BLAIR: 15 Q. Okay. Do you understand that there's there 16 is a specific and proprietary test that Leapfrog has 17 for hospitals to test whether or not their CPOE system 18 is accurate? 19 MR. MARCUS: Object to form. 20 A. I am aware of that. 21 BY MS. BLAIR: 22 Q. And when Delray was providing documents in 23 this litigation sufficient to simulate, do you know 24 whether or not Delray undertook the CPOE evaluation 25 tool to make a determination as to what its score would
Page 123 1 BY MS. BLAIR: 2 Q. And if we look specifically at the four 3 measures that are at issue in this litigation, I would 4 direct your attention to page 57, which is Section 2 5 Medication Safety. 6 Are you there? 7 A. Um-hum. 8 Q. And if we look at page, for example, 59, 9 which is 2A, "Computerized Physician Order Entry," 10 CPOE, is that the CPOE standard that we've been 11 discussing in this deposition that is one of the 12 measures that you understand to be part of the Leapfrog 13 hospital safety grade? 14 MR. MARCUS: Object to form. 15 A. Yes. 16 BY MS. BLAIR: 17 Q. Okay. And if we go to page 69 of this 18 document, do you see where it says, Section 2, 19 "Medication Safety Reference Information. What's new 20 in the 2025 survey and the CPOE evaluation tool." 21 Do you see that section? 22 A. I see that section. 23 Q. And if we juxtapose of that page 59, I 24 apologize, that we were just on, at the very bottom of 25 page 59, it says, "If yes to question number 2 and you	Page 125 1 have been in the fall of 2024 had it participated in 2 the survey? 3 MR. MARCUS: Object to form. 4 A. I'm not sure if they used that. 5 BY MS. BLAIR: 6 Q. Do you know whether they could have used it? 7 MR. MARCUS: Same objection. 8 A. I'm not sure. 9 BY MS. BLAIR: 10 Q. In putting together documents in this 11 litigation sufficient to simulate -- not my word -- 12 sufficient to simulate, did Delray fill out this 13 portion of the Leapfrog survey to make a determination 14 as to what its score would have been for CPOE in the 15 fall of 2024? 16 MR. MARCUS: Object to form. 17 A. From the simulated one at Delray, I do 18 believe they inputted the score that would be there. 19 BY MS. BLAIR: 20 Q. Okay. And do you know how they got to what 21 the score would be? 22 A. I'm not sure how they got there. The 23 quality team did that. 24 Q. Do you know whether there are any documents 25 that were generated from the quality team doing that

Page 126 1 sufficient to simulate that were produced in this 2 litigation? 3 MR. MARCUS: Object to form. 4 A. I haven't seen those documents. 5 BY MS. BLAIR: 6 Q. And don't put that away. 7 A. Okay. 8 MS. BLAIR: Can you mark this as ?? 9 (Defendant's Exhibit Number 7 for i.d.) 10 BY MS. BLAIR: 11 Q. Ms. Havericak, I am now handing you what 12 we've marked as Exhibit 7 in this litigation. And this 13 is Bates labeled PBHN 10582 through 10590. 14 Have you seen this document before? 15 A. I have seen this. 16 Q. And can you just briefly describe what this 17 document is? 18 A. This is the medication administration policy 19 for Delray Medical Center. 20 Q. Would this include -- does medication 21 administration include CPOE? 22 A. I'd have to read through it to tell you. 23 Q. Okay. 24 A. Okay. What was your question again? I 25 apologize.	Page 128 1 in any way from the document that we've now marked as 2 Exhibit Number 7? 3 A. The rules and regs and bylaws will look 4 different, but they would have the same meaning and the 5 same interpretation -- 6 Q. Okay. 7 A. -- as it relates to computerized order 8 entry. 9 Q. So I'm going to ask it just another way so I 10 make sure I understand. 11 There's nothing in these bylaws and rules 12 that would not otherwise be contained in this document 13 that we marked as Exhibit 7 as it relates to CPOE or 14 BCMA? 15 MR. MARCUS: Object to form. 16 A. Well, CPOE would have -- it would be in 17 rules and regs. Like barcode medication scanning is 18 more of a nursing piece in the hospital. That wouldn't 19 be incorporated into rules and regs. 20 BY MS. BLAIR: 21 Q. Okay. 22 A. Just the CPOE part would. 23 Q. Excellent. Thank you. 24 And so, sorry, to ask it a different way, in 25 order to get a full understanding of Delray's CPOE
Page 127 1 Q. As I read this document that we've marked as 2 Exhibit 7, it appears to include what I would consider, 3 but I want to know your view, both CPOE and BCMA 4 requirements. Is that an accurate reflection of this 5 document? 6 A. It has components of both of those in here. 7 Q. Are there any other documents at Delray that 8 govern the policies and procedures for CPOE at Delray? 9 A. The rules and regs and the bylaws would have 10 information. 11 Q. The Delray bylaws? 12 A. The Delray rules and regs. 13 Q. So the Delray rules and regulations -- 14 A. Um-hum. 15 Q. -- have specific information related to 16 CPOE? 17 A. They would have information about order 18 entry for physicians. 19 Q. Do you know whether or not the Delray rules 20 and bylaws have been produced in this litigation? 21 MR. MARCUS: Object to form. 22 A. I don't know if they've been produced. 23 BY MS. BLAIR: 24 Q. Do you know if the Delray rules and bylaws 25 that contain information related to CPOE or BCMA differ	Page 129 1 policies and procedures, I don't need to also look at 2 the bylaws and regulations; is that a fair statement? 3 A. That's a fair statement. 4 Q. Would you -- 5 Okay. So I've gotten myself lost. 6 So we agree that this covers both CPOE and 7 BCMA? 8 A. It does. 9 Q. Okay. Are there any other documents I 10 should be aware of that Delray has with respect to BCMA 11 compliance that are not otherwise contained in 12 Exhibit 7? 13 MR. MARCUS: Object to form. 14 A. Yes, this is just the policy, the 15 compliance. If you're looking for the data from the 16 compliance, you would need reports on BC, barcode 17 medication scanning. 18 BY MS. BLAIR: 19 Q. Okay. And those barcode compliance reports 20 exist in what form? 21 A. Our chief nursing officer and the unit 22 directors have those. They pull those on a monthly 23 basis. 24 Q. Is that part of the QIPSC reporting? 25 A. They do report that off their QIPSC.

Page 130 1 Q. Is there a compliance -- are there 2 compliance reports with respect to CPOE? 3 A. At those monthly hospitalists meetings. So 4 I have two groups of hospitalists, and we go over those 5 on a monthly basis, and those are embedded in the 6 monthly reports. 7 Q. And what is entailed in a CPOE compliance 8 report? 9 A. So it's just for that it's in a slide deck 10 for those meetings and those presentations, so there's 11 different elements that we look at from a quality and 12 safety perspective for each provider within the 13 hospitalist group. 14 So for CPOE, it's all based on just their 15 name and what their actual compliance is for their 16 overall CPOE for that given month. And we look at it 17 month over month. 18 Q. Okay. Does Delray ever perform any testing 19 on its CPOE system to make sure it's operating in the 20 way in which it should? 21 A. I don't have all that knowledge, but we have 22 teams of people that work on that. We have clinical 23 informatics and our pharmacy teams that may do that 24 that I'm not aware of. 25 Q. So have you ever seen any documents that	Page 132 1 A. Can you repeat that question one more time? 2 I'm sorry. 3 BY MS. BLAIR: 4 Q. Sure. 5 Have you ever done a comparison of your -- 6 sorry -- of Exhibit 7, which is the policies and 7 procedures for medication administration at Delray with 8 the questions and requirements on the Leapfrog Hospital 9 Survey for CPOE and BCMA? 10 MR. MARCUS: Object to form. 11 A. I have not. 12 BY MS. BLAIR: 13 Q. If we could turn in Exhibit 6 to page 219, 14 do you see that 219 is Section "6C: Hand Hygiene"? 15 A. Yes, that's what I have on 219. 16 Q. Perfect. And when you were describing 17 earlier that in or around November or December of 2024 18 when you were reviewing Exhibit 6, because there might 19 be the possibility that Delray would go back to 20 participating in the Leapfrog hospital survey, did you 21 review the hand hygiene standard in the Leapfrog 22 Hospital Survey? 23 A. I do remember vaguely going over that. 24 Q. And for purposes of my record, it looks like 25 the hand hygiene survey questions go from 219 through
Page 131 1 show that testing is done on the CPOE system to make 2 sure it's functioning properly? 3 A. I haven't personally seen those documents. 4 Q. And if I wanted to get those documents, I 5 would need to ask clinical informatics? 6 A. Clinical informatics is where I think those 7 would come from, yes. 8 Q. And would you agree with me that both CPOE 9 and BCMA are important to patient safety? 10 A. They are both important to patient safety, 11 yes. 12 Q. In preparing for this litigation, did you 13 have the occasion to compare Exhibit Number 7 against 14 the questions and requirements in the Leapfrog Hospital 15 Survey that we've marked as Exhibit 6? 16 MR. MARCUS: Object to form. 17 Have you produced Exhibit 6 in the 18 litigation? 19 MS. BLAIR: Yes. 20 MR. MARCUS: But you don't know the Bates 21 number? 22 MS. BLAIR: I don't, no. I just use the 23 Exhibits. I'm traveling between places so... 24 MR. MARCUS: No, it's okay. I'm just 25 asking.	Page 133 1 224. Is that your view of this as well? 2 A. Yes. 3 Q. And is it your position as the CEO of Delray 4 that complying with the Leapfrog hand hygiene -- the 5 questions for hand hygiene on the Leapfrog Hospital 6 Survey is onerous? 7 MR. MARCUS: Object to form. 8 A. I do believe the way in which they have it 9 set up looks onerous, but hand hygiene is the most 10 important thing we can do to prevent patient safety 11 issues, so we just developed a tool appropriately for 12 us at Delray. 13 MS. BLAIR: And I'll mark this as Exhibit 8, 14 and it is a group Exhibit. 15 (Defendant's Exhibit Number 8 for i.d.) 16 BY MS. BLAIR: 17 Q. Ms. Havericak, I am now handing you what's 18 been marked as group Exhibit 8. And I'll submit to you 19 that it is PB -- the Bates numbers are PBHN 10530 to 20 10547, and then there is an extra page at the end which 21 is PBHN 10735. 22 Do you have that? 23 A. Um-hum. 24 Q. Can you briefly describe for the record what 25 this document or group Exhibit is?

Page 134 1 A. It's the infection prevention and control 2 hand hygiene policy. 3 Q. And that last document in this group 4 Exhibit, what is that? 5 A. That's the hand hygiene tracer observation 6 tool. 7 Q. And I think you testified earlier -- but 8 correct me if I'm wrong -- these are the documents that 9 are filled out regularly by staff with respect to hand 10 hygiene, correct? 11 A. These are the tracer observation tools used 12 by staff and leaders to do hand hygiene observations. 13 Q. So are they like hanging in a room and 14 people just fill them out or how does it work? 15 A. No, we have them in each of the units, so we 16 have them in little binders and folders so they have 17 them. And then they have a certain amount of these 18 that they have to do every month, and they have to be 19 turned in by a certain time. 20 Q. Okay. And so -- I just don't understand how 21 it works so I apologize for these questions. 22 But so is there like, I'm watching Kevin 23 wash his hands and I denote Kevin washed hands? Like 24 who is validating? 25 A. Yeah so, for example, if I was the manager	Page 136 1 therapy and occupational therapy may be coming into the 2 units. We need to make sure they're doing hand 3 hygiene. So that's why you have a legend of all the 4 different specialties that work in the hospital. 5 Q. So do -- thank you for that. 6 A. Um-hum. 7 Q. And so do they write like a "yes" or "no"? 8 A. They write a "yes" or "no," and then they 9 usually have some like additional notes on the side 10 that we're able to then compile because then this all 11 gets turned into the infection prevention manager, and 12 she compiles all the data by department. So these are 13 all turned in by department so we can see the trends 14 throughout the hospital. 15 Q. Okay. So just so I know what it should 16 looked at filled out -- 17 A. Yeah. 18 Q. -- if I'm watching and I see a nurse, so 19 let's just take column one, washing their hands, do I 20 put a check mark under nurse in row one and then I 21 write "yes" over -- 22 A. That's exactly what you would do. 23 Q. Okay. 24 A. And that would show compliance. 25 Q. Okay. And these get turned into a report
Page 135 1 on the unit, and I'm in the intensive care unit, and I 2 see the doctors rounding and the nurses rounding, I'll 3 go through and just be watching people as they go. 4 So, say, Kevin is a registered nurse, I'd 5 mark that he was a registered nurse and then what he 6 did with hand hygiene, did he do the hand hygiene; did 7 he not do the hand hygiene. 8 And then in addition to that, if there was 9 an opportunity where you didn't see hand hygiene, you 10 would politely stop them and give them realtime 11 education so that they knew to do the hand hygiene, so 12 you stop it in the chain when it's happening. 13 Q. Got it. And so like what would be put into 14 these little boxes on each of these columns? 15 A. So this is just telling you what kind of 16 workforce member is so that you can get data trends on 17 all the different disciplines because we want to look 18 at hand hygiene across the whole spectrum of all the 19 different employees that work in the hospital. 20 So the tracer, you may one day do a lot of 21 tracers on nurses just because that's who's on your 22 unit, but then you want to be able to get some of these 23 other folks, too, because you may have the lab coming 24 in and drawing blood on patients, and we want to make 25 sure they're following the same practices. Physical	Page 137 1 somewhere? 2 A. Yes, they get turned into a report that the 3 infection control team produces every month. 4 Q. Do you know whether or not those reports 5 have been produced in this litigation? 6 MR. MARCUS: Object to form. 7 A. I'm not sure. I think they have. I can't 8 be certain. I haven't seen this. 9 BY MS. BLAIR: 10 Q. And so based on what I -- do you -- strike 11 that. 12 Do you know is this a requirement for all 13 five hospitals in the Palm Beach Health Network? 14 MR. MARCUS: Object to form. 15 A. I can only speak for Delray Medical Center. 16 BY MS. BLAIR: 17 Q. And we talked earlier about, though, there 18 is some quality control that overarches all five 19 hospitals, correct? 20 A. That's correct. 21 Q. And so I'm just asking in your involvement 22 with the Palm Beach Health Network, do you know if this 23 was a tool that's developed for Delray, or is it a tool 24 that was developed by Palm Beach Health Network for all 25 five hospitals?

Page 138 1 A. I just know that it's our Delray tool. 2 Q. And so if I've not seen something similar to 3 this for another one of the plaintiffs in this 4 litigation, that could be because this is something 5 that Delray has individually and the other four 6 hospitals don't have? 7 A. That's correct. 8 MR. MARCUS: Object to form. 9 BY MS. BLAIR: 10 Q. Do you know in connection with the 11 sufficient to simulate production that has been made in 12 this litigation, do you know whether documents related 13 to these logs that we just talked about, the hand 14 washing logs, were reviewed in order to make a 15 determination as to how Delray would have scored on 16 hand hygiene in fall of 2024? 17 MR. MARCUS: Object to form. 18 A. I do believe that they inputted the hand 19 hygiene scores into that simulated model. 20 BY MS. BLAIR: 21 Q. And do you know whether there was a document 22 that was created after they inputted the hand hygiene 23 scores into the Leapfrog survey model? 24 MR. MARCUS: Object to form. 25 A. What kind of document are you referencing?	Page 140 1 Q. And you don't know whether any of the other 2 four plaintiff hospitals do hand hygiene in the same 3 way that Delray does, correct? 4 A. Correct. 5 Q. Do you know whether CMS measures CPOE? 6 A. I'm not familiar with CMS measuring CPOE. 7 Q. Do you know if there's any other regulatory 8 agency that governs CPOE? 9 MR. MARCUS: Objection. 10 BY MS. BLAIR: 11 Q. Or I'm sorry. That measures CPOE? 12 MR. MARCUS: Object to form. 13 A. Not that I'm aware of. 14 BY MS. BLAIR: 15 Q. Do you know whether the Joint Commission 16 looks at CPOE? 17 A. They will look at, yeah, they look at it 18 when they come in to make sure that we're working 19 according to our policy and that physicians, where 20 appropriate, are putting in CPOE orders and not using 21 verbal or telephone orders. 22 Q. Does the Joint Commission perform a test on 23 a hospital's CPOE system to make sure it is performing 24 correctly? 25 MR. MARCUS: Object to form.
Page 139 1 BY MS. BLAIR: 2 Q. Well, so I thought you said that you do 3 believe that they inputted the hand hygiene score into 4 that simulated model, correct? 5 A. That's correct. 6 Q. And so was there like something that was 7 generated from that simulated model so we would know 8 how Delray would have performed on the hand hygiene in 9 the fall of 2024? 10 MR. MARCUS: Object to form. 11 A. So from what I remember there -- it looks 12 like kind of how the Leapfrog score comes out. They 13 created kind of a simulated model that looks like that. 14 I think it's an Excel spreadsheet, though. 15 BY MS. BLAIR: 16 Q. And so if you had to comply with just the 17 hand hygiene section of the Leapfrog survey, based on 18 the work that you're already collecting, how onerous 19 would that be? 20 MR. MARCUS: Object to form. 21 A. The hand hygiene part is already something 22 that's integrated into our daily practice. 23 BY MS. BLAIR: 24 Q. So not onerous for that part? 25 A. Correct.	Page 141 1 A. They don't perform testing. They actually 2 come in and validate your practice every three years. 3 BY MS. BLAIR: 4 Q. In terms of BCMA, is that a measure that CMS 5 measures? 6 A. It's not necessarily a measure CMS measures, 7 but, again, Joint Commission does look at our barcode 8 medication scanning as part of our patient, proper 9 patient ID policy and our medication administration 10 policy. 11 Q. Do you know whether Healthgrades® has 12 anything where it comes in and verifies your BCMA data? 13 A. Not that I'm aware of. 14 Q. Does the Florida Department of Health 15 measure BCMA compliance? 16 A. Not that I've seen. 17 Q. Does the Florida Department of Health 18 measure CPOE in any way? 19 A. Not that I've seen. 20 Q. Does -- well, does CMS measure ICU staffing? 21 A. Not that I've seen. 22 Q. What about NHSN? 23 A. No, NHSN just looks as hospital-acquired 24 infections and surgical site infections and preventable 25 harm in hospitals.

Page 142 1 Q. What about Joint Commission, do they look at 2 your ICU staffing? 3 A. That is something they look at when they 4 come in for their validation surveys, yes. 5 Q. And what are they looking at, to the best of 6 your knowledge? 7 A. To ensure that the model is there that we 8 have the appropriate coverage and that credentialing 9 files that they have the proper training, board 10 certifications and education and that their DOPs are 11 appropriate and that they're going through ongoing OPPE 12 and FPPE where appropriate. 13 Q. What is OPPE? 14 A. It's Ongoing Professional Practice 15 Evaluation, and then the other is Focused Peer Practice 16 Evaluation. 17 Q. Thank you. Do you know whether CMS measures 18 hand hygiene? 19 A. Not that I've seen. 20 Q. Do you know whether Joint Commission 21 measures hand hygiene? 22 A. Yes, they do. 23 Q. And in what way? 24 A. They -- so when they come in for their 25 validation surveys, they have a whole session where we	Page 144 1 Q. Right. So they, Joint Commission, does not 2 publicly share, for example, how a hospital does on 3 hand hygiene even though they may be evaluating 4 policies, correct? 5 MR. MARCUS: Object to form. 6 A. That's correct. 7 BY MS. BLAIR: 8 Q. And what about the Florida Department of 9 Health, do they share publicly how a hospital does, for 10 example, on hand hygiene? 11 A. They do not. 12 Q. What about does the Joint Commission 13 share -- well, they don't -- they only share publicly 14 that you are accredited, right? 15 A. That's correct. 16 Q. So CPOE information they don't share, 17 correct? 18 MR. MARCUS: Object to form. 19 A. Correct. 20 BY MS. BLAIR: 21 Q. And same question with respect to BCMA, the 22 Joint Commission does not share any BCMA-specific 23 information with the consuming public, correct? 24 MR. MARCUS: Object to form. 25 A. That is correct.
Page 143 1 go through all of our data for the last three years, 2 all of our infection control committee minutes. They 3 look at our infection prevention plan. And then that's 4 part of what they do when they go out on to the units. 5 In a hospital our size because we're 6 536 beds, typically three to four surveyors come at a 7 time and stay for four days with us, and they'll watch 8 the hand hygiene episodes on every single unit while 9 they're tracing patients. 10 Q. Do you know if the Florida Department of 11 Health reviews your hand hygiene compliance? 12 A. They sure do. So they come in, and they do 13 a site visit. And they do the same thing where they go 14 around and trace in different areas to look at 15 physicians and staff members, how they're taking care 16 of patients and utilizing hand hygiene. Then they look 17 at our hand hygiene data and look at our infection 18 control practices as well. 19 Q. And would you agree with me that none of the 20 data that the Joint Commission collects is publicly 21 available to patients? 22 MR. MARCUS: Object to form. 23 A. Joint Commission only shows whether a 24 hospital is accredited or not. 25 BY MS. BLAIR:	Page 145 1 MS. BLAIR: So it's 12:15. 2 MR. MARCUS: I was going to say, is this a 3 good time for a break? 4 MS. BLAIR: How do you feel? Yeah. 5 THE WITNESS: I'm okay. Whatever you want 6 to do. 7 MS. BLAIR: Yeah. It's really up to you. 8 (A discussion was held off the record.) 9 THE VIDEOGRAPHER: This is the end of media 10 two. The time is 12:20 p.m. 11 (A recess was taken from 12:19 p.m. to 1:05 p.m.) 12 THE VIDEOGRAPHER: This is media number 13 three in the deposition of Heather Havericak. 14 The time is 1:06 p.m. We are back on the 15 record. 16 BY MS. BLAIR: 17 Q. Ms. Havericak, I just want to talk a little 18 bit about Delray and the Leapfrog grade for the spring 19 of 2024, so this would have been prior to the 20 methodology change. And I just have a few Exhibits I 21 want to go over somewhat quickly. So we are on 9. 22 (Defendant's Exhibit Number 9 for i.d.) 23 BY MS. BLAIR: 24 Q. This will be Exhibit 9. 25 Ms. Havericak, do you have in front of you

Page 146 1 what we've marked as Exhibit 9 which is an email from 2 Heather Wehmeyer to Andrea Nunez dated March 7th, 2024? 3 A. Yes. 4 Q. And this document has -- bears the Bates 5 range of PBHN 13590 through 13593. 6 Did you see this document -- have you seen 7 this document before today? 8 A. No. 9 Q. Okay. And just for purposes of the record, 10 in or around March of 2024, Heather Wehmeyer would have 11 been the director of quality for Delray? 12 A. Yes, she would. 13 Q. So this would have been before 14 Stephany Johnson, correct? 15 A. That is correct. 16 Q. And if you look at the last page of this 17 document, which is 13592. Oh, sorry. No, it's not. 18 15 -- 19 13593, again, this is the email or the email 20 from Bonnie to lots of people. And she says, "Hello, 21 everyone. Good morning. Leapfrog has released the 22 hospital's preliminary numerical score for 2024 spring 23 safety grade. Please share your preliminary numerical 24 score." 25 Do you see that?	Page 148 1 A. Yes, it looks like Gina sent it out to 2 Andrea, Heather, Taylor and Kathleen, yes. 3 Q. And she say, "Hi, quality warriors. It's 4 time again." 5 Do you see that? 6 A. I do see that. 7 Q. And she's asking for these quality directors 8 to send preliminary Leapfrog scores to Regina West, 9 correct? 10 A. Yes, that's what the request looks like. 11 Q. Okay. And then if you look at the top of 12 13591, Gina West says to Heather Wehmeyer, "Just a 13 heads-up that you may fall to a D if they use the same 14 calculation methodology." 15 Do you see that? 16 A. I do. 17 Q. And this would have been before the fall 18 2024 methodology change, correct? 19 MR. MARCUS: Object to form. 20 A. Well, based on this email that I'm seeing 21 that I have in front of me, it looks like it would be 22 because it was March of 2024. 23 BY MS. BLAIR: 24 Q. Right. And for the record, and that's 25 probably why I got an objection, do you understand that
Page 147 1 A. I do. 2 Q. And we saw an Exhibit earlier this morning 3 where Bonnie was asking for this type of information 4 from an earlier period in 2023, correct? 5 A. That's correct. 6 Q. And does this refresh your recollection in 7 any way that someone from Tenet home office asked for 8 the Leapfrog scores on a regular basis? 9 MR. MARCUS: Object to form. 10 A. I can see through these emails that someone 11 has asked for it. 12 BY MS. BLAIR: 13 Q. Okay. But you have no recollection that 14 that's what happens on every grading period? 15 A. No, I do not. 16 Q. Do you know if in spring of 2025 you 17 received, you being Delray, received an email like this 18 from Tenet home office asking for the preliminary 19 Leapfrog scores? 20 A. I don't remember if I did. 21 Q. And if we look at this, then Regina West 22 sends it out, correct, to Andrea Nunez and 23 Heather Wehmeyer, among others? 24 I'm sorry. This is 13592. 25 Do you see that?	Page 149 1 the spring -- the spring grades for Leapfrog are 2 released at the end of April each year? 3 A. Yes. 4 Q. Okay. So if we're talking in the March of 5 2024 time frame, this would have been prior to the 6 spring 2024 Leapfrog grades being released, correct? 7 A. Correct. 8 Q. And the methodology change that we're 9 talking about here today did not occur until fall of 10 2024, correct? 11 A. That is correct. 12 Q. And is it your memory that, in fact, for 13 spring of 2024 Delray received a D grade from the 14 Leapfrog hospital safety grade prior to the change in 15 the methodology in the fall of 2024? 16 A. I believe it did based on the score that's 17 in front of me. 18 Q. Okay. And when you say "based on the score 19 that is in front of you," are you referring to the 20 third page of this document, the 2.2946? 21 A. Correct. 22 Q. Okay. 23 MS. BLAIR: I'll mark this one as 10. 24 (Defendant's Exhibit Number 10 for i.d.) 25 BY MS. BLAIR:

Page 150 1 Q. Ms. Havericak, I am now handing you what 2 we've marked as Exhibit 10, which is an email from 3 Monica Stillman-Vormittag dated March 26, 2024 to 4 Regina West and CC'ing Heather Wehmeyer. 5 Do you see that? 6 A. I do. 7 Q. And this is talking about SIR benchmarks, do 8 you see that? 9 A. Yes. 10 Q. And I believe earlier you referred to them 11 as SIR's benchmarks, correct? 12 A. Correct. 13 Q. What does SIR's stand for? 14 A. It's your predicted model of what kind of 15 infections you're going to say based on your patient 16 population and your number of patients. 17 Q. Okay. And if we look at the first line -- 18 Well, first of all, who is Monica Vormittag 19 in or around March of 2024? 20 A. She was in that time and still is our 21 manager of infection prevention. 22 Q. Okay. So her title at the bottom of this 23 email remains the same? 24 A. Correct. 25 Q. And she says, "Hi, Gina. Please see the	Page 152 1 information related to Delray benchmarking itself 2 against the Leapfrog SI -- SIR's as we're calling them? 3 A. He did not. 4 Q. Okay. So have you seen this document before 5 today? 6 A. No. 7 Q. And in looking at these scores, I don't know 8 what they mean, so when you see it says "CLABSI 9 predicted 13, infections eight. SIR equals 6.15," do 10 you see that? 11 A. Yes. 12 Q. Is that an above average score, below 13 average score, do you know? 14 A. I have to see it in relation to the 15 benchmarks. Like this doesn't tell me anything with 16 this information the way it's presented. 17 Q. Okay. And that was going to be my question. 18 Who would have set the benchmarks that you need to look 19 at it against? 20 A. They would pull those benchmarks out of 21 NHSN, like I mentioned earlier. 22 Q. Okay. So this -- is it your 23 understanding -- and if you don't know, I understand -- 24 A. Sure. 25 Q. -- but so this .615 refers to an NHSN number
Page 151 1 following items to meet Leapfrog SIR benchmarks." 2 Do you see that? 3 A. I do. 4 Q. Why were -- why was Delray benchmarking 5 itself with respect to the Leapfrog benchmarks if it 6 wasn't participating in any way with Leapfrog? 7 MR. MARCUS: Object to form. 8 A. I'm not sure. 9 BY MS. BLAIR: 10 Q. Were you the president of Delray in March of 11 2024? 12 A. I was not. 13 Q. Okay. You became -- were you associated in 14 any way with Delray in March of 2024? 15 A. I was the chief operating officer. 16 Q. And so this type of benchmarking would not 17 have been within your purview in March of 2024? 18 A. It would not. 19 Q. Who was the acting CEO in or around March of 20 2024? 21 A. Daniel Listi, L-i-s-t-i. 22 Q. Did you take over the job from Daniel Listi? 23 A. I did. 24 Q. Did -- during the transition between 25 Mr. Listi and yourself, did he provide you with any	Page 153 1 or a Leapfrog number? 2 MR. MARCUS: Object to form. 3 A. I can't make out what it's referencing in 4 this document in the way in which it's presented. Like 5 I need more context to this. 6 BY MS. BLAIR: 7 Q. Okay. Fair enough. And is it surprising to 8 you as you sit here today to know that the infection 9 prevent manager and the director of quality were 10 benchmarking hospital-acquired infections against 11 Leapfrog SIR's benchmarks? 12 MR. MARCUS: Object to form. 13 A. Yes, it's surprising because Leapfrog and 14 SIR's benchmarks are different things. 15 BY MS. BLAIR: 16 Q. Right. I thought so, too, so that's why I'm 17 trying to understand this email. But you don't 18 understand what they're doing here? 19 A. I don't understand what's presented in front 20 of me, no. 21 (Defendant's Exhibit Number 11 for i.d.) 22 BY MS. BLAIR: 23 Q. Ms. Havericak, I've just handed you what 24 we've marked Exhibit 11, which is an email from 25 Heather Wehmeyer. Her title, per her signature block

Page 154 1 at that time, was director of clinical quality 2 improvement dated April 17th, 2023 to Regina West, 3 Andrea Nunez, Carola Kuret, K-u-r-e-t, Taylor Pool and 4 Kathleen McDonald. 5 Do you see that? 6 A. I do. 7 Q. And if we turn to the second page of this 8 document, which is Bates labeled PBHN 12146 -- and I 9 specifically want to look at this email, it starts in 10 the middle of the page from Regina West dated 11 April 17th at 3:40 p.m. 12 Do you understand that April 17th, 2023 13 would have been before the Leapfrog spring 2023 grades 14 would have been released, correct? 15 A. Can you repeat that? 16 Q. Sure. 17 A. Sorry. 18 Q. So I showed you Exhibit 9 and 10 were right 19 before the spring 2024 grades were released in April of 20 2024. This document, though, is from April of 2023, a 21 year earlier, correct? 22 A. That's what it appears to be, yes. 23 Q. And so do you have an understanding that the 24 Leapfrog spring hospital safety grade would have been 25 released at the end of April 2023?	Page 156 1 Q. Okay. And it says, the second bullet point, 2 "the largest opportunity continues to lie in patient 3 experience." 4 Do you see that? 5 A. Yes. 6 Q. And patient experience, is that the HCAHPS 7 that we've been discussing today? 8 A. It's measures taken from the HCAHPS, yes. 9 Q. Have you as the president of Delray, had an 10 opportunity to go back and look at Delray's historic 11 performance on patient experience? 12 A. I have. 13 Q. Would you agree that in or around April of 14 2023, there was a large opportunity for Delray to 15 improve in patient experience? 16 A. I would say there's always opportunity to 17 improve in patient experience. 18 Q. And then you see she goes on to say, "West 19 Boca would need to participate in the fall 2023 survey 20 and change their BCMA and IPS performance as well." 21 Do you see that? 22 A. I see that. 23 Q. Do you know how performing in the fall 2023 24 Leapfrog Hospital Survey would have impacted 25 West Boca's BCMA and IPS performance if it was already
Page 155 1 A. Yes. 2 Q. Okay. And if we look at Regina's email, she 3 says, "Hello, fellow quality leaders." 4 Do you see that? 5 A. Yes. 6 Q. And she says, "I completed an analysis of 7 our Leapfrog scores for spring 2023." 8 Do you see that? 9 A. Yes. 10 Q. Does this refresh your recollection at all 11 that, in fact, Palm Beach Health Network was monitoring 12 its Leapfrog hospital safety grades in or around 2023? 13 MR. MARCUS: Object to form. 14 A. From the email I'm looking at, it appears 15 they were, but I wasn't with the company then. 16 BY MS. BLAIR: 17 Q. Understood. 18 And if we go down, it says, the second 19 bullet point -- well, the first bullet point says, "All 20 five hospitals scored at a C level." 21 Do you see that? 22 A. Yes. 23 Q. Do you know what Delray's Leapfrog hospital 24 safety grade was in the spring of 2023? 25 A. I do not.	Page 157 1 being based on the cohort median? 2 MR. MARCUS: Object to form. 3 A. I don't know what would have impacted West 4 Boca. 5 BY MS. BLAIR: 6 Q. Okay. And so we talked a little bit earlier 7 about your understanding of the Leapfrog hospital 8 safety grade methodology prior to 2024. Do you recall 9 that discussion earlier today? 10 A. Yes. 11 Q. And I'm going to bring you back to another 12 Exhibit if I can find it. I think it's either 13 Exhibit 4 or 5. Can you get those out in front of you? 14 A. The 4 and 5 we already looked at? 15 Q. Yes. And it's 4, I believe. That is your 16 Exhibit 4 from Stephany Johnson dated November 4th, 17 2024. 18 A. Yes. 19 Q. Okay. Making sure I have the right number. 20 If we go to Bates number, in that Exhibit if 21 you go to Bates number PBHN 2074, it's a chart. 22 A. Yes. 23 Q. And for the record, I will submit to you 24 that this chart and the scores come from the fall 2024 25 safety grade, but I just want to ask about the measures

Page 158 1 themselves. 2 A. Okay. 3 Q. So if we look at the first column of the 4 measures, do you know whether or not these were the 5 same measures that were being evaluated to come up with 6 Delray's spring 2024 hospital safety grade? 7 MR. MARCUS: Object to form. 8 A. Can you repeat that question? 9 BY MS. BLAIR: 10 Q. Sure. So do you understand that there are 11 22 measures that make up the Leapfrog hospital safety 12 grade? 13 A. I do. 14 Q. Do you -- do you believe that the measures, 15 not the scores but the measures were the same in spring 16 of 2024 as they were in fall of 2024? 17 MR. MARCUS: Object to form. 18 A. Yes. 19 BY MS. BLAIR: 20 Q. And looking at this list, and if you look 21 one page before, this is sent to you by 22 Stephany Johnson, correct? 23 A. That is correct. 24 Q. And she's attaching this list for you, is 25 that --	Page 160 1 Q. And what is your understanding of how CPOE 2 was measured prior to -- well, let's just say how it 3 was measured in spring of 2024? 4 A. Just with that like median score of all the 5 different cohorts, like it was just being assigned that 6 way. 7 Q. And do you understand that this 15, and 8 we'll just stick with CPOE, do you understand that this 9 score of 15 is a limited achievement score -- 10 MR. MARCUS: Object to form. 11 BY MS. BLAIR: 12 Q. -- for CPOE? 13 A. I understand it to be the lowest ranked 14 score that can be assigned, yes. 15 Q. Do you have an understanding that whether it 16 be spring 2024 or fall 2024, the numerical score 17 assigned for the measure for CPOE fell into four 18 different categories -- 19 MR. MARCUS: Object to form. 20 Q. -- which is achievement, considerable 21 achievement, somewhat achievement and limited 22 achievement? 23 MR. MARCUS: Same objection. 24 BY MS. BLAIR: 25 Q. Did you have any understanding of that prior
Page 159 1 A. It looks like this was an attachment, yes. 2 Q. Okay. And so we look at all these different 3 measures. And of these measures, you'll see the third 4 column here, and, again, this is PBHN 2074, has the 5 data source links. Do you see that? 6 A. The reporting period or, I'm sorry, the 7 second column data source links. 8 Q. Oh it's the third column for me. 9 A. Oh, mine is -- mine is -- oh, yeah, I guess 10 it is -- 11 Q. Oh, okay. 12 A. -- the third if you look at the name. 13 Q. Yeah. 14 A. Sorry. 15 Q. No, no, I just want to make sure for the 16 record. 17 And so the computerized physician order 18 entry on the third column, right, data source/links it 19 says, "Assigned score due to missing." "Due to 20 missing," correct? You see that? 21 A. Yes. 22 Q. And we see here that the assigned score, if 23 we go all the way to the last column, is 15 for CPOE, 24 correct? 25 A. That is correct.	Page 161 1 to fall of 2024? 2 A. Yes. 3 Q. Okay. And did you have an understanding 4 that any hospital that fell within limited achievement 5 would get a 15 whether they participated in the survey 6 or not? 7 A. No, I didn't realize that that's exactly 8 what the number was. 9 Q. Okay. Did you have an understanding -- do 10 you have an understanding that if a hospital's 11 numerical score fell into the highest category, 12 achievement, that they would get 100 points out of 13 100 points? 14 A. Yes. 15 Q. Do you understand that Delray in the spring 16 of 2024 received 100 points out of 100 points for CPOE 17 because its cohort median fell within highest 18 achieving? 19 MR. MARCUS: Object to form. 20 A. Again, I need to see results of that. 21 BY MS. BLAIR: 22 Q. Okay. 23 A. I don't recall the numbers off the top of my 24 head. 25 Q. And I don't have that Exhibit here today.

Page 162 1 A. Okay. 2 Q. But I've seen it. If that were the case, 3 would you have any reason to dispute it? 4 MR. MARCUS: Object to form. 5 A. Again, I have to see the document. 6 BY MS. BLAIR: 7 Q. Sure. 8 Do you know how many points total Delray was 9 getting for the four imputed measures in spring of 10 2024? 11 A. I don't know the total without having it in 12 front of me. 13 Q. So you don't know that it was 100 points out 14 of -- 400 points out of 400 at that time? 15 MR. MARCUS: Object to form. 16 A. I would need the document in front of me. I 17 don't know the numbers. 18 BY MS. BLAIR: 19 Q. Sure. I guess I'll pull it up at a break. 20 All right. And let's look at barcode 21 administration, which is the second row on this chart. 22 You see here that if we look at the third 23 column again, data source/links, it says, "Assigned 24 score due to missing." 25 Do you see that?	Page 164 1 agree with the fact that that's, in fact, what 2 happened, they just assigned you a score? 3 A. That score -- 4 MR. MARCUS: Same objection. 5 A. That appears from this document to be what 6 they did in assigning us that score. 7 BY MS. BLAIR: 8 Q. And the next row on this sheet is 9 ICU physician staffing. And do you see that it says 10 "data source" there, "CMS cost report"? 11 A. I do. 12 Q. Do you know what the CMS cost report is? 13 A. I know about the CMS cost report. 14 Q. Can you just tell me what the CMS cost 15 report is? 16 A. I mean, I'm not involved. The CFO does all 17 the CMS cost report, but that's just taking into 18 account all of the different components from the 19 hospital operations on a yearly basis. 20 Q. Do you have any understanding of whether or 21 not the CMS cost report contains any information 22 regarding ICU physician staffing for Delray? 23 A. I am not aware of that. 24 Q. Did you understand that in 2023 Leapfrog had 25 changed its imputation model such that nonreporting
Page 163 1 A. I do. 2 Q. And do you agree with me that that is what 3 Leapfrog did, they just assigned you a score for that? 4 MR. MARCUS: Same objection. 5 A. Can you repeat that? 6 BY MS. BLAIR: 7 Q. Sure. Would you agree that in -- well, do 8 you agree with the denotation [sic] here in this third 9 column for BCMA for fall of 2024 that Delray was simply 10 assigned a score due to missing information and didn't 11 actually earn that score? 12 MR. MARCUS: Object to form. 13 A. I agree that we were given a score and we 14 didn't submit data. 15 BY MS. BLAIR: 16 Q. Okay. So you agree that that statement for 17 BCMA in that third column assigned score due to missing 18 is accurate? 19 MR. MARCUS: Object to form. 20 A. I don't agree with the score being assigned 21 because there's no data that can be validated to 22 provide that score. 23 BY MS. BLAIR: 24 Q. I understand you disagree with the fact that 25 they assigned you a score, but I'm just asking if you	Page 165 1 hospitals were going to get a 5 if they had an ICU but 2 did not report any data? 3 MR. MARCUS: Object to form. 4 A. I did not know that. 5 BY MS. BLAIR: 6 Q. And then if we go down to seventh column, 7 hand hygiene, are you there? 8 A. I am. 9 Q. And you see where it says "assigned" -- oh, 10 sorry -- third column, "Assigned score due to missing"? 11 A. Yes. 12 Q. And do you understand that Delray was 13 assigned a score of 15 because there was no data based 14 on the fact that Delray had not participated in the 15 survey? 16 A. Yes. 17 Q. And if we look at the fourth column for all 18 four of these measures, the first three columns in 19 that -- or, sorry -- the first three rows in the 20 seventh row, it says "reporting period." And do you 21 see where it says "not applicable"? 22 A. Yes. 23 Q. Do you understand that under the prefall 24 2024 methodology if a hospital had an annual survey 25 within the last four rounds, that hospital score would

Page 166 1 have been used to calculate this score? 2 MR. MARCUS: Object to form. 3 A. I don't know all the inner workings of the 4 Leapfrog definitions. 5 BY MS. BLAIR: 6 Q. Okay. And then if we look at the three 7 measures that are kind of in the middle of the four we 8 just discussed, so that would be column four, five -- 9 I'm sorry -- row four, five and six, if we go, if we 10 follow those rows all the way across to the last 11 column, each one of them say "declined to report." 12 Do you see that? 13 A. I do. 14 Q. Do you have any understanding as to 15 Leapfrog's methodology and why these three measures say 16 "declined to report"? 17 A. I do not. 18 Q. For the remaining measures, so now I'm going 19 to talk about the -- and it is 22 measures, 20 22 additional rows underneath. 21 No, no, I'm sorry. Forget that. 22 So we have this seven, correct, the seven we 23 just talked about? 24 A. Yes. 25 Q. And then below that there are 25 measures	Page 168 1 it's showing for some of these CMS data that goes all 2 the way back to 2020, correct? 3 MR. MARCUS: Object to form. 4 A. They go back to 2020, yes. 5 BY MS. BLAIR: 6 Q. And that's because the publicly available 7 data from CMS was only available from that time period 8 to Leapfrog, correct? 9 MR. MARCUS: Same objection. 10 A. That's correct. 11 BY MS. BLAIR: 12 Q. Do you know or can you tell by looking at, 13 let's just take H-COMP 1, nurse communication do you 14 see how there was a score for 78, of a 78? 15 A. I do see that. 16 Q. Do you know whether that score was above the 17 average, average or below the average for Leapfrog in 18 or around November of 2024? 19 A. I wouldn't be able to tell you that without 20 the comparison data because that is constantly changing 21 depending on how hospitals are improving or not 22 improving. 23 Q. Right, because Leapfrog grades on a standard 24 deviation, correct? 25 MR. MARCUS: Object to form.
Page 167 1 below those rows, correct? It goes on to PBHN 2075. 2 Do you see that? 3 A. Yes. 4 Q. Okay. And for those measures, each one of 5 them it says the data source links for each one of 6 those measures is CMS, correct? 7 MR. MARCUS: Object to form. 8 A. That's correct. 9 BY MS. BLAIR: 10 Q. Do you have any understanding as to whether 11 or not the CMS data that Delray had provided to CMS for 12 the dates that are listed in the reporting period in 13 the second to last column was accurate? 14 MR. MARCUS: Object to form. 15 A. I believe it was accurate. 16 BY MS. BLAIR: 17 Q. And this CMS data that is listed, that is 18 publicly reported data, correct, from CMS? 19 A. That is correct. 20 Q. And we talked about earlier that the CMS 21 data, the publicly available CMS data lags in terms of 22 what the public has access to, correct? 23 A. That's correct. 24 Q. And so this table that Heather Wehmeyer -- 25 I'm sorry -- that Stephany Johnson had provided to you,	Page 169 1 A. I don't know if Leapfrog does that on a 2 standard deviation. You asked me about the HCAHPS 3 scores and CMS. 4 BY MS. BLAIR: 5 Q. Right. And I guess my question is, do you 6 know -- yeah, that was a bad question. They're not all 7 winners. 8 So if we look at the H-COMP 1 score, that 9 78, do you know if that's how you're scored by CMS on 10 H-COMP 1? In other words, do they give you a numerical 11 score like that? 12 A. They give you a numerical score, yes. But I 13 can't tell you in context if it was average, above 14 average without looking at other data with it. 15 Q. Okay. And in or around November of 2024, do 16 you know what Delray's overall CMS star rating was? 17 A. Yes. 18 Q. What was it? 19 A. A 1. 20 Q. Do you know in or around November of 2024 21 what Delray's patient experience star rating at CMS 22 was? 23 A. It was a 1. 24 Q. And do you know in or around November of 25 2024 what Delray's Google ratings were?

Page 170 1 A. Which month in '24? I'm sorry. 2 Q. November. 3 A. We were -- we were climbing. In September 4 of 2024, we were a 1.8, but we really had been working 5 on patient experience, so it was probably around a 6 2. something because we're at a 4.5 now. 7 Q. That's what I was going to ask you. You're 8 a 4.5 now? 9 A. We're a 4.5 now. 10 Q. Did you ever have any discussions with Tenet 11 home office about your CMS star ratings? 12 MR. MARCUS: Object to form. 13 A. Not that I recall with the home office. 14 BY MS. BLAIR: 15 Q. Do you recall any discussions at the 16 Palm Beach Health Network level about Delray's star 17 ratings? 18 A. Yes, we had discussion about our star 19 ratings in our group CEO meeting. 20 Q. And do you recall when or around what time 21 that was? 22 A. I don't recall the exact date just because 23 we have so many meetings, but we had that discussion, I 24 think, towards the end of '24 and we've had that 25 discussion, you know, throughout this year as well.	Page 172 1 A. Yeah, I would say the middle more recently 2 in the last couple of months. 3 Q. Do you know what -- how much of Delray's 4 budget has been committed to these improvements that 5 began in the middle of 2025 to increase scores? 6 MR. MARCUS: Object to form. 7 A. There aren't any additional dollars that I'm 8 aware of. 9 BY MS. BLAIR: 10 Q. Any additional staff? 11 A. No. 12 Q. Do you have any understanding as to why 13 Leapfrog made the change to its methodology for fall of 14 2024? 15 A. I'm not familiar with why. 16 Q. Did you have any discussions at the med exec 17 level about Delray's CMS star ratings? 18 A. Yes. 19 Q. When did those start? 20 A. I've had those a couple of times in 2025. 21 Q. Did you have any discussions with the 22 med exec about Delray's CMS star ratings prior to 23 Leapfrog issuing its fall 2024 safety grade? 24 A. We talked. It wasn't specifically to CMS 25 star ratings, but we talked about the quality measures
Page 171 1 Q. Prior to the end of 2024, do you recall any 2 discussions at the Palm Beach Health Network level 3 regarding the hospitals' -- and I'm using them, the 4 plural -- CMS star ratings? 5 A. I only started going to the group meetings 6 in July of '24 so I remember us talking about those 7 probably towards the end of the year in '24. 8 Q. Okay. 9 A. But they could have been before my time. 10 Q. What was said at the meeting about the 11 hospitals' -- again, plural -- CMS star ratings to what 12 you can recall? 13 A. We had discussion about the lagging in the 14 data so it wasn't an accurate reflection of where we 15 were at and just the need to really focus on improving 16 our publicly -- publicly reported scores and then more 17 recently just some of the tools we created to help us 18 be a predictor of where we were going to land as 19 different data rolls off. 20 Q. And were additional tools put in place in or 21 around the end of 2024 to improve scores? 22 A. Not at the end of '24, no. 23 Q. What about the beginning of 2025? 24 A. No. 25 Q. What about the middle of 2025?	Page 173 1 that feed up into those star ratings and the care 2 experience scores. 3 Q. Okay. 4 A. So that's -- in '24, we definitely did that 5 too. 6 Q. Okay. And then, I think you said you did 7 have some med exec meetings regarding the CMS star 8 ratings after the Leapfrog grade came out, correct? 9 A. Yes. And I actually went one by one through 10 every single one of the CMS measures that make up the 11 star rating and the weighted category to show where we 12 were doing well, where we had opportunities and just 13 looking at, you know, which ones we already had 14 improvement plans in place and how we were performing 15 based on our predictive model. 16 Q. Did you have that same sort of going through 17 each measure with respect to the Leapfrog hospital 18 safety grade with the med exec? 19 A. I don't think we went into it as much 20 detail. We talked about a lot of the self-reported 21 measures and then just the CMS measures that went into 22 it. 23 Q. And the CMS, do you understand that -- have 24 you ever seen the Leapfrog scoring calculator? 25 A. Yes.

Page 174 1 Q. And do you understand that 50 percent of the 2 grade is outcome measures? 3 MR. MARCUS: Object to form. 4 A. I do. 5 BY MS. BLAIR: 6 Q. And would you agree with me that of those 7 outcome measures, all of them come from publicly 8 reported CMS data? 9 A. Yes. 10 Q. And then there are twelve measures that make 11 up the structural/process measures that Leapfrog 12 reviews in putting together its hospital safety grade, 13 correct? 14 A. That's correct. 15 Q. And for a nonreporting hospital, do you 16 understand that five of those twelve measures come from 17 CMS data? 18 MR. MARCUS: Object to form. 19 A. That's not my full understanding. 20 BY MS. BLAIR: 21 Q. Okay. What is your understanding? 22 A. That four of those measures actually come 23 from self-reported data. 24 Q. Oh, yeah. So I said it the opposite. 25 A. Okay.	Page 176 1 the three decline to report measures. 2 BY MS. BLAIR: 3 Q. Understood. 4 A. So I don't know that that actually is 5 50 percent. 6 Q. So and I just want to talk about -- I'm not 7 talking about weights. I'm just talking about the 8 measures themselves. 9 A. Okay. 10 Q. I want to make sure we understand. 11 So there are five other measures. Other 12 than the imputed measures we talked about and other 13 than the three measures that -- so I don't want to talk 14 about the weight. I just want to talk about what 15 measures are. 16 You understand there are five additional 17 measures, or five additional process and structural 18 measures in the Leapfrog hospital safety grade 19 methodology, correct? 20 A. That's correct. 21 Q. I was asking the question about weight, so I 22 apologize. 23 And those five measures, they come from CMS 24 data, correct? 25 A. Correct.
Page 175 1 Q. So there are twelve measures in the 2 process/structural, correct? 3 A. Uh-huh. 4 Q. Of those twelve measures, four come from -- 5 are the imputed measures that we've been talking about, 6 correct? 7 A. Correct. 8 Q. And those measures are BCMA, CPOE, hand 9 hygiene and ICU physician staffing, correct? 10 A. That's correct. 11 Q. And three of those measures that make up the 12 50 percent structural process measures are declined to 13 report, and a nonparticipating hospital does not get 14 graded on them, correct? 15 A. That is correct. 16 Q. So we have the four imputed measures that 17 we've been referring to, the three decline to report 18 measures, and so there are five additional measures 19 that make up the 50 percent of the structural process 20 measures, correct? 21 A. So there's -- 22 MR. MARCUS: Object to form. 23 A. -- there's the five other measures, but I'm 24 not -- without having the calculator in front of me, 25 because the percentage changes when you extrapolate out	Page 177 1 Q. So if we were to look at the methodology 2 itself without respect to weights, because I do 3 understand your position there, you have ten outcome 4 measures plus five structural and process measures that 5 come from CMS data, correct? 6 A. That's correct. 7 Q. 15 total, then, 5 plus 10, correct? 8 A. Yes, correct. 9 Q. Do you have an understanding of how the 10 weights and the z-scores are redistributed in the 11 methodology for a nonparticipating hospital when those 12 three measures are taken out? 13 MR. MARCUS: Object to form. 14 A. I have the understanding that more weight is 15 placed on those self-reported measures. So if, for 16 example, they were initially weighted at a 6, they're 17 going to be weighted to an 8.5 or a 9. It makes them 18 carry more weight in your survey. 19 BY MS. BLAIR: 20 Q. Okay. 21 A. In your results. 22 Q. Not mine, but, okay. 23 A. Yeah, in the survey. I apologize. 24 Q. Thank you. I'm teasing. 25 So your understanding is that the weight

Page 178 1 that would have been attributed to those three decline 2 to report are distributed evenly across the remaining 3 nine measures? 4 A. I know that they're redistributed. I don't 5 know if it's evenly amongst those four measures, but it 6 makes them carry more weight collectively. 7 Q. How did you first come to learn that the 8 methodology was changing for fall, the Leapfrog 9 methodology for the hospital safety grade was changing 10 for the fall of 2024? 11 A. At Delray because we were going through a 12 transition with quality I think it came closer to the 13 time that the grades were coming out. 14 Q. And is that transition the transition of 15 Heather Wehmeyer to Stephany Johnson? 16 A. Correct. That's what I'm referencing. 17 Q. Are there -- no other transitions? 18 A. No. 19 Q. Okay. And so were you ever told as the CEO 20 of Delray that Leapfrog had put out in May of 2024 a 21 request for public comment to hospital about the change 22 in their methodology? 23 MR. MARCUS: Object to form. 24 A. Leapfrog sends those emails out to 25 healthcare leaders. I mean, we get a lot of emails,	Page 180 1 A. I recall that being the case. 2 Q. What do you recall the discussions were 3 about the methodology change in or around November of 4 2024? 5 A. Just like the emails that we've looked at 6 that Stephany provided that our score was going to be 7 impacted because we declined to report those measures. 8 Q. And what was your reaction as the 9 president -- I'm sorry -- as the CEO of Delray Medical 10 to Stephany's conversation with you about the change in 11 the methodology? 12 A. Just like it says. I mean, it's 13 unfortunate. I was concerned because the public 14 doesn't understand all these scoring models, and all 15 they were going to see is the failing grade. 16 Q. And which Exhibit are you referring to when 17 you say "it's unfortunate." Are you referring to 18 Exhibit 4? 19 Sorry. There's a lot. 20 A. Yes. 21 Q. Okay. But Exhibit 4 -- okay. So that's the 22 November 2024 time frame, correct? 23 A. Correct. 24 Q. Okay. So were you -- you then say in this 25 Exhibit 4, you say, "Does your" -- "does our PR team
Page 179 1 and I don't know that I opened them all and looked at 2 them. 3 BY MS. BLAIR: 4 Q. And no one at Delray provided any comment to 5 Leapfrog regarding Leapfrog's request for public 6 comment on the change in methodology, correct? 7 MR. MARCUS: Same objection. 8 A. Not that I'm aware of. 9 BY MS. BLAIR: 10 Q. And what about at the Palm Beach Health 11 Network level, are you aware of whether or not anyone 12 at the group level provided any feedback to Leapfrog's 13 request for public comment to the 2024 methodology? 14 MR. MARCUS: Object to form. 15 A. I'm not aware that anyone did. 16 BY MS. BLAIR: 17 Q. When do you recall first discussing the 18 Leapfrog fall 2024 methodology change? 19 A. I can't recall exact dates, but if I recall, 20 it's around November. It's going to be in the November 21 time frame. 22 Q. November of 2024, correct? 23 A. Correct. 24 Q. And you understand that the grades, the fall 25 safety grades are released on November 20th, 2024?	Page 181 1 have something prepared that talks about not 2 participating in this, hence" -- "in this, hence, the 3 low rating?" 4 Who is the PR team you're referring to then? 5 A. So that would be Shelly Weiss. 6 Q. And Shelly Weiss, is she at the group level? 7 A. She's the group level. 8 Q. And is Lisa Cook involved in this at all? 9 A. They work together. 10 Q. Lisa Cook reports to Shelly Weiss? 11 A. Lisa Cook reports to Derek Collins. 12 Q. Do you know whether or not -- well, then if 13 we look at Exhibit 4, Stephany says to you, to your 14 question about the PR team, she says, "not that I have 15 been made aware of but will inquire about it since this 16 will go public in less than two weeks." 17 Do you see that? 18 A. I do. 19 Q. What do you recall the discussions were 20 regarding how the PR -- how PR was going to react to 21 the safety grade going from a D to an F? 22 MR. MARCUS: Object to form. 23 A. Can you repeat part of that question? 24 BY MS. BLAIR: 25 Q. Sure, sure.

Page 182 1 So we're now at the November 4th, 2024 time 2 frame per Exhibit 4, correct? 3 A. Um-hum, correct. 4 Q. What do you call your discussions as the CEO 5 of Tenet Healthcare were with PR team, as you say in 6 Exhibit 4, around what the PR was going to be when the 7 F grade was released later in November of 2024? 8 A. So from what I recall, I actually went right 9 to our group president so that she would be aware of 10 what this letter grade was going to look like in case 11 she wasn't aware. And then I just asked what kind of 12 talking points we were going to have available so the 13 community could have more accurate information on why 14 we were receiving an F grade and that they could 15 understand it better. 16 Q. And was there a group meeting at the 17 Palm Beach Health Network level between all five 18 hospitals regarding what everybody's grade was going to 19 be in light of the methodology change? 20 A. We have one every month so there would have 21 been one on there. 22 Q. Are they regularly scheduled meetings? 23 A. Our CEO group meetings, yes. 24 Q. Are they the first of the month or last of 25 the month?	Page 184 1 marked as Exhibit 12, which is PBHN 10789, which is an 2 email from Andrew Lofholm to several people. 3 Have you ever seen this email before? 4 A. Well, it looks like I would have gotten it, 5 yes. 6 Q. Okay. Do you recall seeing it? 7 A. I don't. I get so many emails every day, 8 hundreds of them. 9 Q. I feel that. 10 And who is Andrew Lofholm? 11 A. He is another one of our communications and 12 PR folks that works on the team for the network. 13 Q. Okay. And he's at the group level, correct? 14 A. Correct. 15 Q. And this email says, "Hello, everyone. 16 Becker's put out a list this morning naming the 14 17 F-ranking hospitals until the country." 18 Do you see that? 19 A. I see that. 20 Q. So does this refresh your recollection that 21 there were only 14 F's in the whole country? 22 MR. MARCUS: Object to form. 23 A. Based on this email and what Becker's put 24 out, I guess it does. 25 BY MS. BLAIR:
Page 183 1 A. They sometimes fluctuate based on if 2 someone -- like Maggie is over a couple of markets, so 3 sometimes her schedule changes, but typically they're 4 in the middle of the month. 5 Q. So do you recall whether discussions were 6 had with the other five hospitals at your regularly 7 scheduled CEO meeting or whether there was a specific 8 meeting called for the Leapfrog grade issue? 9 A. I'd have to look at my calendar. I know we 10 would have talked about it at a monthly meeting, but I 11 don't remember the additional meetings. 12 Q. And your understanding was that under the 13 new methodology all nonparticipating hospitals were 14 going to receive an F, correct? 15 A. Correct. 16 Q. But Good Samaritan got a D; isn't that true? 17 A. I don't know exactly what their score was. 18 Q. Do you know how many hospitals in the fall 19 of 2024, how many hospitals in the entire country 20 received failing grades? 21 A. I don't. 22 MS. BLAIR: We can mark this as Number 12. 23 (Defendant's Exhibit Number 12 for i.d.) 24 BY MS. BLAIR: 25 Q. Ms. Havericak, I just handed you what we've	Page 185 1 Q. And so do you understand that there are 2 hundreds of hospitals that don't participate in the 3 Leapfrog Hospital Survey? 4 A. I don't know what hospitals haven't 5 participated. 6 Q. And if you see here it says, PBGMC, GCMC and 7 Delray -- I guess I was wrong -- are all on the list. 8 Do you see that? 9 A. I do. 10 Q. And PBG is Palm Beach Gardens, correct? 11 A. Palm Beach Gardens Medical Center, yes. 12 Q. And GCMC, Good Samaritan Medical Center? 13 A. That's correct. 14 Q. And Delray is your hospital, correct? 15 A. That is correct. 16 Q. And so of the -- I was wrong what I said 17 earlier. So there were two hospitals that got a D, 18 which were West Boca -- of your health network, which 19 would have been West Boca and St. Mary's, correct? 20 MR. MARCUS: Object to form. 21 A. That's correct. 22 BY MS. BLAIR: 23 Q. So does this refresh your recollection that 24 it's not the case that all nonparticipating hospitals 25 receive a failing grade?

Page 186 1 MR. MARCUS: Same objection. 2 A. No, a D is a failing grade as well. 3 BY MS. BLAIR: 4 Q. Oh. Okay. So of the hundreds of hospitals 5 that don't participate in the Leapfrog survey, is it 6 your understanding all of those hospitals in fall of 7 2024 that did not participate in the Leapfrog Hospital 8 Survey received a D or an F? 9 MR. MARCUS: Object to form. 10 A. I have to see the list of everyone who 11 participated and not participated and see their grades. 12 BY MS. BLAIR: 13 Q. Okay. But you filed the lawsuit in this -- 14 you are a plaintiff in this lawsuit that we're here for 15 today, correct? 16 A. That's correct. 17 Q. And you've seen the Complaint that's been 18 filed? 19 A. I have. 20 Q. And did you see it before it was filed? 21 A. Yes. 22 Q. And do you understand that one of the 23 allegations is that under the new scoring method that 24 was put into place in fall of 2024, all 25 nonparticipating hospitals receive a failing grade?	Page 188 1 A. We relied on them. 2 Q. If you looked at that document I just showed 3 you, the F one, is that Exhibit 11? I apologize. 12. 4 I apologize. 12, is that a two-page document that I 5 handed you? 6 A. It was a one-page. 7 Q. Oh. Sorry, everybody. I had two pages. 8 I'm my own assistant today. 9 A. Thank you. 10 Q. And this will be a group Exhibit because 11 they did not come together, but it was meant to be a 12 group. We can mark this 13. 13 MR. MARCUS: Okay. This is a separate? 14 MS. BLAIR: Can you mark that Exhibit 13. 15 MR. MARCUS: What was it supposed to go 16 with? 17 MS. BLAIR: 12. 18 MR. MARCUS: The Bates. 19 MS. BLAIR: No, no, it was just going to be 20 a group Exhibit. 21 MR. MARCUS: They're not related. The Bates 22 numbers are very different, right? 23 MS. BLAIR: Correct. 24 MR. MARCUS: Just two separate documents. 25 MS. BLAIR: Okay. So we'll mark this as 13
Page 187 1 Are you aware that's one of the allegations? 2 MR. MARCUS: Object to form. 3 A. I am. 4 BY MS. BLAIR: 5 Q. What did you do to investigate whether or 6 not that allegation was true before the Complaint was 7 filed? 8 MR. MARCUS: Is it, the "you" is referring 9 to her personally? 10 MS. BLAIR: Delray Medical Center. 11 A. We worked with our counsel. 12 BY MS. BLAIR: 13 Q. Okay. Delray Medical Center didn't perform 14 any independent analysis to confirm that the 15 allegations contained in the Complaint were true prior 16 to it being filed? 17 MR. MARCUS: Object to form. 18 A. We worked with our counsel. 19 BY MS. BLAIR: 20 Q. And so you relied on counsel for those 21 allegations, correct? 22 MR. MARCUS: Object to form. 23 A. We worked with counsel. 24 BY MS. BLAIR: 25 Q. But did you rely on counsel?	Page 189 1 so there's no confusion. 2 (Defendant's Exhibit Number 13 for i.d.) 3 BY MS. BLAIR: 4 Q. Before we get to that, though, real quick, 5 in November of 2024, after you learn about the 6 methodology change but before the grade comes out, did 7 you have a meeting with the governing board of Delray 8 to discuss that the grade was going to mostly likely be 9 an F? 10 A. We did it, I think, at our regularly 11 scheduled governing board member meeting because we 12 have a governing board meeting every month. 13 Q. And do you recall what the conversations 14 were with your board of -- your governing board about 15 the fact that Delray was going to be an F in the 16 Leapfrog hospital safety grade for fall of 2024? 17 A. We talked through the measures, talked about 18 not participating and what those consequences of not 19 participating looked like. And then we went over where 20 we were not performing as well in the CMS measures and 21 the time frame of when those measures had been 22 accounted for because, again, like a lot of them are 23 lay people on that board, and they are used -- 24 accustomed to seeing quality data every month, so it 25 looks very different than what they're seeing every

Page 190 1 month because we've made a lot of improvements. So we 2 just went through the methodology, went through the 3 measures and then really talked a little bit, I think 4 we did have talking points at that point that they 5 would be able to use when they were out in the 6 community as well. 7 Q. Was there anybody on the board at that 8 meeting in November of 2024 that expressed that they 9 believed that Delray should participate in the Leapfrog 10 Hospital Survey? 11 A. I don't recall anyone speaking up directly 12 to say that. 13 Q. Do you know whether or not the board was 14 told at that November 2024 meeting that all hospitals 15 that don't participate receive a failing grade? 16 A. I don't recall what I said during that 17 meeting. 18 Q. Do you recall whether or not at that meeting 19 you advised your board of directors that Leapfrog was a 20 brazen play-to-pay [sic] scheme -- pay-to-play scheme? 21 MR. MARCUS: Object to form. 22 A. I don't recall the language that I used in 23 the meeting. 24 BY MS. BLAIR: 25 Q. Do you recall making any statements to your	Page 192 1 members -- I don't remember which ones they were -- 2 that why would we not just do it so we don't have to go 3 through having an F because we knew kind of where we 4 would be positioned and it wouldn't be an F. 5 Q. And what was your position as the 6 president -- or I'm sorry -- as the CEO of Delray about 7 participating in the Leapfrog Hospital Survey in or 8 around that time? 9 A. What I shared with the group was that we 10 were just focusing our attention on our patient safety, 11 on our care experience and on our other accreditations 12 that we felt there was no value in. 13 Q. Did you tell either the med exec or the 14 governing board that home office did not support 15 participating in the Leapfrog Hospital Survey? 16 MR. MARCUS: Object to form. 17 A. I don't recall telling them that. 18 BY MS. BLAIR: 19 Q. Do you recall knowing that in or around 20 November of 2024? 21 MR. MARCUS: Same objection. 22 A. No. 23 BY MS. BLAIR: 24 Q. Do you recall receiving any email to that 25 effect in or around November of 2024?
Page 191 1 board that hospitals that pay Leapfrog -- that 2 hospitals can pay Leapfrog for better grades? 3 A. I don't recall making that statement. 4 Q. Did you make any statements to your board 5 that Leapfrog -- that hospitals can pay Leapfrog 6 consulting fees in exchange for better grades? 7 A. I don't recall discussing that with the 8 board. 9 Q. After you learn about the methodology change 10 for the 2024 Leapfrog hospital safety grade but before 11 the grade comes out, did you have a meeting with the 12 med exec about the change, the anticipated change in 13 Delray's grade? 14 A. Well, our med exec is the week before 15 governing board, so we definitely talked about it that 16 same month. 17 Q. Do you recall what the discussions were at 18 the med exec board? 19 A. It was the same discussions that I was 20 having at the governing board level, but it was just a 21 little bit more clinical. 22 Q. Do you recall anybody on the med exec 23 expressing a desire to participate in the Leapfrog 24 Hospital Survey? 25 A. There was feedback from some of the med exec	Page 193 1 A. Again, I mean, I get hundreds of emails a 2 day, so I don't know when I would have received an 3 email that's a corporate office except for the ones 4 you've shown me today. 5 Q. Going back to Exhibit 13 that we previously 6 marked, these are the Delray Medical Center Leapfrog 7 key messages. Do you see that? 8 A. I do. 9 MR. MARCUS: Before you ask a question about 10 the document can -- do you have the email, the 11 apparent email? 12 MS. BLAIR: I don't. 13 MR. MARCUS: Okay. Because I'm pretty sure 14 this is not a standalone document. 15 MS. BLAIR: Well, then I'll just ask a some 16 foundational questions. 17 BY MS. BLAIR: 18 Q. Have you seen this document before today? 19 A. Yes. 20 Q. Okay. Do you recall who would have sent it 21 to you? 22 A. It would be either Lisa or Shelly. 23 Q. Lisa being Lisa Cook? 24 A. Lisa Cook or Shelly Weiss. 25 Q. Okay. And do you know who put together

Page 194 1 these talking points? 2 A. I don't know who puts them together, but I 3 typically get talking points from Lisa Cook or 4 Shelly Weiss. 5 Q. Do you know if they're approved by home 6 office? 7 MR. MARCUS: Object to form. 8 A. I don't know who approves them because I'm 9 not involved in that process. 10 BY MS. BLAIR: 11 Q. And you see one, two, three, four, five, six 12 bullet points down it says, "CMS does still assign us a 13 score, but it is relying on limited public available 14 data from secondary sources that haven't been 15 verified." 16 What does that refer to? 17 MR. MARCUS: Object to form. 18 A. That's referring to the CMS data. So CMS 19 data is just taking a subset of a population that is 20 the Medicare patient population, and you have to 21 remember at Delray Medical Center we're caring for an 22 elderly population so we're going to have a higher 23 number of complex patients, so, I mean, that's a 24 limited number. That's not all that we take care of. 25 So this CMS star rankings doesn't take into account any	Page 196 1 email that goes with it would be helpful so we could 2 see. 3 Q. Sure. I don't have it. 4 So I'm just asking, does CMS assign you a 5 score, or is that referring to the star rating, do you 6 know? 7 A. I don't know what they're referring to here. 8 In my opinion, CMS gives us a star rating. 9 Q. Okay. And then I understand when you say 10 limited public available data, you believe it's limited 11 because it would only be the Medicare or Medicaid 12 population, correct? 13 A. Correct. 14 Q. And then it says "from secondary sources." 15 Do you know what secondary sources are that 16 CMS relies on? 17 A. I'm not aware. 18 Q. And then it says "that haven't been 19 verified." 20 Do you know what that's referring to in 21 these talking points? 22 MR. MARCUS: Object to form. 23 A. I don't know what their interpretation was 24 here. 25 BY MS. BLAIR:
Page 195 1 of our commercial payers or patients that are outside 2 of that Medicare population, so it is a limited data 3 source. 4 Q. Okay. And when you say CMS still assign -- 5 not you but Delray. When Delray says, "CMS does still 6 assign us a score," is that referring to the star 7 rating? 8 MR. MARCUS: Well, object to form. How do 9 you know that Delray is saying this? 10 MS. BLAIR: Because it says "Delray Medical 11 Center Leapfrog key messages." Is this not -- I 12 guess I should ask. 13 MR. MARCUS: Do you know the author of the 14 document? 15 MS. BLAIR: She just said it was either 16 Lisa Cook or Shelly Weiss. 17 BY MS. BLAIR: 18 Q. Were these Delray Medical Center Leapfrog -- 19 MR. MARCUS: She actually said that she gets 20 talking points from them. She didn't identify 21 these specifically. 22 BY MS. BLAIR: 23 Q. Are these talking points that you would have 24 gotten from Palm Beach Health Network? 25 A. They look like it, but, again, like the	Page 197 1 Q. And then if you look at the bottom bullet 2 point, it says, "Recent quality awards we have won 3 include..." 4 Are those awards that Delray held in or 5 around November, December of 2024? 6 Well, excuse me. Strike that. 7 Do you see here they refer to awards that 8 you have received in 2025, correct? 9 A. Those are awards that we've had in '25, yes. 10 Q. And those are Delray awards, to the best of 11 your knowledge? 12 A. Delray has all of those awards, yes. 13 Q. And then you see the third bullet point it 14 says, "Due to the use of outdated data for this report, 15 we have made the decision not to submit or participate 16 in the annual Leapfrog Hospital Survey." 17 Correct? 18 A. I see that line, yes. 19 Q. Is the outdated data that it's referring to 20 the CMS data? 21 MR. MARCUS: Object to form. 22 A. I don't know what it's referring to. 23 BY MS. BLAIR: 24 Q. We talked a little bit about Larry Edelson 25 previously. Do you recall that?

Page 198 1 A. Yes. 2 Q. And he was a previous board member for 3 Delray, correct? 4 A. He was. 5 Q. And he was not -- he has not been on the 6 board since you've been the CEO of Delray, correct? 7 A. That's correct. 8 Q. And do you know when he first got off the 9 Delray board? 10 A. I'm not sure because it was before I came. 11 Q. Do you deal with him regularly? 12 A. Yes. 13 Q. In what capacity do you deal with him since 14 he's not on the board? 15 A. He's a strong community advocate for us in 16 the community, and he still works in the healthcare 17 space at the Proton Institute that's on our campus. 18 (A discussion was held off the record.) 19 (Defendant's Exhibit Number 14 for i.d.) 20 MR. MARCUS: So 14. 21 MS. BLAIR: 14. 22 BY MS. BLAIR: 23 Q. Ms. Havericak, I've just handed you what 24 we've marked Exhibit 14 for your deposition. And this 25 is a series of, it looks like a series of emails, but	Page 200 1 A. No, he does some business consulting for 2 them. He's just an advocate in our community for our 3 hospital. 4 Q. And when you say for your hospital, is that 5 like he markets Delray? 6 A. On his own, yes. He's just very connected 7 in the community. He's a key constituent in our 8 community, very influential and a big supporter of 9 Delray. 10 Q. Do you know what he did before he consulted 11 with the South Florida Proton Institute? 12 A. Yeah, he's an entrepreneur. He started like 13 1-800 Contacts. He's had a whole bunch of start-up 14 companies that he's developed and sold. 15 Q. Okay. And in this email, and I want to 16 focus on like the last sentence of the first full 17 paragraph, he's -- well, he says, "He likes to bring up 18 how things were five, ten years ago, and I reminded him 19 this is new era." 20 Do you know what he's referring to five, ten 21 years ago. I know you were not the CEO of Delray, but 22 do you have any memory of what he was talking about? 23 A. He just brings up historic things where 24 there were different leaders there that weren't always 25 focused on patient safety and quality.
Page 199 1 there are two, it's a group Exhibit, I think. Is it 2 two pages, what you have? 3 A. Mine are two pages, but they look like two 4 separate emails. 5 Q. I think they're two separate emails. But 6 they both, if you read that, both have to do with 7 Larry Edelson. 8 A. Yes, that's correct. 9 Q. Okay. And so I want to start with the 10 second page of this which is later in time which is the 11 December 17th, 2024 email from you to Lisa Cook and 12 Maggie Gill, the subject being Larry E. 13 If or around this time, December 17th, 2024, 14 what is Larry E's job? 15 A. He's just a community advocate. 16 Q. Okay. 17 A. And his job, though, he does consulting for 18 the South Florida Proton Institute. 19 Q. So say it -- the South Florida Proton -- 20 A. The South Florida Proton Institute. 21 Q. What is the South Florida Proton Institute? 22 A. We have a proton beam institute on our 23 campus. It's a radiology oncology center. 24 Q. Got it. 25 Okay. So is he a business advocate?	Page 201 1 Q. Okay. And so is he focused on patient 2 safety and quality? 3 A. Very much so. 4 Q. Got it. And so he's not speaking about the 5 finances of the hospital. He's speaking about patient 6 safety and quality? 7 A. Correct. 8 Q. So would it be fair to say that he is 9 interested in the types of ratings Delray gets from 10 hospital reviewers like Leapfrog? 11 A. Yes. 12 Q. And then you said, "And I reminded him this 13 is a new era." 14 What do you mean by that? 15 A. That we just are looking at things very 16 differently, that I, you know, that's the year I came 17 in as the new CEO, and I have different focus than the 18 previous CEOs. I'm a clinical person by background, 19 and our top focus and priority is always going to be 20 patient safety, care experience and just recruiting the 21 top talent that we can on the physician side and the 22 staff side. 23 Q. So your, as I understand your testimony here 24 today, your mission would align with Larry's mission to 25 put patient quality first, correct?

Page 202 1 A. Correct. 2 Q. Okay. So when he's talking about how things 3 worked five, ten years ago, is he saying they were bad 4 five, ten years ago, or is he saying that they were 5 good five, ten years ago? 6 A. That they were bad. 7 Q. Got it. 8 Okay. And does he like regularly have 9 meetings with you about patient safety? 10 A. He just calls. He calls me a lot, so I make 11 time for him. 12 Q. How old is Larry? 13 A. Almost 80 maybe or late 70s. 14 Q. Okay. And then if we go to the first page 15 of group Exhibit 14, there's an email from Shelly, 16 "Good afternoon. Attached please find some of T" -- 17 "some TPs for Leapfrog." 18 Do you see that? 19 A. Yes. 20 Q. Do you understand the acronym for TPs would 21 be talking points? 22 A. That's what I would interpret it as. 23 Q. And then Lisa -- 24 MR. MARCUS: Is there an attachment to the 25 document?	Page 204 1 natives. 2 MR. MARCUS: Who created it? 3 MS. BLAIR: I don't know. It's not -- 4 obviously I don't have this document. It's not 5 a big deal, but... my only question with that 6 document is going to be who is Steve Saltzman. 7 Did you just write on it? 8 MR. MARCUS: Did you just introduce it? 9 MS. BLAIR: I'm going to mark it. I only 10 have one copy. 11 MR. MARCUS: Oh. I put on "15" for you. 12 MS. BLAIR: Thank you. 13 Could you mark this as 15? 14 MR. MARCUS: We'll object if it turns out it 15 wasn't produced. How's that? 16 MS. BLAIR: Yeah. If I had found this 17 somewhere, that would be interesting. 18 (Defendant's Exhibit Number 15 for i.d.) 19 BY MS. BLAIR: 20 Q. Ms. Havericak, I'm handing you now what 21 we've marked as Exhibit 15. You'll see you're not on 22 this email. But it's in a man named Steve Saltzman to 23 Larry Edelson, the infamous. 24 I asked you earlier in this deposition if 25 you knew who Steve Saltzman was. In reading this
Page 203 1 MS. BLAIR: No, the way you guys produced 2 emails, you Bates labeled the emails, and all 3 the attachments were in native so I had to go 4 try to figure that out, so, no. If there is, I 5 couldn't find it. 6 BY MS. BLAIR: 7 Q. And then Lisa Cook says, "Thanks, Shelly. 8 Heather, let me know if it's okay to send to Larry." 9 Is this type of document you would send to 10 Larry to sort of quell his concerns about patient 11 safety? 12 A. So just personally, I don't like to just 13 send documents to people, especially someone like him 14 because he's -- he likes to understand all the details, 15 so that's why I wouldn't trust him with it. I'd want 16 to sit down and explain it to him rather than just 17 sending him a piece of paper that he might not 18 understand. 19 Q. Fair enough. 20 A. Because he's very thorough. 21 Q. And I only have one of these, and it is not 22 Bates labeled, but it comes from one of those native 23 productions, so I will show this to you before I mark 24 it. And I will find the other -- find another copy for 25 you, but it comes from your production from the	Page 205 1 email, does this refresh your recollection at all as to 2 who he is? 3 A. No. I don't -- I'm not familiar with him. 4 MS. BLAIR: Okay. That's the last of my 5 Larry Edelson questions so we can take a break 6 at this point. Thank you. 7 THE VIDEOGRAPHER: This is the end of media 8 three. The time is 2:16 p.m. We're going off 9 the record for a media change. 10 (A recess was taken from 2:15 p.m. to 2:31 p.m.) 11 THE VIDEOGRAPHER: This is media number four 12 in the deposition of Heather Havericak. The 13 time is 2:32 p.m. We are back on the record. 14 BY MS. BLAIR: 15 Q. Ms. Havericak, I just wanted to talk briefly 16 about your understanding of how, if at all, in your 17 words, Leapfrog verifies survey data reported to it. 18 Do you have any understanding what Leapfrog does to 19 verify data? 20 MR. MARCUS: Object to form. 21 A. In my understanding, Leapfrog doesn't come 22 on site and verify practices or data. I have never 23 seen that done in my experience. 24 BY MS. BLAIR: 25 Q. Okay. Do you know whether or not Leapfrog

Page 206 1 requests documents from hospitals to verify data? 2 MR. MARCUS: Object to form. 3 A. In my experience they've never requested 4 documents. 5 BY MS. BLAIR: 6 Q. Are you aware from your time as the CEO at 7 Broward at least that hospitals have to sign an 8 attestation when they submit their survey results? 9 A. I am. 10 Q. Are you aware that that attestation tells 11 the hospitals that Leapfrog can perform an audit of the 12 hospital on their survey data responses? 13 A. I don't remember exactly what the 14 attestation says. 15 Q. But as you sit here today, you don't know of 16 any hospital that have ever been audited, onsite 17 audited by Leapfrog? 18 A. Correct. 19 Q. And as you sit here today you're unaware of 20 any hospitals that have been requested to provide 21 documentation to verify their survey responses? 22 A. Correct. 23 Q. Are you aware that after a hospital provides 24 its answers to the Leapfrog Hospital Survey Leapfrog 25 does perform algorithmic review of that data set to see	Page 208 1 Do you see that? 2 A. Yes. 3 Q. And if you look at the attachments, and I 4 specifically didn't attach, do you see attached was the 5 2024 hospital survey scoring algorithm? 6 A. Yes. 7 Q. And do you have an understanding that that 8 is the method -- you provided them with the Leapfrog 9 scoring methodology for 2024? 10 A. Yes. 11 Q. And you go on to say here, "It will show you 12 the standard" -- "what the standard is, where you can 13 meet, achieve or not meet." 14 Do you see that? 15 A. Yes. 16 Q. Does that refresh your recollection in any 17 way that there are certain scores assigned with meet, 18 achieve or not meet? 19 A. Yes. 20 Q. But you still don't recall whether or not 21 for those four imputed measures in spring of 2024 that 22 an achievement was 100 out of 100 points? 23 MR. MARCUS: Object to form. 24 A. I don't remember the exact numerical number 25 associated with those achievements.
Page 207 1 if it is accurate? 2 MR. MARCUS: Object to form. 3 A. I'm not aware of what Leapfrog does on their 4 side. 5 BY MS. BLAIR: 6 Q. You had stated earlier -- and we'll just 7 mark this as 16. And this is the last one. 8 (Defendant's Exhibit Number 16 for i.d.) 9 BY MS. BLAIR: 10 Q. Ms. Havericak, earlier in your discussions 11 at this deposition you told me that you reviewed that 12 358-page [sic] hospital survey because you thought 13 there might be the possibility that your hospital would 14 be reverting to the Leapfrog Hospital Survey. Do you 15 remember that? 16 A. Yes. 17 Q. And I just now have handed you what we've 18 marked as Exhibit 16, which is an email from you to 19 Jennifer Shoemaker, Nicole Jackson on December 11, 2024 20 entitled "Leapfrog Standards." 21 Do you see that? 22 A. Yes. 23 Q. And you say, "Sending this to you both as a 24 prep. We might be going back to Leapfrog and want you 25 both to review the Leapfrog criteria guide."	Page 209 1 BY MS. BLAIR: 2 Q. So this doesn't refresh your recollection? 3 A. It just refreshes that there's the achieve, 4 does not meet or meet. 5 Q. Got it. 6 And then you go on to say, "Nothing has been 7 decided at this time. Just wanted to send it so you 8 all had some time to review and think about some areas 9 where we can really excel." 10 Do you see that sentence? 11 A. Yes. 12 Q. What is your understanding in or around 13 December 11, 2024, what was happening so that you could 14 relay to these women that nothing has been decided at 15 this time? 16 A. Well, that goes back to what we talked about 17 earlier, that we had had discussion of if we were to 18 potentially go back to reporting to Leapfrog. 19 Q. And do you recall who was having that 20 discussion about report to go Leapfrog? 21 A. That was the discussion that I mentioned 22 earlier we were having at our group, Palm Beach group 23 CEO meeting. 24 Q. Did you have an understanding that 25 Maggie Gill was going to ask Tenet home office

Page 210 1 whether -- for an exception for the hospitals in the 2 Palm Beach Health Network to participate in the 3 Leapfrog Hospital Survey? 4 A. There was some discussion to potentially 5 getting an exception to participate because of the 6 damage that it was causing reputationally for us. 7 Q. And do you recall what the outcome of 8 Maggie Gill's discussion was Tenet home office was 9 about getting that exception? 10 A. I just know the outcome as a whole we talked 11 about at the group level at the network level was that 12 we were not going to participate. 13 Q. So your memory is you made the decision at 14 the group level not no participate regardless of what 15 home office had said? 16 A. I recall us having a discussion about it at 17 the group level. 18 Q. Do you recall at a group level coming to the 19 consensus that you were not going to participate in the 20 Leapfrog Hospital Survey regardless of home office's -- 21 home office giving you an exception or not? 22 MR. MARCUS: Object to form. 23 A. I don't -- I don't recall like what the 24 final decision was on the exception. I just recall us 25 speaking about is it as a group and that we were --	Page 212 1 reimbursement need to submit their case for review by 2 Dr. Franklin," you don't recall that? 3 MR. MARCUS: Object to form. You want to 4 show her the email or? 5 MS. BLAIR: I only have one with my markings 6 on it, so, sorry. 7 I'll show it to you. It has my highlight on 8 it. 9 This was previously marked as 10 Sheri Montgomery's deposition, but we can mark 11 this as 17. 12 (Defendant's Exhibit Number 17 for i.d.) 13 BY MS. BLAIR: 14 Q. I'm not trying to be tricky. I just don't 15 fly with all the copies. 16 Ms. Havericak, I'm now handing you what 17 we've marked as Exhibit 17, which was previously -- I 18 don't have copies -- which was previously shown to 19 Sheri Montgomery. 20 MR. MARCUS: Can I just see it? 21 MS. BLAIR: And I'll submit for the record 22 that those highlights are my highlights. 23 BY MS. BLAIR: 24 Q. Have you seen this email before today? 25 A. I don't believe I have.
Page 211 1 still believed it was not adding value and we were not 2 going to participate. 3 BY MS. BLAIR: 4 Q. Okay. So it's your testimony on behalf of 5 Delray in your corporate capacity that the decision not 6 to participate in the Leapfrog Hospital Survey in or 7 around December of 2024 was a decision made at the 8 group level? 9 A. Correct. 10 Q. Are you aware that Maggie Gill went to home 11 office to ask for an exception for these five hospitals 12 to participate in the Leapfrog Hospital Survey? 13 MR. MARCUS: Object to form. 14 A. I'm aware that there was discussion about 15 it. I don't know what she actually went back and asked 16 for. 17 BY MS. BLAIR: 18 Q. Okay. And you don't recall whether or not 19 there was an email from home office, an email from 20 Anna Gunod to Regina West reporting back to -- also 21 CC'ing Andrea Nunez, Heather Wehmeyer, 22 Kathleen McDonald or Taylor Pool that where Anna Gunod 23 says, "It's a no from home office. Facilities who need 24 an exception due to Leapfrog participation being tied 25 to a local requirement, contract compliance or	Page 213 1 Q. Okay. And you'll see it's dated 2 September of 2024, correct? 3 A. Correct. 4 Q. And do you see that sentence where -- first 5 of all, who is Anna Gunod? 6 A. She is the corporate director of 7 infection -- or I'm sorry -- national director of 8 infection prevention, so she's over infection control 9 for the whole Tenet corporation. 10 Q. Okay. And do you see where she says it's a 11 no from home office? 12 A. I see the statement, "It's a no from home 13 office." 14 Q. And what does it go on to say? What's the 15 next sentence? 16 A. "Facilities who need an exception due to 17 Leapfrog participation being tied to a local 18 requirement, contract compliance or reimbursement need 19 to submit their case for review by Dr. Franklin." 20 Q. Okay. And do you know whether or not the 21 five hospitals that are plaintiffs in this litigation 22 submitted a request for review to Dr. Franklin? 23 A. I don't know if they did. I know I didn't 24 personally submit an exception to Dr. Franklin. 25 Q. Okay. And if we look at Exhibit 16, that is

Page 214 1 an Exhibit from December of 2024, correct? 2 A. That's correct. 3 Q. And at that time you're telling your staff 4 that you may be going back to Leapfrog in that December 5 email, correct? 6 A. That's correct. 7 Q. And so as you sit here today, do you have 8 any understanding of whether or not between the 9 September 2024 time frame that I've marked as 10 Exhibit 17 and the December 2024 time frame that's 11 marked as Exhibit 16 there were ongoing discussions 12 about potentially participating in Leapfrog? 13 A. Just the discussions I told you about that 14 we talked about at the network level at our CEO 15 meetings. 16 Q. But you have no memory of being told about 17 Anna Gunod's email where she says "it's a no from home 18 office"? 19 A. No, this is the first time I'm hearing about 20 this. 21 Q. Okay. 22 A. Do you need this one back? 23 Q. No. It's going to be part of the record 24 now. 25 And then you say in this email, I'm going	Page 216 1 counsel. But what involvement did you have, if any, in 2 making the decision to send the cease and desist letter 3 to Leapfrog? 4 A. I just reviewed the letter that was prepared 5 by counsel. 6 Q. Was the cease -- was the plan to send the 7 cease and desist letter discussed at any Palm Beach 8 Health Network meetings outside the presence of your 9 lawyer? 10 A. Not that I can recall. 11 Q. Did the Palm Beach Health Network have to 12 take a vote to make the decision to send the cease and 13 desist letter? 14 A. Not that I recall. 15 Q. Did the Palm Beach Health Network have to 16 get the permission of Tenet home office to send the 17 cease and desist letter? 18 MR. MARCUS: Object to form. 19 A. I wouldn't be involved in that discussion, 20 so I'm not sure what approvals were necessary. 21 BY MS. BLAIR: 22 Q. Who would be involved in that discussion on 23 behalf of Palm Beach Health Network? 24 A. Our group president, Maggie Gill. 25 Q. Anyone else?
Page 215 1 back to 16, Exhibit 16, I'm sorry, you say, "There are 2 many measures we can position" -- "we can be positioned 3 in the top achievement." 4 Do you see that sentence? 5 A. Yes. 6 Q. Do you recall what measures in December of 7 2024 you believed you could be positioned in the top 8 achievement? 9 A. Like I explained earlier, our improvements 10 in our hospital-acquired infections. 11 Q. Ultimately the five plaintiff hospitals did 12 not participate in the Leapfrog Hospital Survey, 13 correct? 14 A. That is correct. 15 Q. And still to this day do not participate in 16 the Leapfrog Hospital Survey, correct? 17 A. That's correct. 18 Q. And are you aware that in January of 2025, 19 there was a cease and desist letter sent by the five 20 plaintiff hospitals to Leapfrog demanding that they 21 cease and desist from grading these five hospitals for 22 the spring 2025 hospital safety grade? 23 A. That's correct. 24 Q. What involvement, if any, did -- and I don't 25 want to know any conversations you had with your	Page 217 1 A. I think that would be it. 2 Q. Do you know whether or not at the time the 3 cease and desist letter was sent in January of 2025 the 4 five plaintiff hospitals had already made the decision 5 to file suit against Leapfrog? 6 MR. MARCUS: Object to form. 7 A. I'm not sure. 8 BY MS. BLAIR: 9 Q. Do you know who all -- and, again, I don't 10 want to know about any conversations you had with your 11 lawyers, but do you know who all on behalf of 12 Palm Beach Health Network was involved in the drafting 13 of the cease and -- the January cease and desist 14 letter? 15 MR. MARCUS: Object to form. 16 A. It, again, was worked on with counsel. 17 BY MS. BLAIR: 18 Q. Did you have any meetings with your 19 governing board advising them that the plan was to send 20 a cease and desist letter to Leapfrog about your 21 hospital safety grade? 22 A. I don't believe I had a conversation with 23 them about the cease and desist letter. 24 Q. Did you ever report the cease and desist 25 letter to the governing board?

Page 218 1 A. We talked about everything holistically when 2 the lawsuit was coming out so that they were aware. 3 Q. So your governing board did not take a vote 4 as to whether or not a cease and desist letter should 5 be sent to Leapfrog? 6 A. They did not take a vote. 7 Q. Did you go to your med exec about the fact 8 that you were sending a cease and desist letter in 9 January of 2025 to Leapfrog? 10 A. I believe we did discuss that in January at 11 the med exec meeting. 12 Q. What do you recall about that discussion? 13 A. Just that the cease and desist was going to 14 go out so that the letter grade could potentially be 15 retracted and not publicly reported. 16 Q. Was the expectation that the fall 2024 grade 17 would be retracted? 18 MR. MARCUS: Object to form. 19 A. I don't know what the expectation was. Just 20 we talked about the letter. 21 BY MS. BLAIR: 22 Q. And what was the outcome of discussion at 23 the med exec meeting about the sending of a cease and 24 desist letter? 25 A. They were supportive of that.	Page 220 1 Q. Do you know who made the decision that a 2 cease and desist letter would be sent? 3 A. No. 4 Q. Do you know whether the decision to send the 5 cease and desist letter was the decision of the Palm 6 Beach Health Network or of Tenet Healthcare home 7 office? 8 MR. MARCUS: Object. 9 A. I don't know. 10 MS. BLAIR: Can you mark this as 18? 11 (Defendant's Exhibit Number 18 for i.d.) 12 BY MS. BLAIR: 13 Q. Ms. Havericak, I'm now handing you what 14 we've just now marked as Exhibit 46 [sic] to your 15 deposition. Do you have in front of you an email, 16 microscopically, dated December 13th, 2024? 17 A. Yes. 18 Q. And it's from Maggie Gill to 19 Teresa Urquhart, U-r-q-u-h-a-r-t, correct? 20 A. That's correct. 21 Q. And also Mohammad Aslam, correct? 22 A. Yes. 23 Q. Who is Teresa Urquhart? 24 A. She's the market president in the Carolinas, 25 I believe, in South Carolina for the two hospitals
Page 219 1 Q. Do you recall any specific statements that 2 were made in support of sending the cease and desist 3 letter? 4 A. I don't remember the specifics. 5 Q. Do you recall whether any of the members of 6 the med exec were supportive of sending a cease and 7 desist letter because they believed that Leapfrog was a 8 pay-to-play scheme? 9 MR. MARCUS: Object to form. 10 A. I don't know what they each believed. 11 BY MS. BLAIR: 12 Q. Were they told that? 13 MR. MARCUS: Same objection. 14 A. I don't remember exactly what we talked 15 about. 16 BY MS. BLAIR: 17 Q. Did they see the cease and desist letter 18 before it was sent? 19 A. I did not personally share a cease and 20 desist letter. 21 Q. Do you know when the decision was made to 22 send the cease and desist letter? 23 MR. MARCUS: Object to form. 24 A. I don't know the exact dates. 25 BY MS. BLAIR:	Page 221 1 there, and Maggie is over that territory as well. 2 Q. Who is Mohammad Aslam? 3 A. I'm sorry. I don't know Mohammad. 4 Q. And Shelly Weiss is CC'd on this? 5 A. She is CC'd, yes. 6 Q. Okay. And if we go down to the first email 7 in this string, which would be the last email here but 8 the first time-wise, from Maggie Gill to Regina West, 9 Ricardo Ramirez, he's chief nursing officer for the 10 group, correct? 11 A. For our group in Palm Beach Health Network, 12 yes. 13 Q. Okay. And then we have Teresa Urquhart and 14 Mohammad Aslam again. And do you see Maggie Gill is 15 saying, "Please send me request, reintroduce Leapfrog 16 reporting. Include rationale, imputed score and 17 clippings of negative press/community and MD feedback." 18 Do you see that? 19 A. I see it. 20 Q. And then she goes on to say, "I will request 21 an exception for PBHN and PMC to start next reporting 22 period." 23 Do you see that? 24 A. I see that. 25 Q. Do you know what PMC is?

Page 222 1 A. Piedmont Medical Center in the Carolinas. 2 So there's Fort Mill and Piedmont. 3 Q. Got it. 4 A. Those are Teresa's hospitals. 5 Q. And then Maggie reports back but not to you, 6 she dropped some people off this, and she says, "I have 7 spoken with several members of ELT about this issue." 8 Do you see that? 9 A. Yes. 10 Q. Is ELT an acronym that's regularly used at 11 Tenet? 12 A. I don't use that. I don't know. 13 Q. Do you know whether that refers to executive 14 leadership team? 15 A. I don't know what she's referring to because 16 it's not my email. 17 Q. Okay. 18 A. And I'm not on any strings of this email. 19 Q. Understood. And you've never seen this 20 email before? 21 A. No. 22 Q. Okay. So when she says, "There are efforts 23 underway to address Leapfrog's ability to score us even 24 though we don't participate," you don't know what that 25 means?	Page 224 1 community that trusts us to provide healthcare and had 2 given the impression, the false impression that we 3 don't provide high value, high quality care, and that's 4 where that decision came from. 5 Q. Did you have any discussions about the fact 6 that filing a lawsuit and going on a PR campaign would 7 further publicize your Leapfrog grades to the 8 community? 9 A. Which question do you want me to answer 10 because there was two questions in there? 11 Q. Sure. Did you have any discussions at the 12 Palm Beach Health Network level about the fact that 13 filing suit would further publicize your Leapfrog 14 safety grades? 15 A. I don't recall having specific conversation 16 about it further publicizing, but that was a risk that 17 existed. 18 Q. And, in fact, are you aware that the 19 Palm Beach Health Network did, in fact, publicize the 20 lawsuit in the local media? 21 A. I'm aware of a statement that went out. 22 Q. Are you aware that lawyers from Gibson Dunn 23 were on TV talking about the grades that your hospital 24 received? 25 A. I am aware.
Page 223 1 A. No. 2 Q. Okay. Do you know whether or not PMC sent a 3 cease and desist letter to Leapfrog? 4 A. I'm not aware of what they've done. 5 Q. Do you know whether or not PMC has filed 6 suit against Leapfrog? 7 A. I'm not aware that they've filed suit. 8 Q. Have you had any discussions either at the 9 Palm Beach Health Network level or with home office 10 level about any other hospitals in the Tenet Healthcare 11 system filing suit against Leapfrog based on their 12 nonparticipation in the Leapfrog Hospital Survey? 13 A. I haven't been part of any of those 14 discussions. 15 Q. Ultimately a lawsuit was filed and that's 16 what we're here for today, correct? 17 A. Correct. 18 Q. What -- and, again, I don't want to know 19 about any discussions you had with your lawyers, but 20 what discussions did you have at the Palm Beach network 21 health level -- Palm Beach Health Network level 22 regarding the decision to file suit against Leapfrog? 23 A. We just had discussion about the 24 reputational harm that had been done to all of our 25 facilities and how it had shaken the confidence of a	Page 225 1 Q. And are you aware that there were several 2 articles written that displayed the fact that Delray 3 received an F as a result of the filed litigation? 4 A. I'm aware of those. 5 Q. And were there any discussions outside the 6 purview of your lawyers at the Palm Beach Health 7 Network level prior to the filing of the lawsuit that 8 the further publicization of your grades could have a 9 further harmful impact on the community's view of the 10 hospitals? 11 MR. MARCUS: Object to form. 12 A. I don't recall exactly what that 13 conversation may be. It was a risk that I think 14 everyone was aware of. 15 BY MS. BLAIR: 16 Q. Okay. Did you have a conversation -- do you 17 recall a conversation generally about that risk? 18 A. Yeah, a general conversation about that. 19 Q. Okay. And what do you recall? 20 A. Just that it could have more attention 21 around it. 22 Q. Do you know whether it did or did not have 23 more attention around it? 24 A. I can't say if it did or didn't. 25 Q. Do you know -- in all of your time as a CEO

Page 226 1 of a hospital, which has been decades, how many times 2 have you had discussions with patients about Leapfrog? 3 A. I've had them a lot recently because 4 consumers are looking at Leapfrog because of the way 5 that things are marketed. 6 Q. Well, let's talk about prior to November of 7 2024. How many conversations had you had with patients 8 about Leapfrog? 9 A. I don't think prior to 2024 I had a lot of 10 conversations with patients about Leapfrog. 11 Q. And you-- what about prior to -- and I think 12 I asked prior and I want to make sure. Prior to 13 November of 2024, how many conversations had you had 14 with patients about Leapfrog? 15 A. I mean, if I -- probably very limited. 16 Q. And that's true even when Delray's grade was 17 a D in the spring of 2024, correct? 18 A. That's correct. 19 Q. And you testified earlier that you consider 20 a D to be a failing grade, correct? 21 A. Correct. 22 Q. What discussions did you have with your 23 board about the decision to file a lawsuit against 24 Leapfrog? 25 A. We just informed them that we were moving	Page 228 1 A. I don't know. I need the financial 2 statements. 3 BY MS. BLAIR: 4 Q. Was the med exec told that a lawsuit was 5 going to be filed against Leapfrog before the filing of 6 the lawsuit? 7 A. Yes. 8 Q. Did the med exec have to approve the filing 9 of the lawsuit? 10 A. They do not. 11 Q. Who has to approve the filing of the 12 lawsuit? 13 A. I mean, we were -- we're able to do that 14 with our Palm Beach Health Network, and I would assume 15 probably our corporate office also has to approve that. 16 Q. Did any of the CEOs of the hospitals that 17 make up the Palm Beach Health Network object to filing 18 the lawsuit against Leapfrog? 19 A. Not that I recall. 20 Q. Do you recall that the lawsuit in this 21 action was filed on April 30th, 2025? 22 A. That date sounds correct. 23 Q. And did you review the Complaint before it 24 was filed? 25 A. I did.
Page 227 1 forward with a lawsuit against Leapfrog. 2 Q. Did the board have to vote to approve a 3 lawsuit against Leapfrog? 4 A. They don't have to vote to approve that. 5 Q. Did the board have any questions about how 6 expensive a suit against Leapfrog would be? 7 A. They didn't, that I remember, ask questions 8 about the cost. 9 Q. And you understand that one of things you're 10 asking for in this lawsuit is for my client to pay 11 attorney's fees that are associated with this lawsuit, 12 correct? 13 MR. MARCUS: Object to form. 14 A. I don't -- I don't know all the things that 15 are being asked for your client. 16 BY MS. BLAIR: 17 Q. Do you know how much in fees Delray has 18 spent to date in prosecuting this lawsuit? 19 MR. MARCUS: Object to form. 20 A. I do not. I would need our financial 21 statements to be able to show you that. 22 BY MS. BLAIR: 23 Q. Do you have any idea if it's over a million 24 dollars? 25 MR. MARCUS: Same objection.	Page 229 1 Q. Did anybody else at Delray review the 2 Complaint before it was filed? 3 A. I just reviewed it. 4 Q. Was there anything in that Complaint that 5 you disagreed with? 6 MR. MARCUS: Object to form. 7 A. I reviewed it with my counsel. 8 BY MS. BLAIR: 9 Q. Okay. And so outside of any discussions 10 with your counsel did you make any changes to the 11 Complaint that you can recall? 12 A. I don't recall making changes. 13 MS. BLAIR: Can we mark this as 18? 14 THE STENOGRAPHER: 19. 15 MS. BLAIR: 19. 16 (Defendant's Exhibit Number 19 for i.d.) 17 BY MS. BLAIR: 18 Q. Ms. Havericak, I am providing you with a 19 document that we've now marked as Exhibit 19. And I'll 20 submit to you that you'll see the Bates number down 21 here is Boca News Now. And it is a response to a 22 subpoena that I sent to Boca News Now. And they 23 produced back to us a press release from 24 Rebecca.Henrikson@scalestrategy.com. Do you see that 25 on page 2 of this document?

Page 230 1 A. I see that. 2 Q. Do you know who Rebecka Henrikson is? 3 A. I do not know Rebecka. 4 Q. Do you know who scalestrategy.com is? 5 A. I do not. 6 Q. And do you recognize this document that is 7 at Boca News Now 2 through 4? 8 MR. MARCUS: Object to form. 9 A. I mean, I don't know if I have seen this, 10 this particular one before. 11 BY MS. BLAIR: 12 Q. Okay. And if you look at Rebecka is writing 13 to Andrew, and she says, "I'm reaching out on behalf of 14 the Palm Beach Health Network." 15 Do you see that? 16 A. Yes. 17 Q. And your hospital is part of the Palm Beach 18 Health Network, correct? 19 A. That's correct. 20 Q. And do you see that this is at the bottom 21 right before her signature, she says, "You can read 22 more about the filing in the press release below." 23 Do you see where she says that? 24 A. Yes. 25 Q. Looking at this, did you see this press	Page 232 1 until last year when they changed their criteria to 2 deliberately fail nonparticipating hospitals." 3 Do you see that? 4 A. Yes. 5 Q. What is that based on? 6 A. That's based on the measures we've been 7 talking about today, the four self-reported measures. 8 Q. And is that based on what you told me today 9 that you believe that non -- all nonparticipating 10 hospitals fail if they don't participate in the survey? 11 MR. MARCUS: Object to form. 12 A. I believe that's consistent with what I've 13 told you. 14 BY MS. BLAIR: 15 Q. And you believe that Leapfrog just 16 deliberately fails nonparticipating hospitals, correct? 17 A. Correct. 18 Q. And so as you sit here today, you have done 19 no research to inform yourself as to whether or not 20 there are non -- there are hospitals that do not 21 participate in the Leapfrog Hospital Survey that 22 receive A's, B's and C's in their hospital safety 23 grade, correct? 24 MR. MARCUS: Object to form. 25 A. I have been going on the advice of counsel.
Page 231 1 release before it was issued to the news on April 30th? 2 A. I don't remember if I saw this press release 3 before it went out. 4 Q. Is this something that someone in the 5 marketing department at Delray hospital would have seen 6 before it went out? 7 A. Yes. 8 Q. Do you see on page 3 of this press release 9 it says, "The legal action comes after repeated efforts 10 by the hospitals to engage with the Leapfrog Group"? 11 A. Yes, I see that. 12 Q. Do you know what the repeated efforts are 13 that are being referred to in the press release that 14 was put out on behalf of your hospital through 15 Palm Beach Health Network? 16 A. I don't know exactly what they're 17 referencing here, but I would imagine it follows the 18 cease and desist letter. 19 Q. Okay. So you believe the repeated efforts 20 being referred to are the cease and desist letter? 21 A. That's what I would believe it to be. 22 Q. Okay. And then if you look at the end, the 23 last sentence of that paragraph says, "Leapfrog did not 24 punish the plaintiff hospitals for the past four years 25 that they did not respond to its voluntary data request	Page 233 1 BY MS. BLAIR: 2 Q. And you see if we go one, two, three, four, 3 five paragraphs down, it starts with "Leapfrog's 4 so-called grades." 5 Do you see that? 6 A. Yes. 7 Q. You say "Leapfrog's so-called grades are not 8 grounded in credible science or independent analysis." 9 Do you see that? 10 A. I see that. 11 Q. What is that based on? 12 A. I'm not sure. I didn't write this. 13 Q. But do you understand that that's an 14 allegation of the Complaint that was filed on behalf of 15 your hospital? 16 MR. MARCUS: Object to form. 17 A. Yes. 18 BY MS. BLAIR: 19 Q. And before filing that Complaint, did you do 20 any research to come to the conclusion as to whether or 21 not it is true that the Leapfrog grading methodology 22 is, quote, not grounded in credible science or 23 independent analysis? 24 A. I relied on counsel. 25 Q. Do you understand that Leapfrog has

Page 234 1 13 independent voluntary expert panels who advise on 2 the hospital -- both the hospital survey and the 3 hospital grading methodology? 4 MR. MARCUS: Object to form. 5 A. I do know they have experts. 6 BY MS. BLAIR: 7 Q. Do you understand that the analysis that 8 goes into the hospital safety grade methodology is 9 fully available on the LeapfrogGroup.org website? 10 MR. MARCUS: Object to form. 11 A. I do. 12 BY MS. BLAIR: 13 Q. Have you ever looked to see who the experts 14 are that make up the Leapfrog hospital safety grade 15 expert panel? 16 A. I have not. 17 Q. Do you have any understanding of whether 18 they are qualified to provide guidance to Leapfrog on 19 the issues of patient safety? 20 A. I would need to study each of their CVs and 21 resumes to understand if they're qualified to be an 22 expert. 23 Q. Okay. And you've not done that as we sit 24 here today, correct? 25 A. I have not.	Page 236 1 Q. So you're referring, though, to the 2 financial harm to the hospitals, so you don't believe 3 this refers to Leapfrog getting a financial incentive? 4 A. I believe it refers to the financial damage 5 to the hospitals. 6 Q. Okay. So you don't believe that Leapfrog is 7 motivated financially to giving failing grades to 8 hospitals, but this refers, rather, to financial issues 9 caused to the hospitals that don't participate? 10 MR. MARCUS: Object to form. 11 A. I think it has a major impact on reputation 12 and harm which is going to impact financials as well. 13 BY MS. BLAIR: 14 Q. Okay. The next paragraph of this press 15 release says, "Leapfrog aggressively pushes hospitals 16 to pay for its consulting services." 17 Do you see that? 18 A. I see that. 19 Q. What consulting services are you referring 20 to in this press release? 21 MR. MARCUS: Object to form. 22 A. Again, I didn't write this press release so 23 I don't know exactly which consulting services they're 24 referencing. 25 BY MS. BLAIR:
Page 235 1 Q. And you say in this same sentence, and when 2 I say "you," I mean, the press release from Palm Beach 3 Health Network that was sent on behalf of all five 4 hospitals, including yours, you say that "they," being 5 the grades, "are riddled with falsehoods," and then you 6 say "distorted by undisclosed financial incentives." 7 What are the undisclosed financial 8 incentives that you believe Leapfrog bases its grades 9 on? 10 MR. MARCUS: Object to form. 11 A. It has to do with the reputational harm that 12 caused -- that is caused as a result of not 13 participating. It's not necessarily an exchange of 14 money. 15 BY MS. BLAIR: 16 Q. Okay. But do you believe that Leapfrog gets 17 a financial incentive? 18 A. They do get a financial incentive, and 19 they're causing harm to us. 20 Q. So what's the financial incentive that 21 Leapfrog gets from its methodology? 22 A. So it's not a financial incentive from the 23 methodology. It's the failure to participate that 24 causes financial harm to those hospitals that choose 25 not to participate.	Page 237 1 Q. As you sit here today, are you aware of any 2 consulting services that Leapfrog provides to 3 hospitals? 4 A. I don't know the specific consulting 5 services that they provide, but I do know that Leapfrog 6 does provide consulting services. 7 Q. You believe that Leapfrog provides 8 consulting services for a fee to hospitals? 9 A. Yes. 10 Q. And what do you believe these consulting 11 services do? 12 A. They -- from what I understand, they are 13 for -- to help improve patient safety and quality in 14 hospitals. 15 Q. And who told you that? 16 A. I have heard that several times through some 17 of my professional connections from colleagues. 18 Q. Which colleagues have told you that? 19 A. I don't remember which colleagues. I have 20 colleagues from all over the country. 21 Q. Do these colleagues tell you that they pay 22 Leapfrog for the consulting services? 23 A. I have heard that you can pay Leapfrog to 24 have consulting services. 25 Q. You've heard it from colleagues, but you

Page 238 1 don't know which colleagues, correct? 2 A. Correct. 3 Q. Okay. But you can't tell me as you sit here 4 today what those consulting services are? 5 A. No, I don't have the specifics of those. 6 Q. And then you say "and professional 7 licenses." 8 Do you see that? 9 A. I do. 10 Q. Are you referring to the fact that if you 11 want to use the Leapfrog logos, you have to pay for use 12 of their trademark? 13 MR. MARCUS: Object to form. 14 A. Again, I didn't write this, but that's what 15 it would appear to me. 16 BY MS. BLAIR: 17 Q. So that would be just like Healthgrades®, 18 correct? 19 A. Correct. 20 Q. And then you say here this whole sentence, 21 "Leapfrog aggressively pushes hospital to pay for its 22 consulting services and promotional licenses in 23 exchange for better grades." 24 Do you see that? 25 MR. MARCUS: Object to form. And the use of	Page 240 1 Do you see that? 2 A. Yes. 3 Q. Why was that the expectation? 4 A. Because we're not -- it's a voluntary survey 5 and we're not giving data so we shouldn't be scored on 6 anything. 7 Q. And you weren't at Delray in 2021 when they 8 stopped participating, correct? 9 A. I was not. 10 Q. How do you know that in 2021 Delray expected 11 that TLG would omit Delray from the hospital safety 12 grade when it stopped participating in the survey? 13 A. Can you repeat that? 14 Q. Sure. 15 You weren't at Delray in 2021 when the 16 decision was made to stop participating in the Leapfrog 17 Hospital Survey. And I'm asking how do you know today 18 or in May of 2025 when you signed this declaration that 19 the expectation of Delray in 2021 was that they would 20 no longer be graded? 21 A. I don't -- I don't think that's relevant to 22 what we're talking about. 23 Q. Well, you say "when the medical center..." 24 which is Delray, correct? 25 A. Correct.
Page 239 1 "you." 2 A. I see that. That's a -- 3 BY MS. BLAIR: 4 Q. Do you have any evidence that hospitals pay 5 Leapfrog in exchange for better grades? 6 A. I don't have evidence. 7 Q. If we look at what I think I marked 8 previously as Exhibit -- well, wait. Hold on. -- if 9 we look at what I previously marked as Exhibit 2, which 10 is your declaration, did you draft this declaration 11 yourself? 12 MR. MARCUS: Object to form. 13 A. I did not draft it. I worked with my 14 counsel on it. 15 BY MS. BLAIR: 16 Q. And I don't want to know about any 17 discussions you had with your counsel about this 18 document so I'm just going to ask you a few questions 19 about... 20 Number 15 of your -- paragraph 15 of Exhibit 21 2 which is your declaration, you say, "When the medical 22 center stopped participating in Leapfrog's -- or in 23 the -- I'm sorry -- in TLG's hospital survey, we 24 expected TLG would simply omit the medical center from 25 its hospital safety grades."	Page 241 1 Q. "...stopped participating in the hospital 2 survey..." 3 It says that, correct? 4 A. It says that, yes. 5 Q. And we know that they stopped participating 6 in 2021, correct? 7 A. Correct. But this document is talking about 8 2024 and 2025. 9 Q. Oh, okay. But I just read it to say like 10 when you stopped participating, which was 2021, you 11 expected to be omitted from the safety grade. 12 A. That's a reasonable expectation. 13 MR. MARCUS: Object to form. 14 BY MS. BLAIR: 15 Q. And my question is, who did you talk to at 16 Delray to come to the conclusion that that was their 17 expectation in 2021 when the medical center stopped 18 participating in TLG's hospital survey? 19 MR. MARCUS: Objection. Mischaracterizes 20 the testimony. 21 A. I didn't talk to anyone about 2021. It 22 doesn't -- that's not what the interpretation of that 23 paragraph is. 24 BY MS. BLAIR: 25 Q. Okay. If we go to paragraph 18, the second

Page 242 1 sentence, you say, "It shows that if you participate in 2 its pay-to-play time-consuming hospital survey, TLG 3 assigns you a better grade." 4 Do you see that? 5 A. I do. 6 Q. What is that based on? 7 A. It's based on the facts of what we're 8 talking about today. If we had participated and put in 9 the data, we would have had a nonfailing grade. 10 Q. What's the evidence for the pay-to-play part 11 of that sentence? 12 A. We've talked about this on several occasions 13 today on the pay-to-play. It has to do with the 14 reputational damage and harm Leapfrog has caused to us 15 from not participating in the survey. 16 Q. Do you think that the regular reader of the 17 Palm Beach post thinks that when you say Leapfrog is a 18 play -- pay-to-play scheme, it's understanding that it 19 has to do with the rep -- that statement has to do with 20 the reputational harm that's being caused to Delray? 21 MR. MARCUS: Object to form. 22 A. I don't know what the readers of the Palm 23 Beach Post, how they're going to interpret it. 24 BY MS. BLAIR: 25 Q. But that's how you meant it, correct?	Page 244 1 Q. And there's an asterisk. Do you see the 2 asterisk? 3 A. I do. 4 Q. And the asterisk corresponds to 5 footnote four on this page. Do you see that? 6 A. Yes. 7 Q. And I understand on this page, this is a 8 reproduction of the Web page. But would you agree with 9 me that this footnote four is in bold and red ink? 10 A. I don't remember if it's in bold red ink 11 here. It looks bold here in the font, but I can't 12 recall the color of the ink. 13 Q. Okay. You don't recall looking at it on the 14 Web page? 15 A. I did look at it, but I don't recall the 16 what the color of it was. 17 Q. That's just my question -- 18 A. Yeah. 19 Q. -- you don't know if it's red. 20 Okay. And I read this footnote. "The 21 hospital declined to report their performance on this 22 measure." 23 Do you see that? 24 A. Yes. 25 Q. Is that a true statement that Delray
Page 243 1 A. That's how we meant it. 2 Q. Is it your position that simply by virtue of 3 participating in the Leapfrog Hospital Survey, a 4 hospital gets a better grade? 5 MR. MARCUS: Object to form. 6 A. Yes. 7 BY MS. BLAIR: 8 Q. If we could go to Paragraph 22 but on PBHN 9 2124, so Paragraph 22, it starts on page 2123, PBHN 10 2123. It says, "When the user clicks on view full 11 score, she sees inaccurate and misleading information 12 about the medical center." 13 Do you see that statement? 14 A. I do. 15 Q. And then I assume if we go to the next page, 16 PBHN 2124, this is the page that you are stating shows 17 "inaccurate and misleading information about the 18 medical center," correct? 19 MR. MARCUS: Object to form. 20 A. That is correct. 21 BY MS. BLAIR: 22 Q. Okay. And if we look at this, you'll see 23 here the hospital score is listed here as a 15, 24 correct? 25 A. That's correct.	Page 245 1 declined to report their performance on the measure? 2 A. That's correct. 3 Q. And then it goes on to say, "So a score was 4 assigned." 5 Do you see that? 6 A. I do. 7 Q. Would you agree with me that Leapfrog just 8 assigned a score, it's not part of any sort of 9 mathematical calculation? 10 MR. MARCUS: Object to form. 11 A. They assigned a score, yes. 12 BY MS. BLAIR: 13 Q. Okay. And it says, "So a score was assigned 14 to reflect the lack of information available." 15 Correct? 16 A. Correct. 17 Q. And if we go back up here, it says, "the 18 worst hospital score" -- do you see that -- is 15." 19 Do you see that, "This hospital score is 20 15*?" 21 A. Yes. 22 Q. Best hospital score is 100, correct? 23 A. Correct. 24 Q. The average hospital score is 80.23, do you 25 see that?

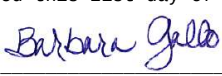
Page 246 1 A. Yes. 2 Q. And then it says the worst hospital score is 3 15, correct? 4 A. Correct. 5 Q. And is it accurate to say that Delray was 6 assigned the worst hospital score? 7 A. Correct. 8 MR. MARCUS: Object to form. 9 BY MS. BLAIR: 10 Q. Do you know how big the font is actually on 11 footnote 4? 12 A. I don't. 13 Q. And I think I asked you this probably four 14 times, but you are unaware as you sit here today 15 whether or not there are any hospitals out of the 3,000 16 hospitals that Leapfrog grades that receive an A and 17 yet don't participate in the hospital survey, correct? 18 MR. MARCUS: Object to form. 19 A. Correct. 20 BY MS. BLAIR: 21 Q. And I've asked you this a thousand times, 22 but you are unaware as you sit here today that when 23 Delray had a D in the spring of 2024, it actually 24 received 100 out of 100 points for all four imputed 25 measures, correct?	Page 248 1 declaration has been withdrawn? 2 MS. BLAIR: I'm testifying Lee Crain has 3 said it multiple times. 4 BY MS. BLAIR: 5 Q. Are you aware whether or not your 6 declaration is still in -- is accurate? 7 A. It's been amended. 8 Q. Your declaration has been amended? 9 A. The declaration? 10 Q. Number 2, yeah, that that's what we're 11 reading. 12 MR. MARCUS: Not the Complaint. 13 BY MS. BLAIR: 14 Q. Not the Complaint. 15 A. Oh. No, no, my declaration is still as is. 16 Q. Okay. Thank you. 17 MS. BLAIR: But you are right, the Complaint 18 has been amended. 19 A. Yes. 20 BY MS. BLAIR: 21 Q. And if we talk about the Complaint, are you 22 aware that Delray Medical as well as the other 23 plaintiffs in this action have withdrawn their request 24 for monetary damages? 25 A. I am aware of that.
Page 247 1 MR. MARCUS: Object to form. 2 BY MS. BLAIR: 3 Q. You're unaware of that? 4 A. I was unaware. I just need to see the 5 document. 6 Q. Did you ever get -- did your board -- did 7 any member of your board ever get inquiries from 8 patients about Delray's Leapfrog grade when it was a D 9 in the spring of 2024? 10 A. Not that I can recall. 11 Q. What about med exec, did they ever get 12 inquiries from patients when Delray's grade was a D in 13 the spring of 2024? 14 A. Not that I can recall. 15 Q. So I want to talk about the damages in this 16 case. Do you understand -- 17 Well, let me, real fast, Exhibit 2, have you 18 ever been told that your declaration has been withdrawn 19 in this litigation? 20 MR. MARCUS: Object to form. 21 A. No. 22 BY MS. BLAIR: 23 Q. Did you ever withdraw your declaration in 24 this litigation? 25 MR. MARCUS: Are you testifying this	Page 249 1 Q. And do you understand as you sit here today 2 that Delray and the other plaintiffs are only 3 requesting injunctive and declaratory relief against 4 Leapfrog? 5 A. Yes. 6 Q. And what do you understand the injunctive 7 relief is that's being requested in this litigation? 8 A. To withdraw the letter grades. 9 Q. Is it to withdraw past letter grades or not 10 grade in the future? 11 MR. MARCUS: Object to form. 12 A. Both. Both from what I understand. 13 BY MS. BLAIR: 14 Q. I want to talk about -- 15 Well, what are the types of damage that 16 Delray has suffered as a result of its Leapfrog 17 hospital safety grades post fall of 2024? 18 A. We have patients that have a less, a lesser 19 confidence in our medical center. I go out on the 20 units every single day in our hospital and do rounding 21 on patients and families, and every day we get 22 feedback. 23 We have people in there that say, "Oh, I was 24 scared to come to Delray because of that Leapfrog score 25 that we see, and I was pleasantly surprised. This is a

Page 250 1 wonderful hospital. We've had incredible care, great 2 nurses and just have been well taken care of." 3 I deal with that every single day. 4 We've had patients that don't want to come 5 for elective procedures because they're nervous about 6 that score that they've seen. We've had physicians 7 that are concerned about coming to the medical center 8 when they have choices and are on staff at multiple 9 places. And then we continue to have community members 10 that tell us, you know, people are still talking about 11 these failing grades. 12 And, you know, I can even be out in the 13 community for dinner, and I can tell you two occasions 14 out with friends, one who's a prominent business person 15 in the community saying, you know, "You have our, one 16 of our only trauma centers in the community, and it 17 makes me nervous to have to go there with that Leapfrog 18 score" and then another whose elderly parents live very 19 close to the medical center and say "We're scared if we 20 have a heart attack or stroke because we have to be 21 taken to Delray and look at that score." 22 I mean, and there's so much -- that's only a 23 little bit of what we know. There's so much damage 24 that we can't even quantify. 25 Q. So these conversations that you've had,	Page 252 1 The end of November, early December 2024? 2 A. And they continue. 3 Q. I understand. 4 A. I mean, they've happened last week, this 5 week. 6 Q. So between the end of November 2024 and 7 April 30th, 2025, how many patients did you speak to 8 that had concerns that were stemming from the Leapfrog 9 hospital safety grade? 10 A. I don't have the number of patients. I 11 don't keep track of those. I mean, it's just on a 12 daily basis I've been talking to patients. 13 Q. Every day? 14 A. Yes, every day, through the workweek Monday 15 through Friday. 16 Q. Okay. So Monday through Friday at least one 17 patient a day talks to you about the Leapfrog hospital 18 safety grade? 19 A. Correct. 20 Q. And these are all patients that are 21 currently in Delray? 22 A. Yes. 23 Q. So they're still coming to Delray? 24 A. They're come to go Delray, but they had 25 apprehension and anxiety about coming to Delray.
Page 251 1 you've had with patients when you're rounding, when did 2 they occur? 3 A. I do those every single day. Typically 4 around 2:00 p.m. I go and do my rounds. 5 Q. Yeah. So it was a bad question. I 6 apologize. 7 Did you have those conversations in 8 November of 2024? 9 A. Yeah, I've always done rounding on patients. 10 Q. Oh, okay. So my questions are bad. I 11 apologize. 12 So I want to break that down a little bit. 13 Okay. So let's talk about the patients that you said 14 are nervous to come to Delray. And I want to talk 15 about specifically about conversations you have had, 16 you personally have had with patients. When is the 17 first time you started having conversations with 18 patients about the Leapfrog grade? 19 A. After the grade came out. 20 Q. Which grade? 21 A. The fall 2024 F. 22 Q. So would that have been in November of 2024? 23 A. It was towards the end of November, 24 beginning of December. 25 Q. Approximately --	Page 253 1 Q. How many conversations have you had between 2 November of 2024 and April of 2025 with patients who 3 refused to come to Delray? 4 A. I had to intervene on a couple in the 5 elective surgical space. 6 Q. "A couple" is two? 7 A. Probably two or three, yeah. 8 Q. And for the record, what is the elective 9 surgical space? 10 A. So patients that were coming for elective 11 surgical procedures. 12 Q. And they did not want to come to Delray? 13 A. They did not. 14 Q. Did they ultimately come to Delray? 15 A. Yes. 16 Q. And then you said -- so there were patients 17 and then you said doctors. 18 A. Um-hum. 19 Q. You talked to doctors about the Leapfrog 20 safety grade? 21 A. Yes. 22 Q. And what are those conversations with 23 doctors? 24 A. That they're concerned to bring patients 25 here, and patients are complaining to them about the

Page 254 1 Leapfrog grade and just being nervous about the quality 2 that Delray is providing to the community based on that 3 grade. 4 Q. How many doctors have you talked with about 5 the Leapfrog grade? 6 A. Probably 15, 20. 7 Q. And these are all doctors that have 8 privileges at Delray? 9 A. Correct. 10 Q. Has any doctor revoked his privileges at 11 Delray? 12 A. Not that I am aware of related to this. 13 Q. When you talk to these doctors about the 14 Leapfrog grade, are they concerned at all about the 15 HCAHPS score? 16 A. They are, but they know that we're working 17 on a plan to improve those that they're a part of. 18 Q. Are they worried at all about the CMS star 19 rating? 20 A. They -- especially the medical staff 21 leadership, and then we talk about that at the 22 department level, they are, but, again, that's old 23 data, and they know about all the improvement plans in 24 place and what the data looks like today. 25 Q. And when you talk to these doctors about the	Page 256 1 associates. One works in healthcare; one does not. 2 Larry Edelson is constantly talking about 3 those things. And then we have other community members 4 that I've talked to just in circles from chamber 5 members and things like that. 6 Q. And your personal friend that's also in 7 healthcare, does she have an opinion about the Leapfrog 8 safety grade? 9 A. He. 10 Q. He. I'm sorry. 11 A. He. I mean, he understands it, but in 12 trying to explain that to elderly parents, it sometimes 13 sounds like you're trying to make excuses, so, you 14 know, it's a difficult story to explain. 15 Q. When you explain to these patients or 16 community members that aren't in healthcare so don't 17 really understand it, how do you explain to them the 18 fact that Delray has 1, they're a one-star CMS 19 hospital, but the Leapfrog safety grade is inaccurate? 20 A. I just go through the measures and explain 21 based on our patient population, based on the limited 22 number, because, again, CMS star ratings are not a full 23 picture of every patient we take care of. It's a 24 snapshot of CMS patients, so it's a snapshot, a piece 25 of our patient population. So I have to explain all
Page 255 1 Leapfrog safety grade, are they also worried about the 2 PSI 90 score of Delray? 3 A. Yeah, because that goes into the whole 4 patient safety component. 5 Q. Correct. 6 A. And we go over all of those components as 7 well. 8 Q. And when you talk to -- you told me earlier 9 that most of the patients that Delray services are 10 Medicare patients, correct? 11 A. There's a large population of Medicare, 12 managed Medicare and commercial. We don't do a lot of 13 Medicaid or underinsured. 14 Q. Do any of the patients that you talk to on a 15 daily basis about the Leapfrog hospital safety grade 16 also have concerns about the CMS star rating? 17 A. They do. They ask about it. Not all of 18 them, but some of them are more savvy than others. 19 Q. And then you said community members talk to 20 you as well, correct -- 21 A. Yes. 22 Q. -- about the Leapfrog hospital safety grade? 23 A. Yes. 24 Q. Who are these community members? 25 A. Two are just personal friends and business	Page 257 1 these measures and explain that that's how we were 2 performing up until 2023. And then I pair that with 3 the data and how we're performing with our performance 4 improvement measures today because the data looks very 5 different. So it's just being able to tell that story 6 and get them to understand all those measures. 7 Q. And do you explain to them that 75 percent 8 of the Leapfrog grade is based on that same CMS data 9 that goes into the one-star rating? 10 MR. MARCUS: Object to form. 11 A. I wouldn't say it's 75 percent based on the 12 calculations I see with the weighting, but they do know 13 that the CMS star rating goes into the Leapfrog and has 14 an impact on it, yes, I explain that. 15 BY MS. BLAIR: 16 Q. Do you feel that you're fairly successful 17 when you have those conversations with patients or 18 community members in explaining to them how the 19 Leapfrog grade and/or the CMS star ratings are not 20 indicative of patient safety at your hospital? 21 A. To some extent I do. 22 Q. And, in fact, I think you told me earlier 23 that you've really not seen admissions decline after 24 the safety grade came out, correct? 25 A. We didn't see admissions decline. But I

Page 258 1 will say in August there was -- in late July there was 2 a viral video that went out that was certainly targeted 3 at our hospitals within the Palm Beach Health Network. 4 Although it didn't reference Leapfrog, it had all the 5 letters assigned to the safety grades. And we did see 6 a significant dip in admissions in the month of August 7 and a dip in people coming for elective procedures in 8 both our cardiac cath lab, electrophysiology lab and 9 our surgical procedures. 10 Q. Is this viral video, this TikTok video from 11 USA Maps? 12 A. It went on to TikTok. It went to Instagram. 13 It went to Facebook. It went everywhere. And that's 14 where there was a lot more feedback from numbers all 15 over. 16 Q. Speaking of Facebook, have you ever gone on 17 Facebook and looked at what people on Facebook say 18 about Delray in the community regardless of the TikTok 19 video? 20 A. Yes. 21 Q. And how -- 22 A. We actually -- and that gets monitored so we 23 can see those comments on a realtime basis, and then we 24 can intervene when we need to, and we do. 25 Q. Would you agree with me that there have been	Page 260 1 not hit us and this grade not been assigned. 2 BY MS. BLAIR: 3 Q. Have you done any quantitative analyses of 4 the impact of the fact that your publicization -- I 5 don't know if that's a word -- of the lawsuit, what 6 impact that had on patient constituents in the 7 community now seeing your grades that they wouldn't 8 have seen previously? 9 MR. MARCUS: Object to form. 10 A. We have not. 11 BY MS. BLAIR: 12 Q. Okay. But you would agree with me, you 13 didn't just file this lawsuit. You also went on a 14 PR campaign -- 15 MR. MARCUS: Object to form. 16 Q. -- about the lawsuit, correct? 17 MR. MARCUS: Same objection. 18 A. I wouldn't agree we went on a PR campaign. 19 BY MS. BLAIR: 20 Q. You would not? 21 A. No. 22 Q. Do you know how many stories the Palm Beach 23 Health Network pitched to local media regarding the 24 lawsuit? 25 MR. MARCUS: Object to form.
Page 259 1 some less than stellar reviews of Delray on Facebook in 2 2023 and 2024? 3 MR. MARCUS: Object to form. 4 A. I don't know that I've seen the 2023 ones. 5 I can say in 2024 there have been. And there -- those 6 would hold true at hospitals all over. People, it's 7 just their perception. 8 BY MS. BLAIR: 9 Q. I agree. 10 Have you done any comparison, any empirical 11 data review to make a determination as to whether or 12 not there has been an actual impact on the reputation 13 of Delray as a result of the Leapfrog hospital safety 14 grade? 15 MR. MARCUS: Object to form. 16 A. We didn't feel we needed to do that. We 17 knew based on the feedback of all of the impact that 18 this was already having. And although the numbers were 19 strong, they were strong for a reason because we had 20 strategically put out a very aggressive strategic plan 21 that we were executing on, like I said, bringing in new 22 physician, elevating quality and service, creating new 23 access points. But we can't even quantify the 24 additional damage because we could have been performing 25 even better than we were performing had this bad press	Page 261 1 A. They pitched stories to tell our side of the 2 story, but I don't think that's a PR campaign. I think 3 it's a defensive strategy to be able to protect the 4 market and give consumers accurate information when 5 they need to have healthcare which is very important 6 and critical for them. 7 BY MS. BLAIR: 8 Q. Do you think that filing the lawsuit and 9 planting these stories in the local news emphasized the 10 F grade at Delray in any way? 11 MR. MARCUS: Object to form. 12 A. I do not. 13 BY MS. BLAIR: 14 Q. Have you had any difficulty retaining 15 doctors as a result of your Leapfrog hospital safety 16 grade? 17 A. Not that I'm aware of. 18 Q. And we talked about nurses. You're not 19 experiencing any nurse retention issues, correct? 20 A. Not at this time except in those key niche 21 departments I talked about earlier. 22 Q. Are there any documents that you produced in 23 this litigation that directly link a decline in 24 admissions to the Leapfrog hospital safety grade? 25 MR. MARCUS: Object to form.

Page 262 1 A. Not that I'm aware of. 2 BY MS. BLAIR: 3 Q. Are there any documents that you're aware of 4 that directly link any decline in revenue to the 5 Leapfrog hospital safety grade? 6 MR. MARCUS: Object to form. 7 A. Not that I'm aware of. 8 BY MS. BLAIR: 9 Q. How does Delray measure its goodwill? 10 A. We look at all of the services that we have 11 provided to the community. We look at the charity care 12 that's been provided and how we've given back to the 13 community. There's a report that is put together. Our 14 chief strategy officer works on it. And how we've 15 served on boards, how we've served our community to 16 give back. 17 Q. Do you quantify in any way, like quantify 18 monetarily in any way what the goodwill of Delray is? 19 A. That's in that report. 20 Q. Oh, it is in that report? 21 A. Yes. 22 Q. Do you know the name of that report? 23 A. I don't. It's one that -- I don't know the 24 name of that one. 25 Q. And you said it's done by the group 2	Page 264 1 MR. MARCUS: Object to form. 2 A. I do not. 3 BY MS. BLAIR: 4 Q. But do you know whether it would be in this 5 report that the group chief strategy officer puts out? 6 MR. MARCUS: Same objection. 7 A. It may have the information that you're 8 asking for. 9 BY MS. BLAIR: 10 Q. Do you know as we sit here today whether 11 that number, that monetary valuation of goodwill for 12 Delray has decreased as a result of the Leapfrog 13 hospital safety grade? 14 MR. MARCUS: Object to form. 15 A. I'm not sure. I'd have to look at the 16 reports. 17 MS. BLAIR: Can we just take five minutes? 18 MR. MARCUS: Sure. 19 MS. BLAIR: Thank you. 20 THE VIDEOGRAPHER: The time is 3:39 p.m. 21 We're going off the record. 22 (A recess was taken from 3:39 p.m. to 3:46 p.m.) 23 THE VIDEOGRAPHER: The time is 3:48 p.m. We 24 are back on the record. 25 MS. BLAIR: Ms. Havericak, I am going to
Page 263 1 strategy officer? 2 A. Group chief strategy officer kind of 3 oversees everything with it. 4 Q. Okay. And that would be Derek? 5 A. Yeah, Derek. It gives you the local impact 6 and how we've served the community and the impact we've 7 had. 8 Q. And you believe that report puts a specific 9 dollar amount on the goodwill of Delray? 10 A. It might not give specifically goodwill, but 11 it gives just the total impact that Palm Beach Health 12 Network has had. 13 Q. Do you understand like when you value a 14 company, let's just say like to sell it, one of the 15 things that goes into that is not only like revenues 16 but also a value for goodwill? Do you understand 17 that's how companies value? 18 A. Yes. 19 Q. Do you know what that monetary value for 20 goodwill of Delray was prior to the fall of 2024? 21 MR. MARCUS: Object to form. 22 A. I do not. 23 BY MS. BLAIR: 24 Q. And do you know what that value associated 25 with Delray's goodwill is today?	Page 265 1 mark one more Exhibit today. This is 20. I 2 want to round it out with an even number. 3 (Defendant's Exhibit Number 20 for i.d.) 4 BY MS. BLAIR: 5 Q. I'm handing you now what we've marked 6 Exhibit 20, and it is entitled Plaintiff Delray Medical 7 Center Inc.'s Amended and Supplemented Responses and 8 Objections to Defendant Leapfrog Group's First Set of 9 Interrogatories to Delray Medical Center. 10 And if we turn to the very last page -- it 11 should be like grayed out -- is that your signature? 12 A. That is my signature. 13 Q. And you signed these interrogatories, 14 correct? 15 A. I did. 16 Q. And my one question is with respect to 17 interrogatory number 20 which says, "State and describe 18 the results of any market analyses, competitive 19 analysis or consumer perception surveys you have 20 conducted or commissioned regarding your competitors 21 from 2020 to present." 22 Do you see that? 23 A. Yes. 24 Q. And if we turn to the next page, the first 25 full paragraph starts "As agreed, during the parties'

Page 266 1 meet and confer on September 3rd, 2025, plaintiff will 2 produce documents showing the results of studies or 3 surveys plaintiff has conducted or commissioned related 4 to internal market analysis, competitive analysis or 5 consumer perception." 6 Do you see that? 7 A. Yes. 8 Q. And then it goes on to say, "Plaintiff will 9 identify the documents responsive to this interrogatory 10 by Bates number in plaintiff's production cover 11 letter." 12 Do you see that? 13 A. Yes. 14 Q. My question is, do you know whether or not 15 you were able to find and/or have produced studies or 16 surveys that Delray has conducted or commissioned 17 related to internal market analysis, competitive 18 analysis or consumer perception? 19 A. I'm not sure if we've been able to produce 20 that yet. 21 MS. BLAIR: Okay. Thank you. 22 And that is all the questions I have for you 23 today. 24 THE WITNESS: Oh, okay. 25 MS. BLAIR: Thank you.	Page 268 1 THE STENOGRAPHER: Okay. Will do. 2 (Thereupon, the proceedings concluded at 3 3:51 p.m.) 4 (The witness did not waive signature.) 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25
Page 267 1 THE WITNESS: Thank you. 2 MS. BLAIR: I will not order the video. I 3 will order the rough plus regular delivery of an 4 eTran with the Exhibits attached. And I'm not 5 sure if you'll read or -- 6 MR. MARCUS: We're going to -- the witness 7 will read. We're also going to designate the 8 transcript as confidential. 9 MS. BLAIR: And I will reserve all rights to 10 assert any objections over portions of this 11 transcript which do not fall within the 12 confidentiality order. 13 MR. MARCUS: And we'll also take a copy. 14 THE VIDEOGRAPHER: The time is 3:51 p.m. 15 This concludes the deposition of 16 Heather Havericak. 17 THE STENOGRAPHER: Do you need regular 18 delivery if I give you a rough tonight, or do 19 you need expedited? 20 MR. SIMMONS: Expedited. 21 THE STENOGRAPHER: When do you need it? You 22 tell me when, and that's when you'll get it. 23 MR. SIMMONS: If you're able to get the 24 final by the end of day Monday, that would be 25 helpful.	Page 269 CERTIFICATE OF OATH THE STATE OF FLORIDA) COUNTY OF PALM BEACH COUNTY) I, the undersigned authority, certify that remotely appeared before me and was duly sworn on the 19th day of September 2025. Signed this 21st day of September 2025.  BARBRIE GALLO, RMR-CRR Notary Public - State of Florida My Commission No. GG939757 My Commission Expires: December 18, 2027

CONFIDENTIAL

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1	10735 133:21	12/11/24 4:12	12/13/24 4:16	17th 154:2, 11, 12 199:11, 13	239:9, 21 247:17 248:10 262:25
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Heather Haverick
September 19, 2025

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EXHIBIT 24

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

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

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

Plaintiffs,

-VS-

THE LEAPFROG GROUP,

Defendant.

VIDEO-RECORDED DEPOSITION OF JERAD HANLON
PURSUANT TO RULES 30 AND 30(b)(6)
Volume 1 (Pages 1 - 247)

DATE: Tuesday, September 23, 2025
TIME: 9:03 a.m. - 12:37 p.m.
LOCATION: One Financial Plaza
100 Southeast Third Avenue
Suite 805
Fort Lauderdale, Florida 33394

Stenographically Reported By:
Theresa Rust, RPR

Job No.: 422123

Jerad Hanlon
September 23, 2025

Page 2 1 APPEARANCES: 2 On behalf of Plaintiffs: 3 GIBSON, DUNN & CRUTCHER LLP 4 2001 Ross Avenue 5 Suite 2100 6 Dallas, Texas 75201 7 (214) 698-3100 8 BY: BETTY X. YANG, ESQUIRE 9 byang@gibsondunn.com 10 BY: ELIZABETH DABANKA, ESQUIRE 11 edabanka@gibsondunn.com 12 13 On behalf of Defendant: 14 WILSON ELSEER MOSKOWITZ EDELMAN & DICKER LLP 15 2063 Main Street 16 Suite 100 17 Sarasota, Florida 34237 18 (941) 866-8561 19 BY: JURA ZIBAS, ESQUIRE 20 jura.zibas@wilsonelser.com 21 22 ALSO PRESENT: 23 Alex Rampone, Videographer 24 25	Page 4 1 Thereupon, 2 the following proceedings began at 9:03 a.m.: 3 THE VIDEOGRAPHER: We are now on the record 4 and the time is 9:03 a.m. This is the 5 video-recorded deposition of Jared Hanlon in the 6 matter of Good Samaritan Medical Center, Inc. 7 versus Leapfrog Group. 8 The deposition is being held in Fort 9 Lauderdale, Florida on September 23, 2025. The 10 videographer is Alex Rampone, and the court 11 reporter is Theresa Rust; both in association 12 with Lexitas Legal Services. 13 Counsel, please announce appearances for 14 the record. 15 MS. YANG: Betty Yang on behalf of the 16 plaintiffs. 17 MS. DEBANKA: Elizabeth Debanka on behalf 18 of the plaintiffs. 19 MS. ZIBAS: Good morning. I'm Jura Zibas 20 with the law firm of Wilson Elser, here on 21 behalf of the Leapfrog Group, and I will be 22 taking your deposition today. 23 THE STENOGRAPHER: Raise your right hand, 24 please. 25 Do you swear that the testimony you are
Page 3 1 INDEX OF PROCEEDINGS 2 WITNESS PAGE 3 JERAD HANLON 4 DIRECT EXAMINATION BY MS. ZIBAS 5 5 CERTIFICATE OF OATH 119 6 CERTIFICATE OF REPORTER 120 7 LETTER TO WITNESS 121 8 ERRATA SHEET 122 9 10 EXHIBITS 11 EXHIBIT DESCRIPTION PAGE 12 1 Amended notice of deposition 7 13 2 Declaration of Jared Hanlon 60 14 3 TLG hospital safety grade 31 15 4 E-mail thread Bates Nos. 91 16 PBHN000005541 - PBHN000005543 17 18 5 E-mail thread Bates Nos. 93 19 PBHN000004906 - PBHN000004910 20 6 WBMCM Meeting minutes 11.19.24 93 21 7 WBMCM Meeting minutes 1.28.24 98 22 23 24 25	Page 5 1 about to give will be the truth, the whole 2 truth, and nothing but the truth? 3 THE WITNESS: Yes. 4 THE STENOGRAPHER: Thank you. 5 THEREUPON: 6 JERAD HANLON 7 Was called as a witness and, having been first duly 8 sworn and responding "I do," was examined and 9 testified as follows: 10 DIRECT EXAMINATION 11 BY MS. ZIBAS: 12 Q. Good morning, Mr. Hanlon. As I indicated, 13 I am here on behalf of the Leapfrog Group to ask you 14 questions related to a lawsuit that was brought in 15 Federal Court by West Boca Medical Center, along with 16 other medical institutions or medical centers, 17 however you want to refer to them, against the 18 Leapfrog Group. I am going to be asking you 19 questions. 20 If you don't understand the question, I can 21 rephrase it, you can tell me. If your attorneys 22 object, they can object. Wait, don't answer until 23 they put their objection on the record. If there's 24 any response I have to give, I'll give the response; 25 otherwise, you will answer the question.

Page 6 1 We're here to get as much information from your 2 memory and your experience as possible. It's not a 3 test of any kind. If you don't know the answer, you 4 say I don't know or I don't remember, it's okay. No 5 reason to try to -- you know, there's no mystery 6 here, so I just want to make sure that's clear. 7 Now, have you been deposed before? 8 A. I have not. 9 Q. Okay. So the rules are you can take a 10 break, as long as there's no question pending. If 11 you need to take a break to go to the restroom, et 12 cetera, speak with your lawyer, like I said, as long 13 as there's no question pending, that's fine. 14 A. Sure. 15 Q. You can take a break at any time. You 16 know, we'll see how the day goes. I'm hopeful maybe 17 we won't be here all day, but I don't know until we 18 start the dialogue. So that's just kind of where we 19 are at this early juncture. 20 And I think as you go along through the process, 21 it will make more sense, rather than me sitting here 22 giving you a lot of instructions. Always, you know, 23 listen to your attorneys, if they do direct you, and 24 if they, you know, give you any type of instruction, 25 make sure that you follow that instruction.	Page 8 1 So as we start the day, I'm going to get -- 2 start out with your -- a little bit of background 3 about yourself. Where do you currently work? 4 A. West Boca Medical Center. 5 Q. And do you have a title there? 6 A. I do. 7 Q. And what is your title? 8 A. Chief executive officer. 9 Q. And when did you become the chief executive 10 officer at West Boca Medical Center? 11 A. October of 2023. 12 Q. Now, going back to your educational 13 background, do you have a college degree? 14 A. I do. 15 Q. Okay. And where did you receive your 16 college degree, your undergraduate? 17 A. James Madison University. 18 Q. And where did you receive, if you received, 19 a higher level degree? 20 A. I received my master's in the hospital 21 administration at Virginia Commonwealth University. 22 Q. And what year was that? 23 A. 2006. 24 Q. And after your master's of hospital 25 administration, did you receive any further
Page 7 1 MS. ZIBAS: So in order to start the day, I 2 have marked what we call a notice of deposition 3 as Hanlon 1. 4 (Exhibit 1 was marked.) 5 BY MS. ZIBAS: 6 Q. I'm putting it in front of you, and I just 7 want to merely ask, have you seen this document 8 before? 9 A. Yes, I have. 10 Q. So we're here today to take your deposition 11 pursuant to this notice, and it's a notice, if you 12 read at the top, of you, Jared Hanlon, individually, 13 and pursuant to 30(b)(6) to West Boca Medical Center. 14 So you're answering on behalf of yourself and the 15 medical center. 16 There may come a point in time where your 17 lawyers may ask who I'm asking a question on behalf 18 of. We can clarify it. I'm sure there's no issue. 19 It does get difficult when you're the individual and 20 the entity because your knowledge is your knowledge. 21 A. Sure. 22 Q. So we'll do our best to make sure it's 23 clear, and if you are ever concerned, you just raise 24 that concern. I don't want you to be confused as to 25 who you're answering a question on behalf of.	Page 9 1 education? 2 A. No, not formal. 3 Q. When you say not formal, are you taking 4 continuing education courses at times? 5 A. Yes, at times. 6 Q. How often do you take continuing education 7 courses? 8 A. I'm a part of the American College of 9 Healthcare Executives, and there's CEUs that are 10 available through that. 11 Q. And do you go to a conference to take those 12 courses? 13 A. You can. I typically do them online. 14 Q. Have you ever taken a course that deals 15 with marketing hospitals? 16 A. I have not. 17 Q. Now, after you finished your education, 18 where is the first -- what's the first job that you 19 had? 20 A. I was an assistant administrator at Davis 21 Regional in Statesville, North Carolina. 22 Q. Okay. And what years or approximately how 23 long were you there? 24 A. I was there about 18 months, from '06 to 25 '08.

Page 10 1 Q. And after that position, where did you go? 2 A. I went to University Medical Center in 3 Lebanon, Tennessee as an associate administrator. 4 Q. Okay. And how long were you there? 5 A. Approximately, three years, from 2008 to 6 2011. 7 Q. And in 2011, what was your -- where did you 8 go for your job or your career move? 9 A. Then I left Lebanon, Tennessee and I moved 10 back home to Petersburg, Virginia and worked for 11 Southside Regional Medical Center as the chief 12 operating officer. 13 Q. And when you were at Southside Regional as 14 chief operating officer, did you have any role in 15 marketing services? 16 A. No, not directly. 17 Q. And what about indirectly? 18 A. Other than just having a -- we had a 19 marketing director that I worked with to -- I was 20 responsible for the overall operations at the 21 hospital, so I worked with the director there. 22 Q. And how long were you at Southside 23 Regional? 24 A. About eight years. I left in 2018. 25 Q. And where did you go in 2018?	Page 12 1 in Virginia and was really impressed with her, and 2 she approached me about an opportunity to come down 3 to Florida. And I as I shared with Betty, once my 4 wife came down here in December, December 7, we 5 walked out of the hotel and it was beautiful and 6 sunny and she said we're coming. 7 MS. YANG: I won't assert protective order 8 on that. 9 MS. ZIBAS: I assumed wouldn't be an issue. 10 BY MS. ZIBAS: 11 Q. So why don't you -- let's talk about this 12 Palm Beach Health Network a little bit. When was the 13 Palm Beach Health Network formed, as far as you know? 14 A. It is a branding as a network. I don't 15 believe it is a formal entity. 16 Q. Now, do all of the Tenet Healthcare 17 corporate employees who work with the Palm Beach 18 Health Network? Are they all at Delray Medical 19 Center? 20 A. No. 21 Q. How many were at Delray Medical Center when 22 you were there as group chief strategy officer? 23 A. I wouldn't know an exact number. There was 24 several. 25 Q. And as far as you know, does Tenet
Page 11 1 A. Start of 2019, I left in December of '18 2 and started in -- at Delray Medical Center as the 3 group chief strategy officer for the Palm Beach 4 network. 5 Q. So were you employed by Delray Medical 6 Center or the Palm Beach network? 7 A. I was employed by Tenet, is the corporate 8 employee. 9 Q. So what was your role? What were your 10 duties as group chief strategy officer? 11 A. I was responsible to look at the overall 12 strategy among the five Palm Beach Health Network 13 hospitals, to look at market share, to look at 14 physician recruitment opportunities in order to 15 direct and organize our strategy going forward for 16 the five hospitals there. 17 Q. And what five hospitals are you referring 18 to? 19 A. West Boca Medical Center, Delray Medical 20 Center, Good Samaritan Medical Center, St. Mary's 21 Medical Center, and Palm Beach Gardens Medical 22 Center. 23 Q. What made you decide to go work for the 24 Tenet Healthcare Corporation? 25 A. My group president, Maggie, I had met her	Page 13 1 Healthcare Corporation direct the strategy for all 2 those five hospitals? 3 MS. YANG: Objection to form. 4 A. As being owned as part of Tenet, yes. They 5 are involved in the strategy that we develop at the 6 local level. 7 BY MS. ZIBAS: 8 Q. And when you were group chief a strategy 9 officer, who did you report to directly? 10 A. Maggie Gill. 11 Q. What was Maggie Gill's title in 2019, if 12 you know? 13 A. She was the CEO of Delray, as well as the 14 Palm Beach market CEO. 15 Q. Did you have a staff as group chief 16 strategy officer working under you? 17 A. Yes. I had a business analyst, a data 18 analyst. I also worked with the strategy officers at 19 each of the facilities. Each facility had a CSO that 20 would -- they were employed by the hospital directly. 21 They were not Tenet employees. I was the only Tenet 22 employee. And so they had a direct line to their 23 respective CEO and a dotted line to me as the group 24 CSO. 25 Q. And what did the data analyst or business

Page 14 1 analyst do in their role? 2 A. Helped us to evaluate market share volumes, 3 presence of medical staff and physicians in the area. 4 Q. And were there reports or documents 5 produced by these analysts that were then shared with 6 all the hospitals about market share? 7 A. Yes. We regularly reviewed market share 8 data. 9 Q. What kind of data did you gather to review 10 market share? 11 A. Combination of both internal and then we 12 used external sources, such as Trilliant and other 13 payer systems that we could analyze and see what the 14 volume was in the area. 15 Q. Who is Trilliant? 16 A. They're an independent company that 17 compiles a lot of data from -- from various biller, 18 billing sources and things like that. 19 Q. Now, in order to prepare for your 20 deposition today, outside of meeting with your 21 attorneys, and I don't want to hear about any 22 conversations you had be your attorney, what else did 23 you do to prepare? 24 A. Just reviewed our policies, reviewed many 25 of the documents that we submitted to Leapfrog.	Page 16 1 A. I don't believe so, that I can recall. 2 Q. Now, when is the first -- going back, have 3 you heard of, obviously, the defendant, the Leapfrog 4 Group? 5 A. Yes. 6 Q. And when did you first hear of the name the 7 Leapfrog Group? 8 A. In my career, I've heard of the Leapfrog 9 Group from even back when I was a COO at Southside 10 Regional. 11 Q. And when you were at Southside Regional, 12 did Southside Regional participate in the Leapfrog 13 Group survey? 14 A. I don't remember. 15 Q. Have you -- are you aware that the Leapfrog 16 Group does have a survey that's at issue in this 17 lawsuit? 18 A. Yes. 19 Q. And do you know how many pages the survey 20 is? 21 A. Not an exact count but it's lengthy. 22 Q. And have you ever personally looked at the 23 survey in the last two years? 24 A. No. 25 Q. Do you know if anyone at West Boca Medical
Page 15 1 Q. And when you said submitted to Leapfrog, 2 are you saying during the course of this litigation 3 or prior to litigation? 4 A. During the course of this litigation. 5 Q. And did you -- were you part of the group 6 or were you the person who gathered documents at West 7 Boca Medical Center for this litigation? 8 A. I was part of the group. 9 Q. How many people gathered documents? 10 A. You know, Andrea Nunes is our director of 11 quality, Gina West, our group director. That was 12 pretty much . . . 13 Q. Are you aware that experts were hired to 14 testify on behalf of West Boca Medical Center in this 15 lawsuit? 16 A. Yes. 17 Q. And did you read any of the expert reports? 18 A. Yes. 19 Q. And which ones did you read? 20 A. I saw our expert testimony showing what we 21 would have received had we have participated in the 22 Leapfrog survey in terms of the grade. 23 Q. Do you remember the name of that expert? 24 A. I don't off the top of my head. 25 Q. Any other expert reports?	Page 17 1 Center has looked at the survey in the last two 2 years? 3 A. Yes. 4 Q. And who would that be, as far as you know? 5 A. Andrea Nunes, our director of quality. 6 Q. Going back to the Palm Beach Health 7 Network. When you were chief strategy officer, who 8 were the other, as you call, C-suite officers in the 9 Palm Beach Health Network? 10 A. For the group? 11 Q. For the group. 12 A. For the group, okay. Our CEO, group CEO 13 was Maggie Gill. Our group CFO was Sheri Montgomery. 14 Our group chief nursing officer was Libby Flippo. 15 And our group chief operating officer was Stephen 16 Garner. 17 Q. Did you have meetings when you were part of 18 the Palm Beach Health Network, meaning the network, 19 the actual group, did you have meetings? 20 MS. YANG: Object to form. 21 A. Yes. 22 BY MS. ZIBAS: 23 Q. How often did you have meetings? 24 A. Regularly. I mean, there would be several 25 ad hoc meetings. I would meet with a lot of those

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Page 18 1 individuals on a daily basis. 2 Q. Did you meet via Zoom, e-mail, phone? 3 A. Combination of all of the above, in person. 4 Q. What were the goals of the Palm Beach 5 Health Network ultimately, as far as you know? 6 MS. YANG: Object to form. 7 A. In terms of what type of goals are you? 8 BY MS. ZIBAS: 9 Q. Well, you talked about you were -- you have 10 responsibility for market share. I mean, is this an 11 organization that merely was put together for 12 marketing purposes, recruitment purposes? 13 MS. YANG: Objection to form. 14 A. No. I mean, we started to brand as a group 15 because of the fact that we were coordinating the 16 care. You know, recruiting staff is challenging, 17 difficult. Capital is very rare to come by, and so 18 we wanted to make sure we were working as 19 collectively as a group to provide efficient 20 high-quality patient care to our community. 21 BY MS. ZIBAS: 22 Q. You had mentioned earlier that you would 23 also look at physician recruitment opportunity. Was 24 physician recruitment at the Palm Beach Health 25 Network difficult?	Page 20 1 Baptist also included Bethesda East and Bethesda 2 West, JFK, both main and north, Palms West, Jupiter 3 Medical Center, Wellington Regional, Broward Health, 4 which is Coral Springs, and north, Broward Health 5 North. I think that covers all of them. 6 Q. All right. Now, you -- you remained in 7 your role as chief strategy officer for the Palm 8 Beach Health Network for how long? 9 A. For a little over a year. 10 Q. Okay. And then what did you do next? 11 A. In March of 2020, COVID hit and there was a 12 need for -- we had a vacancy for our chief operating 13 officer position at St. Mary's and the Palm Beach 14 Children's Hospital, and so Maggie asked if I could 15 help out up at West Boca. And our focus shifted from 16 the strategy role to day-to-day operations with 17 dealing with COVID. 18 Q. And how long did you -- did you 19 simultaneously, while you were COO of St. Mary's and 20 Palm Beach Children's, also remain working as part of 21 the Palm Beach Health Network? 22 A. So I started out in interim basis as chief 23 officer in October of 2019, and was doing dual role 24 from October of '19 until March of 2020. And then I 25 shifted completely to COO of the Palm Beach Health
Page 19 1 A. I think -- 2 MS. YANG: Objection to form. 3 A. I think it's difficult everywhere to 4 recruit physicians. What we do on an annual basis is 5 an annual physician needs assessment to evaluate how 6 many physicians are in the market, and based off of 7 the patient population, how many physicians we're 8 short, and we look to try to fill that, get that gap, 9 that need. 10 BY MS. ZIBAS: 11 Q. Were you able to -- when you were chief 12 strategy officer, were you able to achieve success in 13 recruiting physicians or additional physicians? 14 A. Yes. We recruited several. 15 Q. And in terms of market share, who were the 16 competitors to the Palm Beach Health Network? 17 A. For the Palm Beach Health Network? 18 Q. Correct. 19 A. So I'm going off of my role. This is 20 personally. I'm not representing West Palm. 21 Q. I understand. 22 A. Okay. When I was the group chief strategy 23 officer, I would say it would be Baptist Health, 24 which includes Boca Regional. They had just been 25 acquired by Baptist in July of '19. I would say	Page 21 1 Network, and -- I'm sorry, of St. Mary's and the Palm 2 Beach Children's Hospital. 3 Q. Were you also the group chief COO of Palm 4 Beach Health Network? 5 A. I wasn't until about 2021, I believe, is 6 when Stephen Garner, who was the group chief 7 operating officer, left to go back to Arizona as CEO, 8 and I assumed the role as group COO at that time. 9 Q. So were you both -- you were both the COO 10 of the group, as well as the COO of St. Mary's and 11 Palm Beach Children's; is that correct? 12 A. Yes. 13 Q. And what were your duties? Sounds like a 14 lot of work to be responsible for the network and two 15 hospitals. 16 A. Yeah. It was a lot, especially at that 17 time, given everything going on. I was responsible 18 for the day-to-day operations of St. Mary's and the 19 Palm Beach Children's Hospital, and my role as group 20 was to serve as a liaison and coordinate effective 21 operations from a group-wide perspective, if there 22 were buying opportunities that we could leverage our 23 five hospitals together. So I didn't have direct 24 operational oversight of the other facilities. I had 25 dotted-line reporting of their COOs to me.

Page 22 1 Q. When you were COO of St. Mary's and then 2 obviously the COO of the Palm Beach Health Network, 3 were you aware if these five hospitals were 4 participating in the Leapfrog Group surveys? 5 A. I was not at the time. 6 Q. When did you first learn about West Boca 7 Medical Center's participation or nonparticipation in 8 the Leapfrog surveys? 9 A. When I moved to -- down to West Boca so 10 probably 2024. 11 Q. So prior to taking on your role as CEO of 12 West Boca, did you have any interaction with any of 13 the people at Tenet who made decisions about Leapfrog 14 Group and participation? 15 MS. YANG: Objection to form. 16 A. Can you ask that question, again? 17 MS. ZIBAS: Yes, no. That was a bad 18 question. 19 BY MS. ZIBAS: 20 Q. Until the time you went to West Boca 21 Medical Center as the CEO, prior to that time, were 22 you involved or did you know about Tenet Healthcare's 23 decision to participate or not participate in the 24 Leapfrog Group surveys? 25 MS. YANG: Objection to form, assumes	Page 24 1 Q. And is it today still owned -- is West Boca 2 Medical Center still owned by Tenet Healthcare? 3 A. Yes. 4 Q. And in your day-to-day operations as CEO, 5 do you report to someone at Tenet Healthcare? 6 A. I report to Maggie Gill. 7 Q. And what is Maggie Gill's current title? 8 A. She has taken on -- she's our group 9 president, but is also over multiple groups. So I 10 believe it's division or -- I believe it's division 11 president. 12 Q. Are you currently a Tenet Healthcare 13 employee? 14 A. Yes. 15 Q. And is your compensation based on metrics 16 of success at the hospital? 17 A. Yes. 18 Q. And are the -- do those metrics include 19 revenues of the hospital? 20 A. I have incentive compensation is based off 21 of revenues. 22 Q. Is there a quality director at West Boca 23 Medical Center currently? 24 A. Yes. 25 Q. And was there one there when you started as
Page 23 1 facts. 2 A. I can't speak for Tenet, so I didn't 3 personally have any knowledge of Tenet's decision at 4 the time. 5 BY MS. ZIBAS: 6 Q. And in 2022, were you ever on any e-mails 7 that you recall from Tenet stating that there's a 8 decision not to participate in the Leapfrog Group? 9 A. I don't recall. 10 Q. Now, looking just specifically at West Boca 11 Medical Center, do you know when the medical center 12 was originally founded? 13 A. 1986. 14 Q. And was it an independent medical center or 15 was it owned by a group at that point? 16 A. That I do not know. 17 Q. Did there come a time when West Boca 18 Medical Center was purchased by Tenet Healthcare? 19 A. I'm not exactly sure if Tenet was the owner 20 when it was first built or if it was subsequently 21 acquired. I don't -- I don't know that. 22 Q. When you took on the role of CEO of West 23 Boca, was West Boca Medical Center owned by Tenet 24 Healthcare? 25 A. Yes.	Page 25 1 CEO in October 2023? 2 A. Yes. 3 Q. Do you report at West Boca Medical Center 4 to a board? 5 A. Yes. 6 Q. And is that board called a governing board, 7 a board of directors, what is the name? 8 A. It's a governing board. 9 Q. And how often does that governing board 10 meet? 11 A. Monthly, ten times a year. 12 Q. And how many board members are there? 13 A. Nine voting members and three nonvoting 14 members. 15 Q. And does the governing board have input 16 into your compensation? 17 A. Not directly. 18 Q. Does the governing board have any input 19 into whether a lawsuit is filed? 20 MS. YANG: Objection to form. 21 Hold on one second. 22 I'll just caution you, Dr. Hanlon, not to 23 discuss any substance of any communications 24 between the board and any attorneys or 25 reflecting any attorney advice. You can answer

Page 26 1 that question yes or no. 2 A. Could you repeat the question, please. 3 BY MS. ZIBAS: 4 Q. Yes. Does the governing board have any 5 input as to whether a lawsuit is filed? And like 6 your lawyer said, I'm not interested in legal. I 7 just want to know do they have any input, yes or no? 8 A. They can give guidance and feedback into 9 things they feel are important to the hospital. 10 Q. And in the lawsuit that we're here about 11 today against the Leapfrog Group, did the board 12 provide input, and, again, don't give me any of your 13 attorney's advice or any advice between the board and 14 their attorney, did they provide any guidance or 15 feedback regarding filing this lawsuit? 16 MS. YANG: That I'm going to instruct you 17 not to answer on the basis of privilege. 18 MS. ZIBAS: And the privilege, I assume, 19 just to expands, assumes that there were 20 discussions regarding the guidance and feedback 21 between the board and the lawyers; is that 22 correct. 23 MS. YANG: I'm not sure I understand the 24 question. 25 MS. ZIBAS: I asked him specifically about	Page 28 1 representatives from several of the contracted 2 groups, such as anesthesia, pathology, emergency 3 department, and pediatric coverage, hospitalists. 4 Q. How many physicians are on the medical 5 executive committee? 6 A. Approximately, 15. 7 Q. And how many times a year do they meet? 8 A. Monthly. 9 Q. And do you attend those meetings? 10 A. Yes. 11 Q. Have you discussed the Leapfrog Group with 12 any of the members of the medical executive 13 committee? 14 A. Yes. 15 Q. How many of the physicians? 16 A. All of them. 17 Q. Was it during a meeting or outside of a 18 meeting? 19 A. Both. 20 Q. And how many times in 2024 do you recall 21 did -- was the Leapfrog Group discussed with the 22 physicians? 23 A. I couldn't recall an exact number. 24 Q. More than once, as far as you recall? 25 A. Yes.
Page 27 1 -- he testified about guidance and feedback. I 2 didn't ask for advice. And so I just want to 3 verify that the guidance and feedback from the 4 board to Mr. Hanlon or to the hospital included 5 attorneys, and that's the position that you are 6 taking? 7 MS. YANG: Well, I'm not taking a position 8 on that factual question because I'm not the 9 witness, but you're asking specifically about 10 the lawsuit that we are already in the middle of 11 today, so we would claim privileged work-product 12 over that. 13 MS. ZIBAS: I disagree, but we will go on. 14 That's not how it works. You have to be more 15 specific. There's case law on that. But we 16 will hold that for another day because it's not 17 that important. 18 BY MS. ZIBAS: 19 Q. Do you have -- is there a medical executive 20 committee at West Boca Medical Center, as well? 21 A. Yes. 22 Q. And who is on the medical executive 23 committee? 24 A. The respective chairs for the various 25 departments of the medical staff, as well as	Page 29 1 Q. And what was the sum and substance of the 2 conversation? 3 A. Questions as to why we were scored so low 4 and why it was different from previous Leapfrog 5 grades. 6 Q. And did you respond to their questions? 7 A. Yes. 8 Q. And how did you respond? 9 A. That we didn't feel that the grades 10 reflected by Leapfrog were accurate because it was 11 based off of incomplete information that we hadn't 12 supplied them and an algorithm and formula that 13 didn't support the information that they had or 14 didn't have. 15 Q. What was the incomplete information? 16 A. We didn't participate in the survey. 17 Q. And do you know what measures are used from 18 the survey to give you a grade? 19 A. Yes. 20 Q. And what are those measures? 21 A. There's several questions from the survey 22 that are included. There's CMS measures that are 23 publically reported. Some of those we don't have it. 24 We have too small of a sample size, so that data may 25 not all apply to us, even though it's publicly

Page 30 1 reported. It also includes several questions 2 regarding barcode administration, computerized 3 physician order entry, handwashing, and our ICU 4 staffing levels. There's also other questions that 5 are included in the survey that I don't think are 6 included in the actual grade, but they are reported 7 on Leapfrog's website that come from the survey. 8 Q. Have you ever looked at the Leapfrog's 9 website? 10 A. Yes. 11 Q. When was the last time you looked at it? 12 A. Within the last week or so. 13 Q. And have you ever looked at a website 14 called hospitalsafetygrade.org? 15 A. Yes. 16 Q. What is that website? 17 A. It shows gradings of hospitals. 18 Q. And when you refer to not included in the 19 grade, are you referring to a grade that would be 20 found on the hospitalsafetygrade.org website? 21 A. I don't . . . 22 Q. You referenced grade. You said there were 23 other things in the survey that were not included in 24 the grade. When you refer to grade, I just want to 25 make sure we're on the same page. Are you referring	Page 32 1 safety? 2 MS. YANG: Objection to form. 3 A. How do you define safety? 4 BY MS. ZIBAS: 5 Q. Well, let's go back. Is there a hospital 6 safety plan at the West Boca Medical Center? 7 A. Yes. 8 Q. And who designed or wrote that safety plan? 9 A. It's a variety of committees that review 10 and approve it, draft it, and then it has to be 11 reviewed and approved by our medical executive 12 committee, as well as our governing board. 13 Q. Now, you have -- I think you said that you 14 have a quality officer or quality person? 15 A. Director. 16 Q. Director. And who is that quality director 17 at West Boca Medical? 18 A. Andrea Nunes. 19 Q. How long has she been there? 20 A. Approximately, 21 years. 21 Q. And in general, what is her -- what are her 22 job duties? 23 A. She oversees a lot of our data abstraction, 24 our quality reporting, and the various committees 25 that we need to review or quality satisfaction,
Page 31 1 to the hospital safety grade that's on the website? 2 A. Which website? 3 Q. The hospitalsafetygrade.org. 4 MS. ZIBAS: Here, I'll mark this. I 5 already marked 2 so that throws me off. 6 Here, we'll mark this later, but this is 7 what I'm referring to. I haven't marked yet. I 8 went out of order. I already marked 2 for 9 something else, so we'll mark it as 3, and then 10 we'll go back to two. 11 (Exhibit 3 was marked.) 12 THE WITNESS: And obviously, this 13 particular tab that's highlighted doesn't have 14 -- there's other tabs that have information 15 that's reported that we don't supply. 16 BY MS. ZIBAS: 17 Q. Okay. But when we -- when you reference 18 grade, are you referring to in this Exhibit 3, this 19 website, Leapfrog Hospital Safety Grade? 20 A. Correct. 21 Q. Okay. That's what I was just trying to 22 make sure we were on the same page. 23 A. Yeah. Uh-huh. 24 Q. Now, is there anybody at the West Boca 25 Medical Center that has a role to track hospital	Page 33 1 safety data. 2 Q. Now, you mentioned earlier, CMS, that this 3 is publicly-reported data; is that correct that it's 4 public information? 5 A. There are some measures that are publicly 6 reported via CMS. 7 Q. And is there any one person that oversees 8 the gathering of the information to report to CMS at 9 West Boca Medical Center? 10 A. There's not just one person. We have data 11 abstractors, quality coordinators, as well as our 12 director of quality, and then all of that information 13 goes to committees for regular review. And as I 14 mentioned, we also report out those committee 15 findings to our medical executive committee, as well 16 as to our board. 17 Q. And are the -- is the data that's gathered 18 to report to CMS, to the best of your knowledge, is 19 it accurate? 20 A. Yes. 21 Q. Now, you indicated that some of the sample 22 sizes were too small to report. Can you explain what 23 you mean by that? 24 A. There may be some services that we don't 25 offer at the hospital that CMS collects data on and

Page 34 1 publishes that they list not available for us, either 2 because we don't offer the service or our sample size 3 is too small. 4 Q. How many beds do you have at West Boca? 5 A. 195. 6 Q. What is your occupancy rate? 7 A. It varies, but anywhere from 50 to 70 8 percent. 9 Q. Is there any certain time of year that it 10 is a higher occupancy rate? 11 A. That -- that varies. It has varied 12 recently. Usually, we would see a surge around the 13 wintertime because of all the snowbirds, but since 14 COVID, that's really prevented a lot of people from 15 returning home so it's stabilized out. 16 Q. Have you seen a reduction in the occupancy 17 rate between 2024 and 2025? 18 A. Yes. 19 Q. And do you think that's because people are 20 starting to return back north after COVID? 21 MS. YANG: Objection to form. 22 A. Comparing it to prior years, you know, it 23 -- it's seasonality and there's going to be different 24 years, but we have seen our volume decrease. 25 BY MS. ZIBAS:	Page 36 1 Q. Okay. Did the number of admissions 2 decrease between 2023 and 2024? 3 A. I would have to look at the statistics to 4 be able to honestly answer that. 5 Q. Has revenue decreased between 2024 and 6 2025, overall? 7 A. Revenue has gone up. 8 Q. What's the median age of your patient 9 population at West Boca Medical Center? 10 A. I don't know the exact number. I would 11 suggest it's probably in the 50s. 12 Q. Do you happen to know what percentage of 13 your population, your hospital population, that means 14 both ER, admissions, et cetera, outpatient, that are 15 on Medicare? 16 A. I mean, that can vary each month. I would 17 say probably close to 60 percent. 18 Q. Are you involved, at all, in reviewing the 19 nursing recruitment and retention at West Boca? 20 A. I'm involved in all of the recruitment. 21 Q. And in general at West Boca, as I know 22 there is at most hospitals, has there been a 23 difficulty in recruiting and retaining nursing staff? 24 A. Yes. 25 Q. And what factors have you found impacts
Page 35 1 Q. Do you find when there are a lot of 2 hurricanes in Florida, that less people come to West 3 Boca Medical Center Hospital? 4 A. I don't know if it's hurricane related. 5 Q. Has anyone ever evaluated whether a 6 hurricane, like last year if there were a number of 7 hurricanes in certain parts of Florida, if that 8 impacts the number of admissions or occupancy? 9 A. I mean, it probably impacts the number of 10 people that want to come to Florida, which ultimately 11 could impact the volume at the hospital. 12 Q. Has the -- have the number of ER visits 13 decreased between 2024 and 2025? 14 A. Yes. 15 Q. And do you know how many or what 16 percentage? 17 A. Approximately, 17 percent year over year. 18 Q. And what about between 2023 and 2024, when 19 you first started? 20 A. I don't recall an exact number. But I do 21 know it also decreased. 22 Q. And prior to you taking on the CEO role, 23 did you look at any data to see if there was a 24 decrease between 2022 and 2023? 25 A. I did not look at that time.	Page 37 1 retention and recruitment of nursing staff? 2 MS. YANG: Objection to form. 3 A. What factors impact? 4 BY MS. ZIBAS: 5 Q. The recruitment and retention. 6 A. The staff? 7 Q. Yes. 8 A. I think the type of nurse that we're 9 looking for. I think compensation, the availability 10 of that. We struggle with cost of living here in 11 Florida. And just enough staff to fill all of the 12 needs. 13 Q. Between 2023 and 2025, were you able to 14 hire more nurses, or is it still a continuing problem 15 to hire nurses? 16 A. It -- 17 MS. YANG: Objection to form, vague. 18 A. It's still challenging. 19 MS. YANG: Just give me a second to finish 20 my objection before you answer, Jared. 21 BY MS. ZIBAS: 22 Q. How many -- as you sit here today, do you 23 know how many open positions you have for nurses at 24 West Boca? 25 A. I wouldn't know the exact number, no.

Page 38 1 Q. Looking at the composition, meaning the 2 types of board members that are on your governing 3 board, are there any physicians on the governing 4 board? 5 A. There are. 6 Q. And how many? 7 A. Three voting and two nonvoting. 8 Q. Are there any nurses on the board, 9 governing board? 10 A. There are not. 11 Q. Any other type of medical personnel on the 12 governing board? 13 A. We have the chief of fire and EMS, 14 battalion chief, and then we've got the four 15 physicians, three -- I'm sorry. Five physicians. 16 Q. Does West Boca Medical Center do any type 17 of benchmarking against the other hospitals in the 18 region in Florida, meaning the Palm Beach Health 19 Network, as well as the others that you mentioned 20 earlier in your deposition? 21 MS. YANG: Objection to form. 22 MS. ZIBAS: Benchmarking them. 23 A. Benchmarking what? 24 BY MS. ZIBAS: 25 Q. Surveys, monitoring their data to see how	Page 40 1 Q. How many operatories do you have for 2 surgery? 3 A. Six inpatient ORs, four outpatient ORs, two 4 GI suites, and an interventional radiology lab. 5 Q. Are you a trauma center? 6 A. We are not. 7 Q. Is there a plan for West Boca to become a 8 trauma center? 9 A. Not at this time, no. 10 Q. When West Boca Medical Center compares 11 itself to the competitors, do you look specifically 12 at just those hospitals that are offering the same 13 lines of service? 14 A. No. We include overall volumes. 15 Q. Does West Boca have a marketing department 16 or a person responsible for marketing? 17 A. We do. 18 Q. And is it one person or a team? 19 A. There's one person assigned to the 20 hospital, and then there's a group liaison, as well. 21 Q. And when you say assigned to the hospital, 22 what do you mean? 23 A. There's one marketing. We have a marketing 24 manager that works at West Boca. 25 Q. And are they paid by West Boca or are they
Page 39 1 it compares to West Boca in terms of admissions? 2 MS. YANG: Same objection. 3 A. Surveys based off of just admissions? 4 BY MS. ZIBAS: 5 Q. Admissions, maybe patient satisfaction. 6 MS. YANG: Objection, compound. 7 A. We do look at volume comparisons to other 8 facilities, yes. 9 BY MS. ZIBAS: 10 Q. What are the services that West Boca 11 Medical Center offers? And when I'm talking about 12 that, I'm talking like hip and knee replacement, 13 cardiac, et cetera? What are the lines of services 14 that are offered at West Boca? 15 A. Women's and children's services, including 16 labor and delivery, GYN, pediatrics, and there's a 17 whole plethora of subspecialties within those means. 18 We do a lot of surgery, both in-patient and 19 outpatient, including orthopedic, spine, general, 20 gastroenterology. We offer emergent services both 21 for adult and pediatric. And we offer general 22 medical services for acute care issues requiring 23 either inpatient or outpatient stay. We also offer 24 wide variety of therapies, both on the inpatient and 25 outpatient perspective.	Page 41 1 paid by Tenet? 2 A. They're paid by West Boca. 3 Q. And who is that person? 4 A. Linda-Jean Long. 5 Q. And what are basically the -- does the 6 marketing person have a budget for marketing? 7 A. Yes. 8 Q. And who determines the budget? 9 A. It -- it's involved -- well, the corporate 10 office, as well as local leadership. 11 Q. And when you say local leadership, are you 12 referring to the Palm Beach Health Network 13 leadership? 14 A. As well as myself and my 18 med, plus West 15 Boca Medical Center. 16 Q. And is a marketing plan developed each 17 year? 18 A. Yes. 19 Q. As part of -- tell me some of the things 20 that -- that's a bad question. 21 What -- describe to me what's in the marketing 22 plan. For instance, is it social media? Is it 23 flyers? Is it, you know, Webinars? 24 A. It's a combination of community events, 25 education, social media posts, media, regular media,

Page 42 1 sponsorships. 2 Q. Do you have a social media manager? 3 A. No. It -- we have an outside company that 4 coordinates a lot of our social media posts, but it's 5 overseen and managed by our marketing manager. 6 Q. Who is the outside company, if you know? 7 A. I don't know their name. 8 Q. Are you involved, at all, in the strategy 9 on the social media side? 10 A. Yes. 11 Q. Looking at your patient population and that 12 visits West Boca, would you say most of them are 13 social media savvy? 14 MS. YANG: Objection to form. Calls for 15 speculation. 16 A. I wouldn't be able to answer that honestly 17 for the community or public. 18 BY MS. ZIBAS: 19 Q. Has your marketing person, Linda Long, ever 20 taken -- you know, done a survey to determine if your 21 population of patients is social media savvy? You 22 said median age potentially of 50. I know you don't 23 know for sure. 24 MS. YANG: Objection. 25 BY MS. ZIBAS:	Page 44 1 A. Okay. 2 MS. YANG: Objection to form. 3 Is there a question? 4 MS. ZIBAS: Yes. I asked do they use 5 Google Analytics, and he asked me to explain it. 6 MS. YANG: You can answer that question. 7 A. I know we utilize things such as Google 8 star ratings. I'm not specifically sure if there are 9 -- if they've hired Google Analyst -- Analytics to 10 specifically report anything. 11 BY MS. ZIBAS: 12 Q. What is Google star rating? 13 A. It's an opportunity for the community to 14 express their thoughts on various businesses, 15 entities. 16 Q. Do you know how Google star ratings works? 17 A. It's basically a polling of the patient or 18 the population, if they had a good experience, 19 various business or company. 20 Q. When we talked earlier about your CMS and 21 the reporting that is done, about how many hours are 22 spent in gathering the data for CMS? You said you 23 had a data abstractor, quality coordinator, director 24 of quality involved. Do you know approximately how 25 many hours are spent gathering that data?
Page 43 1 Q. Was any survey ever done or any evaluation 2 ever done? 3 MS. YANG: Objection, form compound. 4 A. I'm not exactly sure what you mean by 5 survey and what that survey would be measuring. 6 BY MS. ZIBAS: 7 Q. Well, has anybody ever tried to figure out 8 if the population uses social media at West Boca 9 Medical Center? 10 MS. YANG: Objection to form, lack of 11 foundation. 12 A. I think we want to go all avenues that we 13 can to educate the community, and social media is one 14 of those avenues that we utilize. 15 BY MS. ZIBAS: 16 Q. Do you utilize Google Analytics for West 17 Boca Medical Center? 18 A. What do you mean by Google Analytics? Is 19 there something specific that you're asking if they 20 measure? 21 Q. Yes. When you -- you can sign up for 22 Google Analytics, and you can ask for measurements of 23 who was searching for your website, who was searching 24 for statistics on the website, what services they're 25 looking for. That's what Google Analytics does.	Page 45 1 MS. YANG: Objection to form. 2 A. I wouldn't be able to give you an exact 3 number or even ballpark. It's going to be numerous 4 hours. 5 BY MS. ZIBAS: 6 Q. Have you ever heard of something called 7 Healthgrades? 8 A. I have. 9 Q. And explain to me what is Healthgrades in 10 your own words. 11 A. Healthgrades is an outside body that 12 utilizes CMS data and analyzes that publicly-reported 13 data to compare hospitals and highlight hospitals 14 that performed well compared to their perspective 15 counterparts. 16 Q. And does West Boca Medical Center 17 participate in Healthgrades? 18 A. Yes. 19 Q. And does West Boca Medical Center pay any 20 money to Healthgrades? 21 A. Yes. 22 Q. And what is the money paid for? 23 A. To advertise and license the data that they 24 have compiled and shared with us. 25 Q. And have you ever looked up the methodology

Page 46 1 of Healthgrades? 2 A. I have not looked up the methodology. 3 Q. Have you ever looked at the methodology for 4 the Leapfrog Group? 5 A. Methodology . . . 6 Q. To determine the safety grade. 7 A. I have looked to try to understand it, 8 but . . . 9 Q. And when did you look to try to understand 10 it? 11 A. Within this year, 2025. 12 Q. And why did you look it up this year? 13 A. Because of the poor rating that we 14 received. 15 Q. Does Tenet Healthcare ask West Boca Medical 16 Center to participate in Healthgrades? 17 MS. YANG: Objection to form. Assumes 18 facts. 19 A. They -- Tenet does not ask West Boca to 20 participate. 21 BY MS. ZIBAS: 22 Q. And is there anyone that has to spend time 23 or resources in providing data to Healthgrades at 24 West Boca? 25 A. Could you restate the question?	Page 48 1 the survey. 2 Q. And what resources were required that would 3 have been beyond the same people doing the CMS? 4 A. To complete the survey. 5 Q. And all right. So let's talk about the 6 survey, to the best of your information. So as far 7 as you -- you had testified earlier -- and I know you 8 went through some of this so I'm not going to ask you 9 to repeat it. But there were four very specific 10 things from the survey that are used in the safety 11 Healthgrades; correct? That was the CPOE, BCMA, hand 12 hygiene, and ICU physician staffing? 13 A. Those are just four of the things that are 14 included in the survey. 15 Q. Okay. So in the survey, beyond those four 16 things, is there anything else that has to be added 17 that wasn't already provided by CMS data? 18 MS. YANG: Objection to form. Vague and 19 lack of foundation. 20 A. There are other questions that are reported 21 on the website that come from the survey. 22 BY MS. ZIBAS: 23 Q. I know that you said you haven't read the 24 survey, but based on the information that you have 25 from your team and talking to them, what is the
Page 47 1 Q. Yes. At West Boca Medical Center, you said 2 that you participate in Healthgrades, correct, or you 3 pay for Healthgrades, licensing data. 4 A. For Healthgrades, yes. 5 Q. Yes. So is there anyone that's assigned or 6 it's their job, as part of their job duty at West 7 Boca to provide data or information to Healthgrades? 8 A. No. They use publicly-reported data. 9 Q. And do you think it's accurate? 10 MS. YANG: Objection to form, lack of 11 foundation. 12 A. Do I think that the CMS data -- 13 MS. ZIBAS: Healthgrades -- 14 A. -- is accurate? 15 MS. ZIBAS: Yes. 16 A. Yes. I believe the CMS data is accurate. 17 BY MS. ZIBAS: 18 Q. Do you know if West Boca Medical Center 19 used to participate in taking the Leapfrog survey? 20 A. Yes. I believe they did prior to 2021. 21 Q. And do you know why that West Boca Medical 22 Center stopped participating? 23 A. It took a lot of resources to complete the 24 survey that we felt could be better dedicated towards 25 improving the overall scores rather than reporting	Page 49 1 percentage of additional information that is required 2 in the survey that isn't already provided through 3 CMS? 4 MS. YANG: Objection to form. Vague and 5 calls for speculation. 6 A. There -- in terms of an exact number of 7 measures, there's probably 12 measures, I believe, 8 that if I'm recalling correctly, that are provided 9 through the survey. 10 BY MS. ZIBAS: 11 Q. And are those 12 measures in addition to 12 the four, the CPOE, the -- 13 A. That includes the four. 14 Q. Okay. And who provided you the information 15 that there were 12 measures? Did you learn that on 16 your own or was that provided to you? 17 A. I learned that from our quality director. 18 Q. Now, did you learn in -- at any point in 19 time that the Leapfrog Group was changing their 20 methodology, their survey and their calculation of 21 the hospital safety grade? 22 A. I learned it when the grades significantly 23 declined. 24 Q. Okay. And who told you about the change? 25 A. Our director of quality.

Page 50 1 Q. And when did the grade significantly 2 decline? 3 A. On or about fall of '24. 4 Q. And do you recall what your director of 5 quality explained to you about the change? 6 A. She explained that the -- we had not 7 participated in the survey, and that if we had 8 submitted some of the information that they were 9 requesting, it would have improved our score. 10 Q. Now, in 2022 and 2023, was West Boca -- was 11 West Boca participating in the survey? 12 A. 2022, we stopped completing the survey, I 13 think, in 2021. 14 Q. Okay. So what was the letter grade in, 15 say, spring of 2023? 16 A. I believe we were a C. 17 Q. And then in fall of 2024, what was the 18 letter grade? 19 A. It dropped to a D. 20 Q. And then in 2025? 21 A. It was an F. 22 Q. So in -- when you -- when West Boca 23 received the C, was there a discussion or concern 24 about the letter grade then? 25 A. I think we -- there was not a discussion	Page 52 1 MS. YANG: Objection to form. 2 A. A number from whom or from -- 3 BY MS. ZIBAS: 4 Q. For in the -- in the calculation for the 5 Leapfrog score, was there a number in the documents 6 you searched and reviewed? 7 MS. YANG: Objection to form. 8 A. I can't speak to -- to what Leapfrog 9 assigned to us. We were focussed on the data points 10 themselves, not necessarily the grade or Leapfrog's 11 calculation of that grade. 12 MS. YANG: We've been going a little over 13 an hour. When you get to a good stopping -- 14 MS. ZIBAS: Oh, we can stop any time you 15 want. That's fine. 16 THE VIDEOGRAPHER: Off the record at 10:13 17 a.m. 18 (Brief recess was taken at 10:13 a.m.) 19 (Back on the record at 10:24 a.m.) 20 THE VIDEOGRAPHER: We're back on the 21 record. Time is 10:24 a.m. 22 MS. ZIBAS: All right. Mr. Hanlon, we're 23 continuing questioning. 24 BY MS. ZIBAS: 25 Q. So let me ask you, does Tenet Healthcare
Page 51 1 about the letter grade at that time. We were 2 focussed on the actual data, not so much the letter 3 grade from Leapfrog. 4 Q. And what data were you focussed on? 5 A. The CMS data. 6 Q. And after -- and in the new methodology or 7 the fall 2024 methodology, was there any discussion 8 or did you ever look up how it changed, specifically 9 how the scoring was done for those that did not 10 participate? 11 MS. YANG: Objection to form, vague and 12 compound. 13 A. Yes. There was discussion when we dropped 14 to a D, and Andrea gave me some insight into why we 15 had dropped. 16 BY MS. ZIBAS: 17 Q. And did -- and what did Andrea tell you? 18 A. That a lot of it was because it was based 19 off of information that was part of the survey that 20 we hadn't participated in. 21 Q. But as far as you understand it, was a -- 22 was there a number given for West Boca Medical Center 23 for hand hygiene and ICU physician staffing, for 24 those four measures, BCMA and CPOE, was there an 25 actual number given?	Page 53 1 ever have meetings with you as CEO of West Boca 2 Medical Center? 3 MS. YANG: Objection to form. 4 A. Tenet Healthcare is a broad term. I guess 5 is there a specific individual? 6 BY MS. ZIBAS: 7 Q. Well, who do you -- is there anyone that 8 you, as CEO, report to at Tenet Healthcare 9 Corporation? 10 A. I report to Maggie Gill. 11 Q. And other than Maggie, do you ever have 12 meetings with other people from Tenet Healthcare in 13 your role as CEO? 14 MS. YANG: Objection to form. 15 A. Yes. I meet with other employees of Tenet 16 Healthcare. 17 BY MS. ZIBAS: 18 Q. Do you ever meet with people in the finance 19 -- well, back up. Is there a finance group or CFO at 20 Tenet Healthcare? 21 A. There is a CFO at Tenet Healthcare. Yes. 22 Q. Do you ever meet with the CFO of Tenet 23 Healthcare? 24 MS. YANG: Objection to form. 25 A. I haven't recently. I think the last time

Page 54 1 I met with the CFO directly was when I interviewed 2 for the position. 3 BY MS. ZIBAS: 4 Q. Do you have to prepare reports on a monthly 5 or quarterly basis to submit to Tenet about West Boca 6 Medical Center? 7 MS. YANG: Objection to form. 8 A. Myself personally, I am involved in a lot 9 of our monthly reporting in coordination with several 10 other individuals at the hospital. 11 BY MS. ZIBAS: 12 Q. And who do you coordinate with at the 13 hospital? 14 A. For the monthly reporting? 15 Q. Correct. 16 A. Our CFO, our chief nursing officer, our 17 chief operating officer. 18 Q. Does Maggie ever ask you for your input 19 regarding participating in the Leapfrog Group? 20 MS. YANG: Objection to form, vague. 21 A. Has she ever asked me? 22 BY MS. ZIBAS: 23 Q. Yes. 24 A. Or does she? 25 Q. Well, has she ever?	Page 56 1 MS. YANG: Objection to form. Vague, 2 assumes facts. 3 A. I personally did not make a request to the 4 home office to participate in Leapfrog Group. 5 BY MS. ZIBAS: 6 Q. Do you know if anyone else in the Palm 7 Beach Health Network officers, of the officers, asked 8 to participate? 9 A. I couldn't speak -- 10 MS. YANG: Objection to form. 11 A. I couldn't speak for them. 12 BY MS. ZIBAS: 13 Q. Do you know -- do you have an understanding 14 of what the CMS star ratings measure? 15 A. Yes. 16 Q. And what is that, what's your 17 understanding? 18 A. There's a wide variety of data measures, 19 both quality and satisfaction, that are included in 20 that. 21 Q. And do you know how West Boca Medical 22 Center has -- what star they received from CMS? 23 A. Two. 24 Q. And when did they receive a two? 25 A. The most recent.
Page 55 1 A. Has she asked me if I wanted to 2 participate -- 3 Q. Correct. 4 A. -- in the Leapfrog Group? 5 Q. Correct. 6 A. She has not specifically asked me if I 7 wanted to participate in the Leapfrog Group. 8 Q. Have you ever -- have you ever attended 9 meetings with the Palm Beach Health Network in the 10 last two years, meaning the officers? 11 A. Yes. 12 Q. And during any of those meetings, did the 13 topic of participating in the Leapfrog Group survey 14 ever come up? 15 A. In those meetings? 16 Q. Yes. 17 A. Yes. 18 Q. And what was discussed, sum and substance? 19 A. Based off of the revised grades, whether or 20 not it was something that we should consider 21 participating in. 22 Q. And was a decision, to the best of your 23 knowledge, made whether the -- there would be a 24 request to the home office to participate in Leapfrog 25 Group, again?	Page 57 1 Q. And prior to the most recent, what was the 2 star rating? 3 A. If I recall, I believe we've been a two for 4 -- more recently. 5 Q. What do you define as more recently? 6 A. As in 2025. 7 Q. What about in 2024, what was the CMS star 8 rating? 9 A. I don't recall off the top of my head. 10 Q. Did -- did West Boca Medical Center ever 11 receive a one CMS star rating? 12 A. I believe we are anticipating a one star in 13 the data that will be coming out. 14 Q. And why are you anticipating a one? 15 MS. YANG: Objection to form. 16 A. Just based off the data that has been 17 submitted to us. 18 BY MS. ZIBAS: 19 Q. And what data was submitted to you that 20 indicates that you would be getting a one? 21 A. The quality data that we report. 22 Q. And what quality data do you report? 23 A. A wide variety, things from CLABSI, central 24 line-acquired bloodstream infections; CAUTIs, 25 catheter-associated urinary tract infections, MRSA,

Page 58 1 C. diff, patient satisfaction. There's a wide 2 variety of measures that come into the CMS star 3 rating. 4 Q. Do you know what the CMS patient experience 5 score is? 6 A. That's a broad question because there's 7 multiple questions as part of the patient 8 satisfaction survey. 9 Q. Prior to January 2025, was there ever a 10 quality improvement plan in place at West Boca 11 Medical Center? 12 A. Yes. 13 Q. And was there a quality improvement plan in 14 place in 2024? 15 A. Yes. 16 Q. What about 2023? 17 A. Yes. 18 Q. And did you participate in the drafting of 19 the quality improvement plan? 20 A. I didn't participate in the drafting, but 21 in the approval and in subsequent changes and review 22 of the quality improvement plan. 23 Q. And what did West Boca consider to be the 24 top areas of need of improvement in the quality 25 improvement plan?	Page 60 1 MS. YANG: Objection to form, vague, lack 2 of foundation. 3 A. Has anyone at Tenet Healthcare? 4 BY MS. ZIBAS: 5 Q. Tenet Healthcare, yeah, headquarters. 6 A. Again, defining headquarters is -- I'm a 7 Tenet employee, Maggie is a Tenet employee, so yes, 8 there's been concern expressed about making sure that 9 we're continuing to improve. 10 Q. And who has expressed the concern? 11 A. As I just said, myself and Maggie Gill. 12 MS. ZIBAS: I am going to hand you what has 13 been marked as Exhibit 2. 14 (Exhibit 2 was marked.) 15 BY MS. ZIBAS: 16 Q. It's the declaration that you may be 17 familiar with. It's declaration of Jared Hanlon, and 18 it is executed on May 13, 2025. 19 A. Yes. 20 Q. Okay. And are you familiar with this 21 declaration? 22 A. I am. 23 Q. Did you draft this declaration? 24 A. I didn't draft it. I reviewed it and 25 modified.
Page 59 1 MS. YANG: Objection to form, outside the 2 scope. 3 A. There's several items that we pay attention 4 to and focus on and do this on a monthly basis. 5 BY MS. ZIBAS: 6 Q. So does the quality improvement plan change 7 monthly? 8 A. The plan itself does not. The review of 9 the data and how we're performing to identify any 10 trends that we need to address and modify our 11 practice or process in order to continue to improve. 12 Q. And does West Boca Medical Center have a 13 patient safety improvement plan in place? 14 MS. YANG: Objection to form, vague. 15 A. Patient safety improvement plan? 16 BY MS. ZIBAS: 17 Q. Yes. 18 A. We have a patient safety plan that includes 19 ways that we want to improve. 20 Q. And is the patient safety plan updated 21 every year? 22 A. It's reviewed. 23 Q. Has anyone at Tenet Health -- Tenet 24 Healthcare headquarters ever expressed concern over 25 the CMS star rating of West Boca Medical Center?	Page 61 1 Q. And do you believe everything in this 2 declaration is accurate to the best of your ability? 3 A. I do. 4 Q. If you turn to page 4, we're looking at the 5 end of paragraph 9. I'm going to be asking you 6 specific questions regarding some of the statements 7 made in this declaration. And at the top of the 8 page, page 4, it says the entities that award and 9 assign these accreditations visit the healthcare 10 facility and performed regular periodic in-person 11 reviews, audits, surveys, and assessments of the 12 facility. 13 A. I'm sorry. I'm trying to -- 14 Q. It's at the top. 15 A. Page 4. 16 Q. That top sentence. 17 A. Okay. Got you. 18 Q. That sentence, it starts, you know, it's 19 the end of your paragraph 9. 20 A. Okay. Okay. 21 Q. When you say the entities that award and 22 assign these accreditations, what entities are you 23 referring to? 24 A. The Joint Commission. 25 Q. Is The Joint Commission the only entity

Page 62 1 that comes in for in-person reviews, audits, surveys, 2 and assessments of the facility? 3 A. It is not the only entity that comes in. 4 There's other entities, such as AHCA and other 5 regulatory entities. 6 Q. Now, if you go down to paragraph 11, there 7 is a reference to Healthgrades. 8 A. Uh-huh. 9 Q. That we had briefly talked about before. 10 Do you consider Healthgrades a pay-to-play scheme? 11 MS. YANG: Objection to form, vague. 12 A. Can you explain what you mean by 13 pay-to-play? 14 BY MS. ZIBAS: 15 Q. You don't know, that's fine. We'll go 16 further along and hopefully we'll be able to figure 17 that out, and we can come back to that based on the 18 language in here. 19 So page -- paragraph 12, page 5, there's a 20 paragraph about when we decide whether to provide our 21 hospital's data to commentators, my colleagues, 22 leadership, and I consider the fairness and accuracy 23 of each commentator's methodology for processing and 24 compiling data because we know the patients base 25 important medical decisions on these types of	Page 64 1 the number of hours. To give you an exact number, I 2 can't say for certain, but it was a -- it's a pretty 3 involved survey. 4 Q. And would it have been -- would it have 5 been more time than the time spent submitting data to 6 CMS? 7 MS. YANG: Objection to form. Vague and 8 calls for speculation. 9 A. The data that we submit to CMS is required. 10 It's mandatory. There are other questions involved 11 in the survey, the Leapfrog survey, that are outside 12 even just the CMS reporting that would have taken 13 time to compile and complete. 14 BY MS. ZIBAS: 15 Q. If you look at paragraph 13, we're going to 16 sort of dissect some of your statements here. Does 17 Healthgrades -- back up. 18 Do you consider Healthgrades a rating? Is 19 that -- do you consider that a rating for the 20 hospital, Healthgrades? 21 MS. YANG: Objection to form, vague. 22 A. I feel like it's a grade, yes. 23 BY MS. ZIBAS: 24 Q. Grade. Okay. And would you consider a 25 Healthgrades' grade the same as the Leapfrog Group
Page 63 1 reports. 2 Are you referring to, in that sentence, to the 3 Leapfrog Group? 4 A. I'm referring to every accreditation that 5 we consider. Leapfrog is not the only, you know, 6 body out there that evaluates hospitals. 7 Q. And was the Leapfrog Group analyzed -- 8 A. Yes. 9 Q. -- as you stated in this paragraph? 10 Okay. And what was done to analyze the Leapfrog 11 Group methodology? 12 A. In terms of we considered the amount of 13 effort and time that would have to be contributed to 14 participate, as well as any cost that might be 15 associated with that to determine which ones we feel 16 provide the most accurate and worthwhile presentation 17 to our patient base and community. 18 Q. And what were the costs associated with the 19 Leapfrog survey that were estimated? 20 A. I think a lot of it is based on the amount 21 of time and effort, and obviously I have to pay the 22 staff members to complete that information. 23 Q. And what was the estimated time that you 24 would have had to pay? 25 A. It would have been significant in terms of	Page 65 1 safety grade? 2 MS. YANG: Objection. 3 MS. ZIBAS: Grade. 4 MS. YANG: Objection to form vague. 5 MS. ZIBAS: Or similar. 6 A. I think they're two different -- they are 7 looking at two different things. 8 BY MS. ZIBAS: 9 Q. And describe the best you can, what are 10 they looking at that are two different things? 11 A. Well, the Leapfrog survey includes, in 12 addition to CMS information, also the information 13 provided through the survey. Healthgrades purely 14 looks at the CMS data. 15 Q. And if you go further down in paragraph 13, 16 you say given the serious problems in TLG's 17 methodology -- and I assume TLG refers to Leapfrog 18 Group -- it was clear to our leadership that the 19 hospital, its doctors, its patients, and the 20 community would benefit far more from us no longer 21 spending time, energy, and funds towards providing 22 TLG the onerous data it sought and instead 23 redirecting those resources towards patient services 24 and providing the highest quality care. 25 Can you explain to me what are -- what are the

Page 66 1 serious problems in the TLG's methodology? 2 A. I think it involves the computation model 3 that they're using to award the grades. It's not -- 4 it's not based solely off of publicly-reported data. 5 There's actual other data that is included that has 6 to be submitted by the facility, requiring them to 7 expend resources to provide that data. 8 Q. Now, are you aware that if you're a 9 nonparticipating hospital in the survey, you still do 10 get a score? 11 A. Correct. 12 Q. And do you understand that that score is 13 just the lowest achieved score. Do you understand 14 that? For all hospitals? 15 A. Correct. And that's why we feel its 16 inaccurate. 17 Q. But prior to the change in the survey, 18 prior to 2024, are you aware that the score that was 19 used for nonparticipating survey hospitals was closer 20 to a perfect score? 21 MS. YANG: Objection to form. 22 A. Again, I don't know enough about the 23 specifics of Leapfrog's methodology and how they're 24 computing these grades. 25 BY MS. ZIBAS:	Page 68 1 submitted and monetizes that by selling licensure and 2 advertising for the ability to do that. And in order 3 to get that data, they ask participants to -- 4 hospitals to submit the survey. That survey costs us 5 time, money, and resources to complete, so therefore, 6 I'm having to pay to participate in that. And if I 7 don't participate in the survey, I'm inappropriately 8 penalized for information that they don't have. 9 Q. So going back to the question I asked you 10 about Healthgrades, aren't you paying for the 11 licensing to use their logo after you get their 12 grade? 13 A. I am. 14 Q. And is that -- is Healthgrades then a 15 pay-to-play, as well? 16 A. The data to play, we don't pay anything to 17 participate, and it doesn't expend resources for us 18 to submit the data anymore than what we're already 19 required to do through CMS. 20 Q. So it's just the additional data that 21 Leapfrog Group asks you about those four measures and 22 a few other measures. Is that what you're referring 23 to as the time-consuming survey? 24 MS. YANG: Objection to form. Misstates 25 testimony.
Page 67 1 Q. Okay. If you go to the next page, page 7. 2 And paragraph 18, you, in that second sentence there, 3 it shows that if you participate in its pay-to-play 4 time-consuming hospital survey, TLG assigns you a 5 better grade. What do you mean by that in that 6 sentence? 7 MS. YANG: I'm sorry. Can you point me to 8 the sentence one more time, what paragraph? 9 MS. ZIBAS: 18, second sentence. 10 MS. YANG: Thank you. 11 A. Could you restate the question? I'm sorry. 12 BY MS. ZIBAS: 13 Q. Yes. What does that mean, pay-to-play, 14 time consuming hospital survey that you wrote there 15 in your declaration? 16 A. So it is a time-consuming survey and if -- 17 for the participants who don't submit the survey, 18 they are penalized. 19 Q. Does it cost money to submit the survey? 20 A. It doesn't cost money to submit the survey, 21 other than the time it takes us and the money that it 22 costs us to pay or employees to compile the 23 information. 24 Q. So what do you mean by pay-to-play? 25 A. Well, Leapfrog Group uses the data that is	Page 69 1 A. It's not only the those -- that data, but 2 it's methodology that they use to award that grade, 3 and the added fact that there is data that's not 4 submitted. 5 BY MS. ZIBAS: 6 Q. That same sentence refers to see Exhibit 3. 7 If you could take a look at your see Exhibit 3, and 8 apologize for the font being so small, but that's the 9 way it was submitted to us. I tried to make it 10 bigger but I can't. 11 A. Okay. 12 Q. Now, in the declaration, you reference 13 Exhibit 3 as a true and correct copy of the TLG 14 spring 2025 calculator TLG shared with the medical 15 center. Do you see that, this Exhibit 3, is this a 16 calculator that you're referring to to figure out the 17 score? 18 A. I'm sorry. Where are you? 19 Q. Exhibit 3, you reference -- 20 A. Okay. 21 Q. Okay. Now, is this, Exhibit 3, the 22 calculator you're referencing when you look at the 23 numbers for the Leapfrog Group score? 24 A. Yes. 25 Q. And do you see that there are scores in

Page 70 1 there for CPOE, BCMA? 2 A. Correct. 3 Q. Physician and hand hygiene. 4 A. Uh-huh. 5 Q. So it's -- so as far as you know, are these 6 accurate or not, these numbers? 7 MS. YANG: Objection to form. 8 A. That's what Leapfrog is saying they awarded 9 to us. 10 BY MS. ZIBAS: 11 Q. But there were numbers in the calculator 12 for these measures, these four measures; correct? 13 A. That was populated by Leapfrog Group and 14 not based on any information that we entered in. 15 Q. And was it based on the fact that it was 16 the lowest achieved score of the participating 17 hospitals? 18 A. I don't know what -- exactly what that's 19 based off of. Again, we didn't submit the data, so 20 we -- I don't feel we should have been graded on 21 that. It's only information that they didn't have. 22 Q. Okay. Going back to when we were 23 discussing what the methodology is, do you understand 24 that as of fall 2024, for those that aren't 25 participating, you're receiving a grade of a	Page 72 1 us is inaccurate and deceptive, and it's available by 2 searching on Google. 3 Q. And who selected the Google search term 4 hospital safety rankings that's listed in your 5 declaration? 6 MS. YANG: Objection to form. 7 A. Can you point me to where you're -- 8 BY MS. ZIBAS: 9 Q. Right there. 10 A. Repeat. 11 Q. I said, who selected that search term, 12 hospital safety rankings? Because you reference 13 Google hospital safety ranking search term. Who 14 selected them for your -- 15 MS. YANG: Objection above. 16 A. This is for an instance, so that's just one 17 example of what we could Google and what pops up. 18 BY MS. ZIBAS: 19 Q. Have you received any complaints from 20 patients about your Leapfrog rating? 21 A. Yes. 22 Q. Okay. How many patients? 23 MS. YANG: Objection to form. 24 A. How many patients have -- 25 BY MS. ZIBAS:
Page 71 1 participating hospital, but it's the lowest score? 2 MS. YANG: Objection to form, vague. 3 MS. ZIBAS: Is that your understanding? 4 A. Again, we didn't participate. 5 BY MS. ZIBAS: 6 Q. But for the methodology, I'm just asking 7 about the methodology. I understand you didn't 8 participate. But is that the methodology? 9 A. I can't speak to -- 10 MS. YANG: Objection to form, vague. 11 A. I can't speak to Leapfrog Group's 12 methodology when it wasn't something that we 13 participated in. 14 BY MS. ZIBAS: 15 Q. When you have reviewed the website, did you 16 ever see anything about how the methodology was 17 determined? How the numbers were determined? 18 A. I did. 19 Q. Now, if you look at page 8 of your 20 declaration, you talk about this paragraph 19 is 21 entitled TLG deceived our potential and current 22 patients with deceptive safety grades easily reached 23 on Google. What do you mean by that statement in 24 your declaration? 25 A. We feel that the grade that was awarded to	Page 73 1 Q. Have contacted West Boca Medical Center 2 about the Leapfrog safety grade? 3 MS. YANG: Objection to form, calls for 4 speculation and outside the scope. 5 You can answer in your individual capacity, 6 to the extent you know. 7 A. Okay. I've had -- I can give some specific 8 examples of patients that have vocalized and 9 verbalized to us. I can't speak for the number of 10 patients that never even gave us an opportunity or 11 voiced their concern to us directly, but have in the 12 community. 13 But yes. I've got examples of patients. We had 14 a patient in our freestanding emergency department 15 that came and sought care, emergency care in our ED, 16 and needed surgery and decided to leave, against 17 medical advice, to go to another facility, and she 18 vocalized that that was because the Leapfrog rating 19 that she had seen publicized and wanted to go to a 20 different facility. 21 BY MS. ZIBAS: 22 Q. Where did she see it publicized? Did she 23 tell you? 24 A. It's been in social media and in the papers 25 and . . .

Page 74 1 Q. Did you ask this patient where specifically 2 they saw the information? 3 A. I did not, no. 4 Q. When you prepared your declaration, I 5 understand these are for instant search terms, but do 6 you have anyone internally at West Boca that is 7 advising you or assisting you with your Google search 8 terms and rankings and addressing any concerns you 9 may have about your Google search term and rankings? 10 MS. YANG: Objection to form, compound. 11 A. No. I think that's just an example of one 12 of the search terms that any person could search in 13 Google. 14 BY MS. ZIBAS: 15 Q. Do you agree that depending on your search 16 term, makes a difference what comes up when you do a 17 Google search? 18 A. I can't speculate to that, no. 19 Q. So this one person that complained in the 20 emergency department, is there any other one example 21 that you can think of of someone who complained that 22 they did not seek care at West Boca because of the 23 Leapfrog Group score or grade? 24 A. I've had numerous physicians approach me 25 with patients that have questioned them about it.	Page 76 1 whether they went to the website first or saw the 2 newspaper articles and some of the advertising in 3 some of the other hospitals are doing and then went 4 to the site. So I can't speculate. 5 BY MS. ZIBAS: 6 Q. For all the examples that you just ran 7 through, do you know for sure -- well, I mean, can 8 you confirm that all the patients that raise concerns 9 actually went to the website? 10 MS. YANG: Objection to form, vague, calls 11 for speculation. 12 A. I can't confirm that, no. 13 BY MS. ZIBAS: 14 Q. Did anyone at West Boca Medical Center ever 15 go out and contact these individuals and ask them for 16 more information about their -- whether they reviewed 17 the Leapfrog website? 18 MS. YANG: Objection to form, outside the 19 scope. You can answer in your individual 20 capacity. 21 A. I can tell you we did with some of the 22 board members. With the patients, I didn't reach 23 out. 24 BY MS. ZIBAS: 25 Q. So if you look at, going back to your
Page 75 1 I've had board members. We've had Google reviews 2 left that specifically site the Leapfrog rating. 3 Q. Did you provide those Google reviews as 4 part of your discovery, documents that you gathered 5 for this lawsuit? 6 A. Yes. 7 Q. And which board members or how many board 8 members talked to you about, you know, concerns about 9 the Leapfrog grade? 10 A. Several. Chief Neil Nemechek posed 11 questions because some of his paramedics and EMTs had 12 been hearing it from patients. Van Williams, Palm 13 Beach State College Provost for the Boca campus. 14 Sheri Scarborough. I've had Dr. Norina Ocampo, who 15 is on our medical executive committee and former 16 chief of staff, reach out because patients of hers 17 have -- had asked her about the Leapfrog Group. 18 Q. Do you know if these people that made 19 mentioned the Leapfrog Group, was it because of the 20 newspaper coverage, or did they actually go to the 21 website? 22 MS. YANG: Objection to form, lack of 23 foundation. 24 A. I think it's probably a combination of 25 both. I can't say with any certainty that they --	Page 77 1 declaration, page 12, paragraph 23. You reference a 2 drop in elective patient encounters after TLG 3 released its fall 2024 grade. What was the 4 percentage drop? 5 MS. YANG: Objection to form. 6 A. The percentage drop, I can't give you an 7 exact amount because it just depends on the timeframe 8 that you're looking at. I just know overall, we have 9 seen a reduction in our elective patient encounters. 10 BY MS. ZIBAS: 11 Q. Was there a drop in revenue? 12 A. For those particular, yes. 13 Q. And what are elective patient encounters? 14 A. It's going to be outpatient, elective 15 surgeries, patients choosing to come to our emergency 16 department and in an emergent condition. 17 Q. Do you think the fact that West Boca 18 Medical Center is not a trauma center deters some of 19 the people coming to your emergency department? 20 MS. YANG: Objection to form, calls for 21 speculation. 22 A. I think -- I don't think patients know 23 necessarily the differentiation between a trauma and 24 emergency. They're just going to their closest 25 emergency room.

Page 78 1 BY MS. ZIBAS: 2 Q. You further -- you go down in paragraph 24. 3 The sentence says the damage caused by the TLG grades 4 has been significant. Can you please describe to me 5 what you mean by that sentence? What is the damage? 6 A. I think in terms of our reputation, our -- 7 which has ultimately led to the volume decline. I 8 think the goodwill and the things that we're 9 providing to the community has been tarnished because 10 of this. I think it's required a lot of expense, 11 resources, and time to explain this to not only our 12 board members, medical staff, and staff, but also to 13 try to convey an accurate portrayal to the community, 14 as well. 15 Q. How much time has been spent trying to 16 counteract the inaccurate, negative picture created 17 in the community? How much time? 18 MS. YANG: Objection to form, vague. 19 A. Numerous hours. 20 BY MS. ZIBAS: 21 Q. What resources have been used to have to 22 counteract the inaccurate, negative picture created 23 in the community? It says time and resources. What 24 resources? 25 A. Time and our -- the skill set and abilities	Page 80 1 Q. So there's -- so the time has not been 2 quantified by West Boca Medical Center; correct? 3 A. What time? 4 Q. The time to counteract or the time to 5 complete the survey? 6 A. It hasn't. There isn't a specific number. 7 It's just a significant amount of time. 8 Q. What do you mean by loss of goodwill to the 9 hospital? 10 A. I think the reputation harm that it has 11 portrayed to the community. 12 Q. And what is that harm? How do you quantify 13 that? 14 A. Again, the example I gave, patients 15 choosing to go elsewhere. We've really done some 16 significant improvements in our patient perception, 17 in our community perception, as indicated by the 18 increase in our Google star rating, and this 19 counteracts a lot of that goodwill that we have built 20 over the last several years with our community. 21 Q. What's the -- how many people participated 22 to reach the Google star rating? 23 A. There's -- we've received well over 2 -- 24 2,000 reviews. 25 Q. But so far, we don't have anything but one
Page 79 1 of our individuals and employees at the hospital that 2 could have otherwise been dedicated towards impacting 3 the actual results instead of responding to TLG. 4 Q. So the -- wait a minute. The resources 5 here is to counteract, is that what you're referring 6 to? I'm asking about the resources spent to 7 counteract the inaccurate, negative picture? 8 A. Correct. We've had to do various community 9 education events to -- whether it be in social media 10 or through conversations with staff, medical staff, 11 board members, community individuals. 12 Q. Has the time and resources spent, has it 13 been quantified and reported to Maggie and/or others 14 at Tenet Healthcare headquarters? 15 A. I would say it can't -- it's challenging, 16 if not impossible, to completely quantify this. 17 Q. Okay. Was it -- was more time spent to 18 counteract the inaccurate, negative picture of TLG 19 than would have been spent in completing the survey? 20 MS. YANG: Objection to form. 21 A. Again, without knowing how many hours it 22 would take to complete the survey, nor understanding 23 an exact amount for how many hours is spent, it's 24 difficult to compare the two. 25 BY MS. ZIBAS:	Page 81 1 specific person that actually said that they wouldn't 2 receive services at West Boca because of Leapfrog; 3 right? Correct? You only have the one person you 4 can really specify? 5 MS. YANG: Objection to form, vague. 6 A. That's just one. There's probably more 7 that you could assume that didn't take the time to go 8 out and complete it online, but just chose to go 9 elsewhere because the negative rating. 10 BY MS. ZIBAS: 11 Q. Do you think the CMS star rating impacts 12 the reputation of West Boca medical? 13 MS. YANG: Objection to form. 14 A. I do. 15 BY MS. ZIBAS: 16 Q. And how do you differentiate whether it's 17 the Leapfrog Group grade or the CMS star rating 18 that's impacting the reputation of Boca -- West Boca 19 Medical Center? 20 MS. YANG: Objection to form, vague. 21 A. I think because they're measuring different 22 things. The CMS star ratings are required mandatory; 23 whereas, the TLG relies upon some additional 24 information, as well as an algorithm or a computation 25 model that's different.

Page 82 1 BY MS. ZIBAS: 2 Q. Now, looking at page 13, paragraph 27. 3 First sentence says the medical center has worked 4 tirelessly to ensure it is providing high-quality 5 care and improving patient health outcomes. Please 6 describe to me what has been at West Boca to ensure 7 it's providing high-quality care and improving 8 patient health outcomes? 9 A. So this is -- this is a multifaceted 10 approach. We review our data on a monthly and even 11 weekly basis to see how we are trending to make 12 improvements to adjust the direction that we're 13 moving to ultimately achieve our goals of providing 14 high-quality care in our community. 15 Q. Have any consultants been hired to help 16 West Boca Medical Center improve its quality care? 17 A. Consultants? 18 Q. Outside consultants. 19 A. I mean, we've -- we've had Press Ganey come 20 in and help us with our patient satisfaction tactics 21 for doing that. We've hired -- well, we paid The 22 Joint Commission to come in and evaluate our programs 23 and give us feedback. So yes, we've hired 24 consultants. 25 Q. So what does -- what has Press Ganey done	Page 84 1 services, or they just looked at general patient 2 experience? 3 MS. YANG: Objection to form, vague. 4 A. They looked at what would have the greatest 5 impact in improving our scores. 6 BY MS. ZIBAS: 7 Q. And what did Press Ganey advise you? 8 A. To really focus in on our nurse 9 communication. 10 Q. Did Press Ganey say there was a lack of 11 nurse communication? 12 MS. YANG: Objection, form. 13 A. No. They just identified that as the -- an 14 area that we could get -- significantly improve our 15 scores by focussing on that component of the HCAHPS 16 questions. 17 BY MS. ZIBAS: 18 Q. Does West Boca Medical Center evaluate the 19 hand hygiene of its employees? 20 A. Yes. 21 Q. And is that done as part of CMS or is that 22 done as part of its quality program? 23 A. It's done as part of our quality program. 24 Q. Does West Boca ever look at the physician 25 ordering entry system as part of its review?
Page 83 1 for West Boca Medical Center? 2 A. Press Ganey is the company that administers 3 or HCAHPS surveys. So the patient satisfaction is 4 required by CMS. And they have come in and shared 5 best practices from some of the other facilities that 6 they also measure. 7 Q. And what about The Joint Commission? What 8 have they specifically been doing to aid West Boca 9 Medical Center? 10 A. So we've invited them to come in and 11 evaluate various programs, such as our hip, knee, and 12 spine programs to give us feedback on ways that we 13 can improve. I think the hip, knee, and shoulder 14 survey that we did was extremely impressive. We 15 didn't have a single recommendation for improvement, 16 and The Joint Commission surveyor highly touted our 17 program there. We're in the process of applying for 18 our spine certification and expect a survey here 19 either later this year or first part of next year. 20 Q. How many surgeons do you -- are on staff 21 with privileges to perform procedures under hip, 22 knee, and spine? 23 A. I can't give you an exact number. 24 Q. Now, with Press Ganey, did they look at 25 specific measures when they provided consulting	Page 85 1 A. Yes. 2 Q. And do they look at staffing of critical 3 care units as part of their review? 4 A. We address our ICU staffing, yes. 5 Q. And does West Boca Medical Center, as part 6 of its quality review, also look at the Barcode 7 Medication Administration? 8 A. Yes. 9 Q. And is this all done by -- is that Ms. 10 Nunes as the director of quality, is it under her 11 group? 12 A. It's her team and it's reported up through 13 QUIPSY. 14 Q. And what does West Boca do with this data 15 that it gathers from these measures? 16 A. We review it and identify any trends, both 17 positive and/or negative to adapt process and 18 improvement, reeducation, those sorts of things, to 19 improve upon those. 20 Q. And by gathering this data, is this not the 21 same data that you would need for the Leapfrog 22 survey? 23 MS. YANG: Objection to form, lack of 24 foundation. 25 A. Again, I don't know the exact questions

Page 86 1 that they are -- that Leapfrog Group is requesting. 2 BY MS. ZIBAS: 3 Q. So when -- since the quality group or the 4 quality team is reviewing these four measures, you 5 would -- West Boca Medical Center must consider these 6 four measures important; is that correct? 7 MS. YANG: Objection to form, vague. 8 A. I guess, yes. 9 BY MS. ZIBAS: 10 Q. Going back to the term goodwill that you 11 had in your declaration, is there any way you can 12 describe how West Boca Medical Center quantifies the 13 loss of goodwill? 14 MS. YANG: Objection to form, vague. 15 A. I think the decrease in volume is just one 16 example of how we've -- if people have goodwill 17 towards or you're in a good reputation to your 18 facility, they will likely utilize your facility 19 more. If they don't, they will seek their care 20 elsewhere. 21 BY MS. ZIBAS: 22 Q. When you talk about volume, what 23 specifically are you referring to as volume is 24 decreased? Are you talking about the elective 25 outcomes, the outpatient treatment?	Page 88 1 You can answer, if you know in your 2 individual capacity. 3 MS. ZIBAS: If you know. If you don't, I 4 understand that. 5 A. It's spread across all. I mean, it's going 6 to be a combination of NICU, labor and delivery, 7 surgical volume, and admission. 8 BY MS. ZIBAS: 9 Q. In 2024 and 2025, had you had any 10 physicians surrender their privileges at the 11 hospital? 12 A. Resign, yes. 13 Q. And how many have resigned? 14 A. Oh, I don't know the exact number off the 15 top of my head. 16 Q. And do you know why they resigned? 17 A. Some have moved out of the state. Some 18 have retired. It's a wide range of reasons. 19 Q. All right. So now we're going to go back 20 to this Hanlon Number 3, which I showed you, which we 21 marked previously. And you pointed out that this -- 22 I'm going to represent to you this is a page from 23 hospitalsafetygrade.org website. And you pointed out 24 earlier that the only the highlighted section is 25 safety problems. And if you go to the second page,
Page 87 1 A. Both elective, and in the example that I 2 gave, the one patient that came to the emergency 3 room, even it's impacting our emergency care. 4 Q. So percentage-wise, are the admissions 5 down? 6 MS. YANG: Objection to form. 7 A. Overall admissions? 8 BY MS. ZIBAS: 9 Q. Yes. 10 A. Yes. 11 Q. And you think that's caused by the Leapfrog 12 Group? 13 A. In part, yes. 14 Q. It's not caused by the CMS ratings? 15 A. That probably has a factor in it, as well. 16 Q. But revenues are up at the hospital 17 overall? 18 A. Revenues for the overall hospital, yes, are 19 up. 20 Q. And where would you say is the most 21 revenue? Is it driven by emergency room transfers, 22 admissions? Where is the highest dollar volume of 23 revenue generated? 24 MS. YANG: Objection to form, vague, and 25 outside the scope.	Page 89 1 you see where number one in red, it says decline to 2 report. The hospital was asked to provide this 3 information to the public but did not. Do you see 4 that sentence? 5 A. I do. 6 Q. Is that accurate? 7 MS. YANG: Objection to form, lack of 8 foundation. 9 MS. ZIBAS: Foundation is I'm asking based 10 on looking at this website page. 11 MS. YANG: Same objection. 12 A. What is the note definition referring to? 13 BY MS. ZIBAS: 14 Q. Well, that's from the website. You had 15 said that you looked at the website at some point. 16 A. Uh-huh. 17 Q. So is that statement, the hospital was 18 asked to provide this information to the public but 19 did not, is that accurate? 20 MS. YANG: Objection to form, vague, and 21 lack of foundation. 22 A. Again, it states it, but it doesn't 23 reference -- I don't see the one notated on which 24 particular item is included in this. 25 BY MS. ZIBAS:

Page 90 1 Q. Yes. I think we need to -- 2 A. Does it technically cover everything? 3 Q. Yes. 4 A. Okay. 5 Q. But is that an accurate statement that West 6 Boca did not provide this information? 7 MS. YANG: Objection to form. 8 MS. ZIBAS: Related to the safety problems. 9 MS. YANG: Objection to form, vague. 10 A. We provided the CMS data. 11 BY MS. ZIBAS: 12 Q. Okay. 13 A. We didn't participate in the survey. 14 Q. But the CMS data was taken from the public 15 information you did provide them; is that correct? 16 A. Correct. That would be correct. 17 Q. Did you ever speak to the press on behalf 18 of West Boca Medical Center or on behalf of Palm 19 Beach Health Network about the Leapfrog grades? 20 A. Did I personally -- 21 Q. You personally. 22 A. -- speak to the press? 23 Q. Yes. 24 A. I have not spoken personally to the press. 25 MS. ZIBAS: Here's Hanlon Number 4.	Page 92 1 Q. And did you have any input into these key 2 messages? 3 A. Yes. I could have. If I had concerns or 4 questions, I could reach back out to Shelly to ask 5 her to review or reconsider. 6 Q. What does Shelly Weiss, does she work for 7 Tenet Health corporate office? Where does she work? 8 A. I don't know if she's on the specific 9 hospital's payroll or if she's direct corporate -- I 10 believe she's a direct corporate employee. 11 Q. So this -- you had started about a month 12 before you sent this e-mail. You started in October 13 2023; correct? 14 A. Correct. 15 Q. And was it your understanding that Tenet 16 Healthcare was monitoring the release of the Leapfrog 17 grades and when they would be released? 18 A. I can't speak for Tenet Healthcare. I know 19 that Shelly Weiss knew that the scores would be 20 coming out, and so she wanted to provide us talking 21 points. 22 Q. Were you at West Boca Medical Center 23 monitoring the timing of the release of the scores? 24 A. Andrea Nunes certainly was. 25 MS. ZIBAS: This is Hanlon Number 5.
Page 91 1 (Exhibit 4 was marked.) 2 BY MS. ZIBAS: 3 Q. Take a look at what has been marked as 4 Hanlon Exhibit 4. 5 A. Okay. 6 Q. Okay. Do you recognize this e-mail that 7 you sent out to A-team? 8 A. Our A-team, yes. 9 Q. And this is dated November 16, 2023. Why 10 did you send this out as a key message for fall 2023? 11 A. Because I received this from our public 12 relations representative that there were -- the 13 Leapfrog scores were going to be getting announced 14 publicly and to have talking points to be able to 15 speak to it. 16 Q. And was this a concern in advance of the 17 release? 18 MS. YANG: Objection to form, vague. 19 A. This was something that public relations 20 wanted us to have in case we were asked about it. 21 BY MS. ZIBAS: 22 Q. So did the public relations team draft the 23 West Boca Leapfrog key messages that are on the third 24 page? 25 A. Yes.	Page 93 1 (Exhibit 5 was marked.) 2 BY MS. ZIBAS: 3 Q. If you can take a look at Exhibit 5, do you 4 recognize this e-mail? I know it was sent to you 5 from Shelly Weiss. Does it jog your memory, at all? 6 A. I don't recall it. But I don't discount 7 that it's not accurate. 8 Q. Did you -- once you reviewed this e-mail 9 with all this attached information, did you do 10 anything further as a follow-up? Did you call 11 anyone? Did you call Maggie? Did you call any of 12 the other -- did you call Shelly to ask if you needed 13 to do anything further regarding these statements? 14 A. I did not. 15 MS. ZIBAS: This will be Exhibit 6. 16 (Exhibit 6 was marked.) 17 BY MS. ZIBAS: 18 Q. Going back to the governing board meetings, 19 who prepared the agendas for each of the meetings for 20 the governing board? 21 A. Our executive assistant actually did the 22 agenda with input from chief of staff, as well as 23 board, governing board chair, Chuck Stout, and 24 myself. 25 Q. And this document, which we marked

Page 94 1 Exhibit 6, says prepared by J. Hanlon. Is that you? 2 A. Document prepared by J. Hanlon. 3 Q. It's at the top. 4 A. Oh, so Alexa, my executive assistant, this 5 was -- normally she takes the minutes, but I think 6 she might have been on maternity leave at this 7 particular meeting, so I may have been the one taking 8 the minutes at this particular meeting. 9 Q. Okay. So I'm looking specifically at page 10 7, and there's a Bates number at the bottom, 15751, 11 but if you go to page 7, that's the focus of my 12 questions. 13 A. Okay. 14 Q. Now, it says administrative report, Mr. 15 Hanlon presented some slides. 16 A. Uh-huh. 17 Q. Okay. Says announced the 2024 18 Healthgrades' awards for West Boca. Leapfrog, Tenet 19 has chosen not to participate in the Leapfrog 20 program, so the scores that they award will not be 21 reflective since they do not have all the information 22 to apply an accurate grade. Reannounce the TJC Gold 23 Seal certification for hip, knee, and shoulder, and 24 Google rating achieved our goal of getting to 4 in 25 2024.	Page 96 1 MS. YANG: Objection to form. 2 BY MS. ZIBAS: 3 Q. And how is it Leapfrog in 2021 provided 4 value, but in 2024, it does not? 5 A. Because the amount of resources that are 6 needed to submit the survey are not there anymore. 7 Q. And was that a decision that was made 8 solely by Tenet? 9 A. I wouldn't say solely. Tenet, as a 10 company, decided to stop participating in the 11 Leapfrog survey, and each hospital had the 12 opportunity to justify the need for it to be 13 reinstated in the particular markets. 14 Q. Did West Boca Medical Center ask to 15 reinstate Leapfrog Group survey in their market? 16 A. Ask who? 17 Q. Ask Tenet. 18 A. Did West Boca, specifically myself? 19 Q. Yes. Correct. 20 A. I did not ask the corporate office or my 21 supervisor to presume participation in The Leapfrog 22 Group. 23 Q. And do you know if Maggie made the request? 24 A. I don't know if Maggie made the request. 25 That's -- again, I didn't make the request so . . .
Page 95 1 Do you see those? Are those accurate statements 2 of the findings? 3 A. Yes. 4 Q. Did you draft those? 5 A. I believe so. 6 Q. And then there were conclusions and 7 recommendations. 8 A. Uh-huh. 9 Q. And it says Mr. Nobles questioned that WBMC 10 used to participate in Leapfrog and Mr. Hanlon 11 clarified that over the years, Tenet has made the 12 decision across the company to not participate in 13 Leapfrog because it does not provide the value that 14 it used to. 15 Can you explain to me what you mean by providing 16 the value that it used to? 17 A. Because we stopped participating in the 18 survey, and so they were basing the grades off 19 inaccurate information? 20 Q. Was -- maybe I'm misunderstanding this. 21 But it says Tenet has made the decision to not 22 participate because it does not provide the value. 23 So I would assume that Tenet based its decision on 24 the value proposition. 25 A. It used to.	Page 97 1 Q. Do you know if Ms. Nunes, in conjunction 2 with Maggie, made the request to home office? 3 MS. YANG: Objection to form. 4 A. I can't speak to what Andrea made to the 5 corporate office. 6 BY MS. ZIBAS: 7 Q. Did you ever discuss with Maggie and Andrea 8 to request the home office to allow them to 9 participate in the Leapfrog survey again? 10 A. Andrea had made requests to participate in 11 the survey, and I ultimately made the decision as CEO 12 that it wasn't worth the time or the resources that 13 we would have to dedicate to it to complete it. 14 Q. And when did you make that decision? 15 A. Well, that's an ongoing decision. This was 16 revisited. It gets revisited whenever the survey or 17 the gradings, grades come out, at those times. 18 Q. And how much time and resources has been 19 spent on gathering documents for this lawsuit at West 20 Boca? 21 MS. YANG: Objection to form. Outside the 22 scope. 23 You can answer to the extent you know. 24 A. Same. It's difficult to quantify. 25 BY MS. ZIBAS:

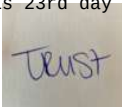
Page 98 1 Q. So if it's difficult to quantify the number 2 of hours spent on the survey or the number of hours 3 to gather documents or the number of hours to rectify 4 an inaccurate -- what did you put in your 5 declaration? Let me get the language. Inaccurate, 6 to counteract the inaccurate negative picture. So if 7 you look at the number of hours -- if you can't 8 quantify how many hours it takes to counteract the 9 negative picture or the number of hours to complete 10 the survey or the number of hours it took to gather 11 documents for the lawsuit, how do you know -- how do 12 you know the resources were really -- one was worse 13 than the other? 14 MS. YANG: Objection to form. Vague, 15 argumentative, compound. 16 A. Without -- you can still know it's going to 17 take countless or numerous amounts of hours without 18 having an exact figure. 19 MS. ZIBAS: This is Hanlon 7. 20 THE WITNESS: Okay. 21 (Exhibit 7 was marked.) 22 BY MS. ZIBAS: 23 Q. Okay. So if we look at, this is meeting 24 minutes from the governing board, January 28, 2024, 25 is that correct, based on the information at the top?	Page 100 1 MS. YANG: Objection to form. 2 And I'll caution you not to get into any 3 discussions with counsel. 4 A. This is actually -- this is dated 5 incorrectly. This should have been January 28 of 6 2025. And the reason I know that is because of all 7 of the participants that are here, this was our 8 transition meeting. So this is an error in the date. 9 This is supposed to be January 28 of 2025. 10 BY MS. ZIBAS: 11 Q. Okay. 12 A. We -- our board members transitioned, and 13 we had several that turned out of the board. And 14 this was a meeting where we had it at a restaurant, 15 private room in a restaurant because we included all 16 the exiting members and the new members, and that was 17 in January of '25. So that's a mistake on the date. 18 Q. Okay. And you say Jared to follow up with 19 the board once more information is provided. Was 20 there further information provided, at some point? 21 A. Yes. This has been a topic of discussion 22 at the many of the board meetings this year. 23 Q. And did the board provide their guidance or 24 input into the lawsuit and filing of it? 25 A. Their guidance or they -- they have given
Page 99 1 A. Correct. 2 Q. And if you look at page 8, the meeting 3 minutes, it states Jared provided clarification on 4 awards that WBMC received in terms of Leapfrog. WBMC 5 does not participate in the survey. Tenet is in the 6 process of pursuing -- pursuing legal action against 7 Leapfrog, as the information provided was an 8 inaccurate reflection of WBMC. Leapfrog does not 9 have the data to support their award. 10 Do you recall discussing this with the board? 11 A. Yes. 12 Q. And what did you tell them? 13 A. What this states here, that we felt like 14 Leapfrog awarded a grade that was inaccurate, and 15 that we don't participate in that, and that we're 16 going to have to pursue legal action to get them to 17 stop or to revise the process. 18 Q. And the meeting was January 28, 2024; 19 correct? 20 A. Correct. 21 Q. When was the lawsuit filed? 22 A. I believe May. 23 Q. Of 2025; correct? 24 A. Correct. 25 Q. What was the reason for the delay?	Page 101 1 us feedback in terms of the things that we needed to 2 improve upon from a quality perspective, and weighing 3 in feedback that they've received in the community 4 about the Leapfrog and what they're hearing in the 5 community from it. 6 Q. And what was the guidance provided by the 7 board to you about the Leapfrog? 8 A. It's they serve as a liaison group to 9 convey what they're hearing in the community. 10 Q. And what were they hearing in the community 11 as a liaison group? 12 A. The things that we've kind of talked about. 13 You know, there's been some social media videos that 14 have been sent out referencing The Leapfrog Group, 15 and they were sharing those with me, asking what we 16 need to do to get these taken down. And what they 17 should be telling their neighbors and their patients 18 and their staff about the accuracy of the claims 19 being made by the Leapfrog. 20 Q. Okay. If you go further down the page, it 21 says Jared touch points. WBMC is working on shifting 22 volume to other locations as WBMC is tapped out with 23 space. Does that mean that the volume was so high 24 that you didn't have space for patients? 25 MS. YANG: Objection to form. Misstates

Page 102 1 the document. 2 A. No. This is related to other locations 3 within the hospital. Our ORs, only have six 4 inpatient ORs, we've seen an increase in number of 5 inpatient surgeries, and we've seen a decrease in the 6 number of outpatient surgeries and other elective 7 volumes. So it's a matter of shifting the volume 8 within the physical facility based on the type of 9 service that's needed. 10 Q. How many outpatient ORs did you have, 11 again? 12 A. Four. 13 Q. And so you were converting those to 14 inpatient? 15 A. No. They're in an outpatient building off 16 campus, which is why we can't do inpatient surgeries 17 in those ORs because they're not in the hospital. 18 They're at an outpatient facility. So even though we 19 have capacity, it's not the right capacity that we 20 needed to accommodate those patients. 21 Q. And was that being addressed or is it being 22 addressed? 23 A. Yes. We're looking to expand an existing 24 OR, as well as add another OR on the inpatient side, 25 as well as trying to counteract the negative	Page 104 1 grade higher than a D or an F? 2 MS. YANG: Objection to form, lack of 3 foundation. 4 A. I can't speak to that. I don't know. 5 BY MS. ZIBAS: 6 Q. Other than Healthgrades, are there any 7 other grades or rating services that West Boca 8 Medical Center participates in? 9 MS. YANG: Objection to form. 10 A. I don't think -- again, defining ratings 11 are grades, there's other accrediting bodies, other 12 entities that we use to help evaluate and convey the 13 quality of care that we provide in West Boca. 14 BY MS. ZIBAS: 15 Q. But I'm not referring to accrediting ones, 16 but ratings or grades where you actually then pay to 17 use their logo or you license their logo, like you do 18 with Healthgrades. Are there any others that West 19 Boca uses or participates in? 20 A. Again, from a grading or rating, there are 21 other entities that we utilize to help convey the 22 quality of care that we provide, such as The Joint 23 Commission, Get with the Guidelines, ACR, 24 Healthgrades. So there are numerous other entities. 25 Q. What is get with the guidelines?
Page 103 1 perception that the community has gotten to build 2 back up our outpatient OR. 3 Q. What type of outpatient procedures have 4 declined? 5 A. A lot of pediatric ENT, pediatric general 6 surgery, some GYN, general surgery. 7 Q. How many pediatrics -- how many surgeons do 8 you have on staff doing the pediatric procedures? 9 A. Pediatric ENT, in particular, we have four. 10 Pediatric general surgery, we have three. I could go 11 down the list. General surgery, I don't -- I can't 12 give you an exact amount. I just -- it's north of 13 20. 14 Q. Going back to the Leapfrog methodology. So 15 did you ever get into a discussion with patients 16 about the methodology that was posted on the website 17 or that was available for them to review? 18 A. Me specifically? 19 Q. You specifically. 20 A. No. 21 Q. Do you know if anyone else at West Boca 22 Medical Center did so? 23 A. I can't speak for it, no. 24 Q. Are you aware that there are hospitals who 25 do not participate in the survey, and they get a	Page 105 1 A. Get with the Guidelines is a demonstration 2 of our stroke care measures, looking at not only 3 quality outcomes, but also processes and things that 4 we've had in place to appropriately care for -- for 5 strokes. 6 Q. And does anyone at West Boca Medical Center 7 have to provide data in order for -- to get with the 8 guidelines? 9 A. It's the registry data that we already 10 provide, that we're required to provide. 11 Q. To provide to who? 12 A. The registry. It's state-mandated. 13 Q. Now, does Joint Commission have any -- do 14 they have any accolades that you pay for? Once you 15 get a good certificate or score from them or pass, do 16 they have anything they sell, like the Healthgrades 17 stuff? 18 A. We do contract with The Joint Commission to 19 come in and evaluate our -- not only just our overall 20 accreditation that we do on a triannual basis that's 21 required by CMS, but we also work with them to come 22 in and evaluate our hip, knee, and shoulder. And 23 we've recently applied for our spine certification 24 for Joint Commission. 25 Q. Do you think it helps West Boca, the fact

Page 106 1 you're paying for a contract with Joint Commission, 2 does that help with your overall evaluation outcome? 3 MS. YANG: Objection to form, vague, lack 4 of foundation. 5 MS. ZIBAS: With Joint Commission. 6 A. I think it does help to have Joint 7 Commission come in and have an onsite inspection and 8 a comprehensive review of our program and award us 9 their seal of approval based off of our quality 10 program that we offer. Yes, I do think it's 11 beneficial. 12 BY MS. ZIBAS: 13 Q. For -- we had previously discussed that 14 your quality department was looking at the 15 computerized physician ordering entries. Is that 16 information that's gathered solely by the quality 17 department, or do you participate in how that's 18 monitored and the data that's gathered? 19 A. I participate in how it's monitored, as 20 it's one of the measures that we report through our 21 quality improvement/patient safety committee. 22 Q. Do you gather data on a quarterly basis or 23 monthly basis for CPOE, BCMA, hand hygiene, and ICU 24 staffing? 25 A. It's a combination of both.	Page 108 1 head, though. 2 BY MS. ZIBAS: 3 Q. Do you know the total amount to be -- 4 that's budgeted? 5 A. We don't have a budgeted amount. 6 Q. Do you have an anticipated amount that West 7 Boca Medical Center will spend in total? 8 MS. YANG: Objection to form. 9 I'm going to instruct not to answer on 10 that. 11 MS. ZIBAS: I assume at the time of trial, 12 he'll be able to testify to that amount since 13 it's been sought. 14 MS. YANG: Well, you're welcome to ask him 15 about any fees that have been incurred, but 16 asking about budgeting gets into attorney 17 work-product information. 18 MS. ZIBAS: Well, he doesn't know what's 19 been incurred. 20 BY MS. ZIBAS: 21 Q. Who would know any amount incurred to date? 22 A. I could get the information, if I could 23 reference our invoicing system. I just don't know it 24 off the top of my head. 25 Q. Do you have any records -- you indicate,
Page 107 1 Q. Now, now are you aware that as part of this 2 lawsuit, West Boca Medical Center is seeking legal 3 fees and costs in this matter? 4 MS. YANG: Objection to form. 5 MS. ZIBAS: Are you aware of that? 6 A. Yes. 7 BY MS. ZIBAS: 8 Q. And who is currently paying the attorney's 9 fees and costs for West Boca? 10 MS. YANG: Objection to form, outside the 11 scope. 12 To the extent you know. 13 A. Each respective facility is paying legal 14 fees. 15 BY MS. ZIBAS: 16 Q. And do you know how much has been spent to 17 date by West Boca Medical Center? 18 A. I don't know of a complete total. 19 Q. Do you know what -- well, what number do 20 you know? 21 MS. YANG: Objection to form, vague, 22 outside the scope. 23 You can answer, if you know. 24 A. I know we reported on it last month, and I 25 can't remember the exact number off the top of my	Page 109 1 you explained the one example of the individual from 2 the emergency department that went to another 3 hospital; and then you referenced a speaking with 4 Sheri Scarborough, several other people on the board. 5 Can you provide any more specifics about individuals, 6 either physicians or patients, who went -- who didn't 7 want to be treated at West Boca Medical Center, 8 specifically because of the Leapfrog grade? 9 MS. YANG: Objection to form, vague and 10 compound. 11 A. I can give another example. Shelley Cueto 12 is a practice manager for Dr. Phipps and Dr. Cueto. 13 She reached out to me because of a Tik Tok video that 14 was going around social media claiming that West Boca 15 was one of the five worst hospitals, referencing in 16 the video the Leapfrog gradings as an F. And she 17 asked me if this was true, and I had to explain to 18 her the reasoning why we didn't feel it was accurate. 19 And she then, in turn, had to convey that to both Dr. 20 Phipps and Dr. Cueto and patients that they were 21 seeking care from those two physicians in particular. 22 Q. And who posted the Tik Tok video? 23 A. I don't know. 24 Q. Did you obtain a copy of the Tik Tok video? 25 A. Yes.

Page 110 1 Q. And you provided that as part of your 2 documents in discovery? 3 A. It was part of numerous text messages that 4 I've received from board members that included the 5 video. 6 Q. Did you provide it as part of your 7 discovery to your attorneys? 8 A. Yes. 9 Q. Were you -- as part of what you've been 10 going through in this lawsuit, were you ever able to 11 -- do you have any evidence that Leapfrog takes -- 12 has paid any money to award better grades to 13 hospitals? 14 MS. YANG: Hold on one second. 15 Without getting into any discussions with 16 the attorneys or legal advice, you can answer 17 the question of what evidence you have. 18 A. Can you restate the question? 19 BY MS. ZIBAS: 20 Q. Do you have any evidence that Leapfrog has 21 been paid any money to award better grades to other 22 hospitals, safety grades? 23 A. I don't have any indication of Leapfrog, 24 any specific examples of Leapfrog Group being paid to 25 award a higher grade.	Page 112 1 compound. 2 A. So I'm a member of the quality improvement 3 committee, and this data goes through that, that 4 committee. 5 BY MS. ZIBAS: 6 Q. And the data, when it's put together, is it 7 in a form of a report or is it just hard data? What 8 kind of format is it in? 9 A. It varies. Like for example, the ICU 10 staffing, that's pretty static. It doesn't change 11 drastically. Handwashing, we do audits monthly, and 12 that data is recorded as to compliance with 13 handwashing. Same thing with CPOE and barcode 14 administration, we pull that information from our 15 electronic medical record and other electronic 16 sources to report out on a regular basis. 17 Q. So when you pull it from the electronic 18 data, then you then assemble a report and send it to 19 the committee, or Ms. Nunes and her department do 20 that; is that correct? 21 A. They do that, yes. 22 Q. Okay. Just wanted to clarify. 23 Now, we talked about the legal fee number, and I 24 know you said that you don't have the system in front 25 of you. Do you recall any of the numbers to date
Page 111 1 MS. ZIBAS: All right. I need to go 2 through my notes. I really don't have -- I'm 3 not an all-day person here. Don't know where 4 you guys were from. You can go off the record. 5 We can go through this. 6 THE VIDEOGRAPHER: We're off the record at 7 11:47 a.m. 8 (Recess was taken for lunch at 11:47 a.m.) 9 (Back on the record at 12:28 p.m.) 10 THE VIDEOGRAPHER: Back on the record. 11 Time is 12:28 p.m. 12 BY MS. ZIBAS: 13 Q. All right. We're back on the record. I'm 14 going to follow up with a few questions, Mr. Hanlon, 15 just to clarify. First of all, we had been talking 16 about the four measures, the ICU staffing, the hand 17 hygiene, the Barcode Medication Administration, the 18 Computerized Physician Order Entry, and based on my 19 understanding, that these are four measures that your 20 quality department reports and gathers data and you 21 monitor it, is that correct, when they report, when 22 they gather the data? And this is done in order to 23 give it to your quality improvement patient safety 24 committee? Is that who gets this information? 25 MS. YANG: Objection to form, vague and	Page 113 1 paid for legal fees, at all? 2 MS. YANG: Objection to form, vague. 3 A. I don't. Not off the top of my head. 4 BY MS. ZIBAS: 5 Q. Does West Boca Medical Center, do you use 6 an organization or partner with Vizient? 7 A. I don't -- I don't recognize that 8 organization so I'm not sure. 9 Q. Do you -- does West Boca Medical Center 10 partner or hire any outside company to help them 11 evaluate healthcare performance? 12 MS. YANG: Objection to form, vague. 13 A. What is your definition of performance? 14 BY MS. ZIBAS: 15 Q. Well, companies such as Vizient, Premier 16 Inc., HealthTrust Purchasing Group, Healthgrades, 17 they all are -- they measure healthcare performance, 18 and do you hire outside companies to assist West Boca 19 Medical Center with gathering data or interacting 20 with these organizations? 21 MS. YANG: Objection to form. 22 A. I don't have any clarity in terms of what 23 we would be hiring them to do. Are you suggesting 24 providing consulting services or -- 25 BY MS. ZIBAS:

Page 114 1 Q. Do you hire consultants? Does West Boca 2 Medical Center hire consultants to work with 3 Healthgrades and to help their grades or to license 4 the logos? I mean, is this done directly with West 5 Boca? 6 MS. YANG: Objection to form, vague. 7 A. Is the -- and I'm sorry. I'm trying to get 8 clarity on your question. So does -- 9 BY MS. ZIBAS: 10 Q. It's okay. 11 A. So are you saying does Healthgrades 12 contract directly with West Boca? 13 Q. Yes. Do they contract directly or do you 14 use an intermediary third-party? 15 A. For Healthgrades, I believe we contract 16 directly with Healthgrades. 17 Q. And what -- and I assume for Joint 18 Commission, you do as well, you contract directly; 19 correct? 20 A. Correct. 21 Q. What about Trilliant? 22 A. That is a database. That's not necessarily 23 a service. 24 Q. Does West Boca Medical Center contract 25 directly to use that database?	Page 116 1 BY MS. ZIBAS: 2 Q. I haven't seen the report so I would like 3 to know what is in that report. Why don't we start 4 there? 5 A. Sure. It looks at percentage of positive 6 opinions on like social media and Google reviews and 7 things like that, and kind of gauges community 8 perception of the facility. 9 Q. And you mentioned that Google ratings, 10 Google star went up; is that correct? 11 A. Yes. 12 Q. And what's the percentage of positive 13 opinions in the last report that you can recall? 14 A. I know it was -- it had improved. I can't 15 speak to exactly the exact percentage improvement 16 without seeing the report in front of me. 17 Q. And does West Boca Medical Center 18 participate in or retain anyone to do any market 19 research reports comparing West Boca Medical Center 20 to its competitors? 21 MS. YANG: Objection to form. 22 A. What are you defining as market research? 23 BY MS. ZIBAS: 24 Q. That would be a good question because I am 25 not sure what market research reports or studies your
Page 115 1 A. I do not know. Our chief strategy officer 2 would have to answer that. I'm not exactly sure -- 3 Q. And who -- 4 A. -- if it's Tenet or West Boca. 5 Q. And who is your chief strategy officer, 6 again? 7 A. Derek Collins. 8 Q. And has West Boca Medical Center 9 participated in any consumer perception surveys to 10 compare the public views of your hospital versus 11 competitors? 12 A. We get a report on, I would say, probably 13 on a quarterly basis that looks at community 14 perception that's sent to us from our marketing 15 leader. 16 Q. And who compiles this report? 17 A. I'm not sure if it's -- I think it is an 18 outside agency. I don't know what that agency's name 19 is. I just get the quarterly report that looks at 20 community perception. 21 Q. And in the latest report that you can 22 recall receiving from West Boca, what was -- what was 23 that results of the community perception survey? 24 MS. YANG: Objection to form, vague. 25 A. How are you evaluating the results?	Page 117 1 marketing department has done. So market research 2 would be same as a survey, asking the public their 3 opinion? 4 MS. YANG: Objection to form. 5 A. There are -- I mean, we participate in 6 HCAHPS, for example, which are required for CMS that 7 evaluates patient satisfaction levels. And again, we 8 do look at overall perception of the facility through 9 either positive or negative reviews and feedback from 10 that perspective. 11 MS. ZIBAS: I think that's all the 12 questions I have at this point. Obviously, if 13 there's documents during the meet and confer 14 process that the other attorneys are going 15 through that -- you know, additional documents 16 arise that are related to West Boca Medical 17 Center, we'll reserve the right to call him back 18 or ask questions in writing, deposition by 19 writing. 20 MS. YANG: We disagree with that, but of 21 course we're happy to take that up with you 22 after, and we'll reserve for trial. 23 THE VIDEOGRAPHER: No questions. 24 MS. YANG: No. We'll reserve for trial. 25 MS. ZIBAS: Thank you for your time.

Page 118 1 THE WITNESS: Thank you. 2 THE VIDEOGRAPHER: Off at 12:37 p.m. 3 MS. YANG: We'll read. 4 (Thereupon, the proceedings concluded at 5 12:37 p.m.) 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25	Page 120 1 CERTIFICATE OF REPORTER 2 3 THE STATE OF FLORIDA) 4 COUNTY OF MIAMI-DADE) 5 6 I, Theresa Rust, Florida Professional 7 Reporter, certify that I was authorized to and did 8 stenographically report the video-recorded deposition 9 of JERAD HANLON, pages 1 through 118, that a review 10 of the transcript was requested, and that the 11 transcript is a true and complete record of my 12 stenographic notes. 13 I further certify that I am not a relative, 14 employee, attorney, or counsel of any of the parties, 15 nor am I a relative or employee of any of the 16 parties' attorney or counsel connected with the 17 action, nor am I financially interested in the 18 action. 19 20 DATED this 23rd day of September 2025. 21 22  23 Theresa Rust, RPR, FCRR 24 25
Page 119 1 CERTIFICATE OF OATH 2 3 THE STATE OF FLORIDA) 4 COUNTY OF MIAMI-DADE) 5 6 7 8 9 I, THERESA RUST, the undersigned authority, 10 certify that JERAD HANLON, appeared before me and was 11 duly sworn on the 23rd day of September 2025. 12 Signed this 23rd day of September 2025. 13 14  15 16 17 THERESA RUST, RPR 18 Notary Public - State of Florida 19 Commission No. #GG145788 20 Expires: October 25, 2025 21 22 23 24 25	Page 121 1 October 8, 2025 2 BETTY X. YANG, ESQUIRE 3 byang@gibsondunn.com 4 5 JERAD HANLON 6 IN RE: GOOD SAMARITAN VS. THE LEAPFROG GROUP 7 CASE NO.: 9:25-CV-80526-DMM 8 TYPE OF PROCEEDING: DEPOSITION 9 DATE: 9.23.25 10 11 The transcript of the above proceeding is now 12 available and requires signature by the witness. 13 Please e-mail fl.production@lexitaslegal.com for 14 access to a read-only PDF transcript and PDF-fillable 15 errata sheet via computer or use the errata sheet 16 that is located at the back of the transcript. 17 18 Once completed, please print, sign, and return to the 19 e-mail address listed below for distribution to all 20 parties. 21 22 If you are in need of assistance, please contact 23 Lexitas at 888-811-3408. 24 If the witness does not read and sign the transcript 25 within a reasonable amount of time, the original transcript may be filed with the Clerk of the court. If the witness wishes to waive his/her signature now, please have the witness sign in the blank at the bottom of this letter and return to the e-mail address listed below. Very truly yours, Theresa Rust, RPR Lexitas fl.production@lexitaslegal.com I do hereby waive my signature. JERAD HANLON Job No. 422123

1ERRATA SHEETPage 122 2DO NOT WRITE ON TRANSCRIPT - ENTER CHANGES HERE 3IN RE: GOOD SAMARITAN VS. THE LEAPFROG GROUP 4CASE NO. 9:25-CV-80526-DMM 5WITNESS: JERAD HANLON TAKEN: 9/23/2025 6 7PAGE LINE CHANGE REASON FOR CHANGE 8 9 10 11 12 13 14 15 16 17 18 19 20Under penalties of perjury, I declare that I 21have read the foregoing document and that the facts 22stated in it are true. 23 24Date JERAD HANLON 25 Job No. 422123 fl.production@lexitaslegal.com	

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Zoom

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EXHIBIT 25

UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF FLORIDA
WEST PALM BEACH DIVISION
CASE NO.: 9:25-CV-80526-DMM

GOOD SAMARITAN MEDICAL CENTER, INC.,
DELRAY MEDICAL CENTER, INC.,
PALM BEACH GARDENS COMMUNITY
HOSPITAL, INC. d/b/a PALM BEACH
GARDENS MEDICAL CENTER,
ST. MARY'S MEDICAL CENTER, INC.,
AND WEST BOCA MEDICAL CENTER, INC., et al.,

Plaintiffs,

v.

THE LEAPFROG GROUP,

Defendant.

VIDEOTAPED DEPOSITION OF SHERI MONTGOMERY
(CONFIDENTIAL)

DATE TAKEN: Monday, September 15, 2025
TIME: 9:09 a.m. - 5:45 p.m.
PLACE: Quest Workspaces West Palm Beach
515 North Flagler Drive
Suite 350
West Palm Beach, Florida 33401

Stenographically Reported By:
Barbie Gallo, RMR-CRR
www.lexitaslegal.com
888-811-3408

Job No.: 421985

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1	APPEARANCES:	1	Exhibit 9
2	On behalf of the Plaintiffs:	2	1/6/23 EMAIL CHAIN SUBJECT: 221
3	MARCUS, NEIMAN, RASHBAUM & PINEIRO, LLP	3	DECEMBER 2022 CPOE REPORT
4	125218 2 South Biscayne Boulevard	4	PBHN000011534, PBHN000011535,
5	Suite 2530	5	PBHN000011477, PBHN000011478,
6	Miami, Florida 33131	6	PBHN000011454, PBHN000011455,
7	(305) 400-4268	7	PBHN000011457, PBHN000011458,
8	BY: JEFFREY E. MARCUS, ESQUIRE	8	PBHN000011463, PBHN000011464,
9	jmarcus@mnrlawfirm.com	9	PBHN000011451, PBHN000011452,
10	AND	10	PBHN000011448, PBHN000011449,
11	GIBSON, DUNN & CRUTCHER, LLP	11	PBHN000011439, PBHN000011440,
12	811 Main Street	12	PBHN000011436, PBHN000011431,
13	Suite 3000	13	PBHN000011432, PBHN000011428,
14	Houston, Texas 77002-6117	14	PBHN000011429
15	(346) 718-6706	15	Exhibit 10
16	BY: KEVIN SIMMONS, ESQUIRE	16	6/13/23 EMAIL CHAIN SUBJECT: 226
17	kmsimmons@gibsondunn.com	17	STET MEDIA GROUP RELEASES
18	AND	18	TODAY THIS DATA FROM MEDICARE
19	GIBSON, DUNN & CRUTCHER, LLP	19	COMPARE ON DEATH RATES,
20	200 Park Avenue	20	OUTCOMES BY HOSPITAL
21	New York, NY 10166	21	PBHN000011460 - PBHN000011461
22	(212) 351-4000	22	11/8/23 EMAIL CHAIN SUBJECT: 231
23	BY: LEE R. CRAIN, ESQUIRE	23	QUALITY WEEKLY UPDATE W/
24	MARC AARON TAKAGAKI, ESQUIRE	24	ATTACHMENTS: WEEKLY REPORT
25	mtakagaki@gibsondunn.com	25	11.7.23.DOC;
	lcrain@gibsondunn.com		CALCULATOR_FALL2023_
	(via realtime streaming)		EMBARGOPERIOD.XLSX
	On behalf of the Defendant:		PBHN000011442, PBHN000011437,
	WILSON, ELSE, MOSKOWITZ, EDELMAN & DICKER LLP		PBHN000011443, PBHN000011444,
	161 North Clark		PBHN000011445, PBHN000011446,
	Suite 4500		September 2023 CHART
	Chicago, Illinois 60601		4/29/24 EMAIL CHAIN SUBJECT: 239
	(312) 821-6139		WEEKLY QUALITY UPDATE
	BY: KIMBERLY E. BLAIR, ESQUIRE		PBHN000011422 - PBHN000011427
	kimberly.blair@wilsonelser.com		5/2/24 EMAIL CHAIN SUBJECT: 241
	ALSO PRESENT:		RE: WEEKLY QUALITY UPDATE
	Ashley Taylor, videographer		PBHN000011409 - PBHN000011411
			7/17/24 EMAIL CHAIN SUBJECT: 243
			RE: AMERICA'S BEST HOSPITALS
			RANKED
			PBHN000011398 - PBHN000011401
			11/19/24 EMAIL CHAIN SUBJECT: 246
			FW: CI SCOPE OF WORK AND
			ASSOCIATED TRANSITION W/
			ATTACHMENTS: CI TRANSITION
			TASKS FOR REVIEW -
			10.31.24.XLSX
			PBHN000011018 - PBHN000011019

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4	SHERI MONTGOMERY	4	BEACH GROUP IMPROVEMENT
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6	BY MS. BLAIR	6	PBHN000005827 - PBHN000005829
7	CERTIFICATE OF OATH	7	5/1/25 SUBJECT: FW: PALM BEACH
8	CERTIFICATE OF REPORTER	8	HEALTH NETWORK LEAPFROG SAFETY
9	READ & SIGN LETTER TO WITNESS	9	SCORES
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11		11	5/1/25 EMAIL CHAIN SUBJECT: 264
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13		13	PBHN000008116
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15		15	FW: LEAPFROG
16		16	PBHN000005132 - PBHN000005137
17		17	11/4/24 EMAIL CHAIN SUBJECT: 280
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15		15	FW: LEAPF

Page 6 1 Thereupon, 2 the following proceedings began at 9:09 a.m.: 3 * * * 4 THE VIDEOGRAPHER: We are now on the record 5 and the time is 9:09 a.m. This is the 6 video-recorded deposition of Sheri Montgomery 7 taken in the matter of Good Samaritan Medical 8 Center, Incorporated, et al. versus The Leapfrog 9 Group. 10 This deposition is being held in 515 North 11 Flagler Drive, West Palm Beach, Florida on 12 Monday, September 15, 2025. 13 The videographer is Ashley Taylor, and the 14 court reporter is Barbie Gallo with Lexitas. 15 Will counsel please announce their 16 appearances for the record. 17 MS. BLAIR: Kim Blair on behalf of 18 defendant, Leapfrog. 19 MR. MARCUS: Jeff Marcus of Marcus, 20 Rashbaum, Pineiro & Meyers. 21 I'm joined by Kevin Simmons of Gibson, Dunn 22 on behalf of plaintiffs. 23 THE STENOGRAPHER: And, if you would, raise 24 your right hand, I'll swear you in. 25 Do you swear or affirm that the testimony	Page 8 1 for the record? 2 A. Sure. Sheri Montgomery, S-h-e-r-i; 3 Montgomery, M-o-n-t-g-o-m-e-r-y. 4 Q. And have you ever been deposed before? 5 A. I have. 6 Q. How many times? 7 A. I believe once only. 8 Q. And was that in connection with your 9 employment at Good Samaritan? 10 A. Yes. 11 Q. And so I'll just go over just a few ground 12 rules, probably things you've heard before. 13 As you know, the court reporter is taking 14 down everything I say and everything you say, so for 15 the convenience and sake of the court reporter, I will 16 try not to talk over you while you're answering. And I 17 ask that you try not to talk over me so that Barbie can 18 get down everything everyone is saying. 19 Is that okay? 20 A. Yes. 21 Q. Again, the court reporter can't take down a 22 shrug of the shoulders, an "uh-huh," "huh-uh" so all of 23 your answers must be verbal here today. 24 Does that make sense? 25 A. It does.
Page 7 1 you're about to give in this matter will be the 2 truth, the whole truth and nothing but the truth 3 so help you God? 4 THE WITNESS: I do. 5 THE STENOGRAPHER: Thank you. 6 MS. BLAIR: And let the record reflect that 7 this is both the fact witness deposition of 8 Sheri as well as the corporate representative 9 30(b)(6) deposition of Good Samaritan taken 10 pursuant to agreement of counsel. I do have a 11 notice coming, And I will introduce that as an 12 Exhibit shortly. This deposition is also taken 13 pursuant to the federal Rules of Civil Procedure 14 as well as the local rules for the Southern 15 District of Florida. 16 THEREUPON, 17 SHERI MONTGOMERY, 18 Being by me first duly sworn to tell the whole truth, 19 as hereinafter certified, testified as follows: 20 DIRECT EXAMINATION 21 BY MS. BLAIR: 22 Q. Ms. Montgomery, as I just announced, my name 23 is Kim Blair. I represent the defendant, Leapfrog in 24 this matter. 25 Could you please state and spell your name	Page 9 1 Q. In addition, it's clearly not an endurance 2 test so if at any time you need to take a break, please 3 ask me. The only caveat is that if there's a question 4 pending I ask that you answer that question before we 5 take a break. 6 Is that fair? 7 A. Yes. 8 Q. If at any time you don't understand one of 9 my questions, and that will happen today, please ask me 10 to rephrase that question. If you answer a question I 11 ask, I'm going to assume you understood it. 12 Is that fair? 13 A. Yes. 14 Q. Can you describe for us your education 15 background, starting after high school? 16 A. I got my undergrad at FAU in business 17 administration, and then I went to Nova University for 18 my master's in business administration with a 19 concentration in finance. 20 Q. Do you hold any certificates or licensing? 21 A. I do not. 22 Q. What year did you graduate from Novo [sic]? 23 A. I think around 2010 or '11. 24 Q. And did you go straight through undergrad to 25 Novo [sic]?

Page 10 1 A. I did not. 2 Q. What did you do between FAU and Novo [sic]? 3 A. I was just working. 4 Q. Where did you work? 5 A. I believe Delray Medical Center at the time. 6 Q. What did you do at Delray Medical Center? 7 A. I was probably the controller at the time. 8 Q. So tell me a little bit about your 9 employment. So right out of FAU you began working at 10 Delray? 11 A. Yes. I was working at Delray prior to FAU. 12 Q. Okay. So did you go straight to college 13 from high school? 14 A. Probably. Palm Beach State, I was at Palm 15 Beach State for a while for my associate's degree and 16 FAU for my bachelor's. 17 Q. Okay. So when did you get your associate 18 from Palm Beach State? 19 A. I don't know. 20 Q. What about when did you graduate from FAU? 21 A. I'm not sure. 22 Q. You're not sure when you graduated? 23 A. Maybe three years prior to my master's 24 maybe. 25 Q. So in or around 2006, 2007, does that sound	Page 12 1 Q. And so you were at Delray prior to Delray 2 being purchased by Tenet, correct? 3 A. Yes. 4 Q. What was your last position at Delray prior 5 to going to Coral Gables? 6 A. ACFO. 7 Q. And what's the A stand for in the ACFO? 8 A. Assistant CFO. 9 Q. And can you briefly describe in or around 10 2004 when you were the assistant CFO at Delray what 11 your job duties entailed? 12 A. I don't think -- I wasn't the A -- did you 13 say "2004"? 14 Q. Well, I thought you told me you left Delray, 15 you were at Delray for about ten years, 1994 to 2004. 16 That was my math. 17 A. Oh, no -- 18 Q. And then you got -- 19 A. -- no, I said like 20 years was -- 20 Q. Oh. 21 A. -- my whole career at Delray. 22 Q. I'm so sorry. My math is bad. 23 A. I went to Coral Gables in 2012. 24 Q. Okay. Got it. That was my math mistake. 25 Okay. So when you leave Delray in 2012, you
Page 11 1 about right? 2 A. Potentially. 3 Q. And so you started working at Delray. Did 4 you start working at Delray after you got your 5 associate's degree but before you finished at FAU? 6 A. Before. I was working probably at Delray by 7 the age of 19, you know, and going to school at the 8 same time throughout my whole career really. 9 Q. Okay. So let's start with your job at 10 Delray in or around the age of 19. What was your job? 11 A. I worked in central supply. 12 Q. And what did you do in central supply? 13 A. You know, stock supplies, things of that 14 nature. 15 Q. What was your next -- where did you -- how 16 long did you work at Delray? 17 A. Since '94, I believe. 18 Q. And at some point you left Delray? 19 A. I was at Delray for the majority of my 20 career, and then I went to Coral Gables as the CFO. 21 Q. Okay. So -- 22 A. I was there probably 20 something years. 23 Q. At Delray 20 something years? 24 A. Yeah. My whole career has -- was at Delray, 25 Coral Gables and Good Sam.	Page 13 1 were the assistant CFO, correct? 2 A. (Nodding head). 3 Q. And what did your job duties entail in, 4 let's just use 2012, your last year at Delray as the 5 assistant CFO? 6 A. Right. Ensuring the financial statements 7 accurate, you know, working with the CFO, you know, was 8 training at the time for the next position, so I got 9 other responsibilities like departments, overseeing IT 10 maybe or case management, things like that. 11 Q. Did you have any responsibilities at Delray 12 for overseeing quality of the hospital? 13 A. No. 14 Q. So I asked a question before, and I think I 15 asked a bad question so I'm sorry. 16 So, as I understand it, Delray was purchased 17 by Tenet in 2007; is that correct? 18 A. I don't know the exact date. 19 Q. Do you recall if whether or not when you 20 were working at Delray they were owned by Tenet? 21 A. Originally when I was 19, no. It was like 22 AMI, I think, or, no, NME. They merged with AMI, so... 23 Q. By the time you leave are they owned by 24 Tenet? 25 A. Yes.

Page 14 1 Q. Okay. 2 A. Yes. 3 Q. And was there any sort of shift at Delray 4 once Delray became purchased by Tenet in terms of how 5 the hospital was organized or operating? 6 A. I don't recall. 7 Q. Did your job duties change in any way when 8 Delray became affiliated with Tenet? 9 A. I don't recall. I don't even remember if I 10 was in accounting at that time or -- it was so long 11 ago. 12 Q. So you just don't really recall any -- no 13 changes come to mind? 14 A. No. I mean, as far as I'm concerned, I 15 worked for Tenet my entire career that I recall. 16 Q. Okay. So -- 17 A. You know... 18 Q. -- as far as you're concerned, you worked 19 for Tenet your whole career? 20 A. Yeah, because it was so long ago when I 21 worked for NME, I don't even know if I was a supply 22 clerk at the time or -- it -- I don't remember the year 23 that that occurred, but it was a long time ago, so... 24 Q. And in your role as the assistant CFO at 25 Delray, did you report in any way to Tenet Healthcare's	Page 16 1 A. I don't recall. 2 Q. Would that have fallen within your ambit as 3 the assistant CFO? 4 A. Not necessarily. 5 Q. Would it have fallen within the ambit of the 6 CFO if payments were being paid to Leapfrog to 7 participate in the Leapfrog annual survey? 8 A. I mean, the way it works is whoever is 9 requesting, or someone could fill out a purchase order 10 that, you know, goes to, depending on the amount, it 11 might not ever reach the CFO so it really depends. You 12 know, it could be the ACFO. It could be the 13 controller. It depends on what the amount is. Since 14 there are so many payments that go through a hospital, 15 one might not know, if that makes sense. 16 Q. That makes sense. 17 A. If it's \$200,000, the CFO would know about 18 it. 19 Q. Do you have any -- let me ask it more 20 broadly. 21 Do you have any recollection of making any 22 payments to Leapfrog while you were -- strike that. 23 Do you have any recollection of Delray 24 making any payments to Leapfrog while you were the 25 assistant CFO of Delray?
Page 15 1 home office in Dallas? 2 A. I wouldn't see it that way, but, I mean, I'm 3 sure our organization did, but, you know, I was working 4 for the CFO at the time or, you know... 5 Q. Do you recall having any direct contact with 6 the Tenet home office when you were at Delray in your 7 position as the assistant CFO? 8 A. Sure. 9 Q. And what kinds of oversight did 10 Tenet Healthcare have with respect to your functions as 11 the assistant CFO while you were at Delray? 12 MR. MARCUS: Object to form. 13 A. So the corporate office has departments like 14 revenue cycle, for example, that support us, a tax 15 department that supports us, so we would talk to them 16 about things like that, you know. Contract management 17 is done at the home office. 18 BY MS. BLAIR: 19 Q. Do you know whether or not Delray 20 participated in the Leapfrog survey while you were 21 associated with Delray? 22 A. I don't recall. 23 Q. Do you recall in your position as the 24 assistant CFO at Delray whether or not Delray paid any 25 monies to Leapfrog for participating in the survey?	Page 17 1 A. I do not. 2 Q. So after you leave Delray I think you told 3 me you went to Coral Gables, correct? 4 A. Yes. 5 Q. And that was sometime in 2012, right? 6 A. I believe that's correct. 7 Q. And you were the chief financial officer of 8 Coral Gables? 9 A. I was. 10 Q. How long were you the chief financial 11 officer of Coral Gables? 12 A. 18 months. 13 Q. And what were your job duties as the CFO of 14 Coral Gables? 15 A. Business planning, you know, ensuring 16 financial statements are accurate, contract management, 17 vendor management. 18 Q. Did you have any oversight while you were at 19 Coral Gables with respect to marketing? 20 A. No. 21 Q. Did you oversee the marketing budget in any 22 way? 23 A. I would say I was responsible ultimately 24 that they didn't overspend, yes. 25 Q. Do you recall whether or not the marketing

Page 18 1 department at Coral Gables had a budget? 2 A. Yes. 3 Q. And same question with respect to your work 4 at Delray back when you were the assistant CFO at 5 Delray, did they have a marketing budget? 6 A. Yes. 7 Q. Do you recall whether or not the marketing 8 budget of Delray was a percentage of overall revenue? 9 MR. MARCUS: Object to form. 10 A. I don't recall anything like that, no. 11 BY MS. BLAIR: 12 Q. And same question with respect to CF -- with 13 Coral Gables, do you recall whether or not the 14 marketing budget was a percentage of the overall 15 revenue? 16 A. I do not. 17 MR. MARCUS: Same objection. 18 BY MS. BLAIR: 19 Q. How is -- just speaking generally, you 20 obviously have a lot of experience in a CFO role of a 21 hospital. How generally is the marketing budget come 22 to at a hospital? 23 A. Really based off history. So, you know, if 24 you spent a certain amount the previous year, if you 25 have some business plan initiative, there's -- you're	Page 20 1 we've always been a group. 2 Q. And what do you mean "always a group"? What 3 does that mean? 4 A. You know, working together, planning 5 together, having meetings together. There was group 6 leadership, you know, a CEO, a CFO, CHRO over the five 7 hospitals. 8 Q. And was that true even though -- Palm Beach 9 Gardens doesn't get owned by Tenet until 2017, so when 10 you say "always," I'm just curious. 11 A. Palm Beach Gardens. That doesn't make 12 sense. 13 Q. That doesn't make sense. Do you know when 14 Tenet -- maybe my research is wrong. 15 Do you know when Palm Beach Gardens was 16 purchased by Tenet? 17 A. I've always known them to be part of Tenet. 18 Q. Okay. So Palm Beach Health Network is 19 formed in 2022, April of 2022, correct? 20 A. That sounds about right. 21 Q. Okay. But before April of 2022, the five 22 hospitals that are the -- and when you say "the five 23 hospitals," I assume you're referring to the five 24 hospitals that are plaintiffs in this lawsuit, correct? 25 A. Yes.
Page 19 1 wanting to increase the budget, then obviously you 2 request for those reasons, but, honestly, it's really 3 based off history for the most part. 4 Q. And why did you leave Coral Gables after 5 18 months? 6 A. To go back to Delray Medical Center as the 7 CFO. 8 Q. Okay. So you go back to Delray. And what 9 year was that? 10 A. '14. 11 Q. And how long did you stay as the CFO of 12 Delray hospital? 13 A. I would say probably, I guess, six years 14 because, yeah, I went to Good Sam in 2020. 15 Q. What month did you start at Good Sam in 16 2020? 17 A. April. 18 Q. Right in the middle of the pandemic? 19 A. Yes. 20 Q. Prior to the Palm Beach Health Network being 21 formed in 2022, was there a connection between Delray 22 and Good Sam? 23 A. Yes. 24 Q. And what was that connection? 25 A. We were always a group, so five hospitals,	Page 21 1 Q. And those five hospitals are St. Mary's, 2 Good Sam, Palm Beach Gardens, West Boca and Delray, 3 correct? 4 A. Yes. 5 Q. Yes. 6 So tell me about prior to April of 2022 how 7 the hospitals functioned as a group. 8 A. Pretty much the same. I mean, the structure 9 is there's group leadership. The reason it's five is 10 that they were the five Tenet hospitals so there's 11 local leadership that you report up to that is over the 12 five. 13 Q. And prior to April of 2022 who was the local 14 leadership of these five hospitals? 15 A. Maggie Gill, Michelle Cartwright, 16 Shannon Wills for CHRO, Ricky Ramirez for the CNO. 17 That's changed over time so I don't know exact dates 18 because before I went to Good Sam, I was the 19 Michelle Cartwright of the group, the CFO. 20 Q. Okay. 21 A. And the CFO of Delray Medical Center. 22 Q. Got it. So prior to Palm Beach Health 23 Network being formed in April of 2022, was there a 24 formalized structure for these five hospitals? 25 A. Yes.

Page 22 1 Q. From a -- 2 Okay. And what did you call yourselves, 3 just were you just it was just part of Tenet? 4 A. Yeah, the Palm Beach group. 5 Q. And so if I'm understanding you correctly, 6 and please correct me if I'm wrong, there was a 7 functional group within Tenet overseeing these five 8 hospitals, and you were the functional group CFO at one 9 point, correct? 10 A. Correct. 11 Q. And prior to April of 2022, did Maggie Gill 12 work at one of the five hospitals? 13 A. Delray. 14 Q. And what was her title at Delray prior to 15 April of 2022? 16 A. So she was the CEO of Delray at sometime, 17 and then she was pulled up to not have a hospital at 18 all. I don't remember what year that was. 19 Q. Got it. So but until '20 -- April of 2022 20 when Palm Beach Health Network was formed, Maggie Gill 21 would not have been the CEO of Palm Beach Health 22 Network; is that fair? 23 MR. MARCUS: Object to form. 24 A. She was. She was at the Palm Beach group. 25 BY MS. BLAIR:	Page 24 1 for? 2 A. Chief human resource officer. 3 Q. And Ricky Ramirez, was he associated with a 4 specific hospital? 5 A. He's at West Boca, and he's the chief nurse 6 officer there. 7 Q. And he's still the chief nurse officer of 8 West Boca, correct? 9 A. Correct. 10 Q. And is Shannon Wills still the CHRO at 11 Delray? 12 A. She is. 13 Q. And is Michelle Cartwright still the CFO at 14 St. Mary's? 15 A. She's at Delray. 16 Q. She's currently at Delray? 17 A. Yes. 18 Q. And Maggie Gill, she -- I thought you just 19 said -- but if I'm wrong -- she no longer has any 20 responsibilities at a specific hospital; is that 21 correct? 22 A. Correct. 23 Q. Is there anyone else associated with the 24 Palm Beach Health Network that is not also associated 25 with one of the five hospitals specifically?
Page 23 1 Q. Okay. Yeah, that was a terrible question. 2 So functionally she was the CEO of the Palm 3 Beach group prior to April of 2022, correct? 4 A. Correct. 5 Q. And in April of 2022, these five hospitals 6 of which you are the CEO of Good Samaritan rebranded as 7 the Palm Beach Health Network, correct? 8 A. Correct. 9 Q. Okay. And Michelle Cartwright, you said she 10 was the group -- or was the group CFO at one point? 11 A. She is. 12 Q. She is now. Does she come from one of these 13 five hospitals? 14 A. Correct, yes. 15 Q. Which one? 16 A. St. Mary's. 17 Q. And then what about Shannon Willis [sic], 18 was she at a hospital, one of these five hospitals as 19 well? 20 A. Yes. Her last name is Wills. 21 Q. Oh, I'm sorry. Wills. 22 A. That's all right. 23 Q. What hospital was she at? 24 A. Delray. 25 Q. And you said CHRO. What does that stand	Page 25 1 A. That's not associated, no. 2 Q. Okay. So just Maggie Gill? 3 A. Right. 4 Q. And Maggie Gill reports directly to Tenet 5 hospital in Dallas, to the best of your knowledge? 6 A. Yes. 7 Q. Do you know who she reports to in Dallas? 8 A. Lisa Foo. 9 Q. Can you spell "Foo" for me? 10 A. F-o-o. 11 Q. And who is Lisa Foo? 12 A. She's the COO. 13 Q. Of Tenet hospitals? 14 A. Yes. 15 Q. Or I'm sorry. Tenet Healthcare? 16 A. Yes. 17 Q. Do you know who Lisa Foo reports to? 18 A. Saum Sutaria. He's the CEO. 19 Q. So with respect to your employment history, 20 in April of 2020, you become the CEO of Good Samaritan, 21 correct? 22 A. Correct. 23 Q. Can you describe for me briefly what your 24 roles are as the COO -- CEO, excuse me, of 25 Good Samaritan?

Page 26

1 A. Did you say "goals"?

2 Q. I'm sorry. Roles.

3 A. Roles.

4 Q. Yeah. Sorry.

5 A. My role is to oversee the strategy, business

6 initiatives, ensure that the hospital is, you know,

7 quality, financially sound.

8 Q. In terms of the corporate structure of

9 Good Sam, I assume if you're the CEO you're at the top,

10 correct?

11 A. Correct.

12 Q. How many direct reports do you have?

13 A. Really only the A-team, so that would be the

14 CHRO, COO, CNO and the CFO.

15 Q. Okay. And who is the CHRO?

16 A. Kevin Caracciolo. It's

17 C-a-r-r-i-c-c-l-o [sic] I think.

18 Q. And the COO?

19 A. Austin Champoux.

20 Q. The CNO?

21 A. Colleen Thielk.

22 Q. And the CFO?

23 A. Taylor Guittap.

24 Q. Is there a chief marketing officer for

25 Good Sam?

Page 27

1 A. No.

2 Q. Is there a chief quality officer?

3 A. No.

4 Q. Does the Palm Beach Health Network share a

5 chief quality officer?

6 MR. MARCUS: Object to form.

7 A. Not officers.

8 BY MS. BLAIR:

9 Q. Is there a chief quality director?

10 A. We would call them a group director.

11 Q. Who's the group director?

12 A. Gina West.

13 Q. And so her will title is the Palm Beach

14 Health Network group director?

15 A. Quality director.

16 Q. Okay. So she is the Palm Beach Health

17 Network group quality director?

18 A. Correct.

19 Q. And she oversees all five hospitals?

20 A. Yes.

21 Q. And are there quality personnel at Good Sam?

22 A. Yes.

23 Q. Who is in the quality department? My word.

24 I don't know if you call it the quality department, but

25 who's in charge for quality for Good Sam directly?

Page 28

1 A. Erin Britt.

2 Q. And what is her title?

3 A. The quality director.

4 Q. And who reports to Erin Britt?

5 A. Infection control; Lauren. I'm drawing a

6 blank on her last name. There's also an infection

7 control coordinator that reports to her.

8 Q. Does she only have one direct report?

9 A. Two. So there's two. There's the -- Lauren

10 who's really over infection control, and then there's a

11 coordinator as well, so there's two, I believe.

12 Q. Who is Taylor Pool?

13 A. She is the group infection control director.

14 Q. So Regina West, she's not associated with

15 any specific hospital?

16 A. I don't believe she is any longer.

17 Q. And what about Taylor Pool, is she

18 associated with any specific hospital?

19 A. I believe she's also the infection control

20 director at St. Mary's, but I'm not sure.

21 Q. So Gina West and Maggie Gill, they're direct

22 employees of Tenet Healthcare home office to the best

23 of your knowledge?

24 A. Gina West, no.

25 Q. Okay. What hospital is Gina West affiliated

Page 29

1 with?

2 A. I believe she either might be on my books or

3 St. Mary's.

4 Q. Does she have an office at Good Samaritan?

5 A. St. Mary's.

6 Q. So in terms of the finances of these five

7 hospitals, do you share sort of the cost of Regina West

8 if she's overseeing quality for all five hospitals?

9 How does that work?

10 A. Yes.

11 Q. So is it the case that any -- well, strike

12 that.

13 Is that the same with Maggie Gill, then?

14 A. I don't believe so.

15 Q. Okay. But it is for Regina West, correct?

16 A. Yes.

17 Q. And in your role as CEO of Good Samaritan,

18 what oversight do you have with respect to quality?

19 A. Well, the CNO is -- has direct oversight,

20 and I have oversight of the CNO, so...

21 Q. So the CNO, does -- I think it's a

22 "she" report to you regularly?

23 A. Yes.

24 Q. And that's Colleen Thielk, correct?

25 A. Correct.

Page 30 1 Q. And what are Colleen Thielk's 2 responsibilities as the chief nursing officer as it 3 relates to quality and safety? 4 A. She has direct oversight of the clinical 5 operations of the hospital, safety risk, infection 6 control. 7 Q. Does she report to you regularly regarding 8 clinical operation, safety risk and infection control? 9 A. Yes. 10 Q. Do you have regularly scheduled meetings 11 with respect to that? 12 A. We do. 13 Q. How often do you meet? 14 A. Once a week. 15 Q. And, generally speaking, what are the 16 substance of these meetings? 17 A. All types of things, I mean, down to 18 recruitment, to culture, to what we're doing, patient 19 safety, mentorships. 20 Q. How much time does Colleen Thielk spend 21 on -- well, strike that. 22 Can you tell me what are Colleen Thielk's 23 duties as the chief nursing officer of Good Samaritan? 24 A. To oversee the clinical operations of the 25 building. I mean, to me that encompasses the things	Page 32 1 Q. I can't pronounce it. Does he have direct 2 interaction with the unions? 3 A. Very little. A union rep might come to the 4 hospital like a couple times a year maybe. 5 Q. Why did the five hospitals decide to rebrand 6 as Palm Beach Health Network? 7 A. I think it was more of, you know, getting an 8 identity to show that we're an encompassing network of 9 hospitals that work together. 10 Q. Do you compete with each other these five 11 hospitals? 12 A. No. 13 Q. All five of these hospitals are acute care 14 hospitals, correct? 15 A. They are. 16 Q. And they're all in the general geographic 17 region, correct? 18 A. Yes. 19 Q. But you don't consider each other to be 20 competitors in any way? 21 A. No. 22 Q. Why not? 23 A. We support each other. We work on business 24 plans together. We're all specialized really in 25 different areas.
Page 31 1 that I mentioned before about risk, safety, infection 2 control, patient satisfaction, you know, all those 3 types of things. 4 Q. Does she oversee the nursing staff? 5 A. She has directors, of course, but, yes. 6 Q. And how many people report to 7 Colleen Thielk? 8 A. She probably has eight to ten direct report, 9 maybe ten direct reports, and then they have managers 10 that report to them. 11 Q. How many full-time nurses are employed by 12 Good Samaritan? 13 A. Probably about 370 maybe, 350. 14 Q. Are they unionized? 15 A. Yes. 16 Q. What union are they in? 17 A. 1199. 18 Q. Does Colleen have any direct interaction 19 with the union on behalf of the nursing -- the nurses? 20 A. Not typically. It's not very -- the union 21 there is not really active. 22 Q. What about the chief -- do you have a CHRO? 23 A. Yeah. 24 Q. You do. Kevin? 25 A. Yes.	Page 33 1 Every hospital has, general surgery, for 2 example, so that's not really an identifier. So Delray 3 is a trauma hospital. St. Mary's is a trauma hospital. 4 They're very far from each other. They're the only two 5 trauma hospitals in the county. 6 Q. Do you have any -- do you keep any 7 statistics as to how many patients choose one of the 8 five hospitals over the other four? 9 A. No. 10 Q. Do you understand that one of the 11 allegations that's made in this case is that people are 12 bypassing Good Sam to go to other hospitals, correct? 13 A. Correct. 14 Q. Do you know whether they bypass Good Sam to 15 go to St. Mary's or Delray or Palm Beach Gardens? Have 16 you done a study as to that? 17 A. We have not, but I would gather not. 18 Q. Why would you gather not? 19 A. Because we all had failing grades. 20 Q. Well, there's a lot of other things that go 21 into choosing a hospital, wouldn't you agree with me? 22 A. Could you be more specific? 23 Q. Well, yeah. I mean, do you have any 24 understanding that a patient may choose another 25 hospital because they like the doctor at that hospital

Page 34 1 better than another hospital? 2 MR. MARCUS: Object to form. 3 A. Sure. 4 BY MS. BLAIR: 5 Q. Right. And so I'm just sort of saying like 6 there are a lot of reasons people might choose one 7 hospital over another, correct? 8 A. Yes, but I would say with the failing 9 grades, it definitely people have chosen not to choose 10 our hospitals and would hinder people to actually 11 question their doctors to even come to our hospitals. 12 Q. Do you believe that's the same with respect 13 to a one-star CMS rating? 14 A. I do not. 15 Q. Why not? 16 A. So with CMS, in general, if you looked at 17 the Palm Beach County hospitals, there are many 18 one-star hospitals. It never hit the news. I was 19 never questioned from any patient, any doctor until we 20 were all F's and it was all over the news, which is, in 21 people's minds, obviously, a failing grade. 22 Q. So no one on your board of directors cared 23 that you're a one-star CMS hospital? 24 MR. MARCUS: Object to form. 25 A. They never said anything. They never really	Page 36 1 that you think that should impact somebody's decision 2 to come to your hospital? 3 MR. MARCUS: Object to form. 4 A. That's not what I said at all. 5 BY MS. BLAIR: 6 Q. Okay. I just want to make sure I understand 7 what you said. 8 Patients have experiences at hospitals, 9 correct, when they're admitted? 10 A. Correct. 11 Q. And patients report on those experiences at 12 the hospitals, correct? 13 A. Some of them do. 14 Q. And that's what ultimately turns into the 15 HCAHPS scores that CMS looks at, correct? 16 A. That is correct. 17 Q. And so in your long history of working at 18 hospitals, do you have any opinion about whether or not 19 word of mouth from patients can affect whether or not 20 other patients want to go to a hospital? 21 A. Certainly. 22 Q. And have you ever looked at comments on 23 social media from patients about their experiences at 24 Good Samaritan? 25 A. I have.
Page 35 1 looked that what's -- what is a star hospital and what 2 do the stars really mean. 3 In my opinion, in Palm Beach County, CMS 4 star ratings never made the news. It was not like that 5 everyone was looking at. 6 When it makes the news that you have a 7 failing red F, that's very, very different to people, 8 so you're a failing hospital. You failed. That's what 9 it looked like. 10 BY MS. BLAIR: 11 Q. But isn't it important to you as a CFO that 12 you have good marks for patient experience whether or 13 not it's in the news or not? 14 A. Yes, patient experience is important to us. 15 Q. And you have a one-star for patient 16 experience at Good Sam, correct? 17 A. I do. 18 Q. And you've looked at the HCAHPS scores from 19 CMS for patient experience, correct? 20 A. I have. 21 Q. And so whether it's in the news or not, 22 isn't that important to your board of directors, how 23 patient experience is at Good Samaritan? 24 A. Patient experience is important, yes. 25 Q. Okay. But it's only if it's in the news	Page 37 1 Q. Do you have any understanding as to 2 whether -- as to whether or not comments by patients on 3 social media impacts whether or not their friends and 4 neighbors might want to go to that hospital? 5 A. They could. 6 Q. And have you done any studies at 7 Good Samaritan to make a determination as to whether or 8 not patient experience at your hospital impacts your 9 brand? 10 A. A specific study, no. 11 Q. Getting back to the rebranding of the Palm 12 Beach -- the rebranding of these five hospitals as Palm 13 Beach Health Network, do you understand that occurred 14 in or around April of 2022? 15 A. I mean, I don't remember the exact date. 16 Q. I read a newspaper article from April of 17 2022, and it says, "Five Tenet hospital" -- "five 18 Tenet Healthcare owned hospitals in Palm Beach County 19 are retooling their image to emphasize ties to local 20 physicians and communities." 21 Does that comport with your recollection as 22 to why the rebranding occur? 23 A. I mean, local communities, yes. I'm not 24 really sure about the physician statement. I don't 25 recall that.

Page 38 1 Q. Okay. And that same article said, "The move 2 comes as more residents pour into the region." 3 In April of 2022, is it your recollection 4 that more residents were pouring into the region that 5 Good Samaritan services? 6 MR. MARCUS: Object to form. 7 A. I mean, the community has been growing for 8 quite sometime. I don't know if it had anything to -- 9 in that time, April. I mean, the last several years, 10 yes, it would have been -- 11 BY MS. BLAIR: 12 Q. Do you live in this community? 13 A. Yes, I do. 14 Q. And then it says -- so that sentence goes on 15 to say, "The move comes as more residents pour into the 16 region and rival medical providers vie for new and 17 often wealthy patients." 18 As the CEO of Good Samaritan in around April 19 of 2022, would you agree that rival medical providers 20 were coming to the area? 21 A. Yeah, I would definitely say so. There's 22 definitely been a movement in the Palm Beach County 23 with different organizations in healthcare. 24 Q. Does Palm Beach Health Network have a -- 25 have someone that oversees marketing for these five	Page 40 1 St. Mary's -- or for Good Samaritan? 2 A. Nancy Morales. 3 Q. Is she related to Maria Morales? 4 A. She's not. 5 Q. What is the marketing budget for 6 Good Samaritan? Well, let's do it this way. 7 What was the marketing budget for 8 Good Samaritan in 2024? 9 A. I don't have a number. 10 Q. Is it a percentage of the overall budget? 11 A. No, it was based on whatever, honestly, we 12 spent last year. 13 Q. At any time from April of 2022 through 14 present, has Palm Beach Health Network encouraged the 15 hospitals to increase their marketing budget due to the 16 fact that rival hospitals were coming into the area and 17 competition was getting bigger? 18 A. No. 19 Q. So there was no effort to increase marketing 20 despite the fact that Cleveland Clinic and Langone and 21 other hospitals were coming to the area? 22 A. It doesn't really work like that. You know, 23 we would look at what our service lines are and that's 24 what we support. If there was something else 25 marketing-wise, a budget I'm not aware of, I'm not
Page 39 1 hospitals? 2 A. Yes. 3 Q. And who is that? 4 A. Lisa Cook. 5 Q. And is Lisa Cook affiliated with any of the 6 five hospitals? 7 A. Delray. 8 Q. Is there a reason why it appears the 9 majority of people that have responsibilities for the 10 Palm Beach Health Network as the group come from Delray 11 as opposed to the other hospitals? 12 MR. MARCUS: Object to form. 13 A. No. Ricky is at West Boca. And I did 14 forget to mention Maria Morales. She's COO. 15 BY MS. BLAIR: 16 Q. And where is she from? 17 A. St. Mary's. 18 Q. What are Lisa Cook's responsibilities for 19 marketing for the Palm Beach Health Network? 20 A. So the marketing managers at the hospitals 21 have, you know, a dotted line to her, so she helps 22 oversee them and their activities, you know, assisting 23 them with budgeting, assisting them with, you know, 24 branding. We work very well as a group, I would say. 25 Q. And who is the marketing manager for	Page 41 1 aware of that. 2 Q. Was there any direction from 3 Tenet Healthcare home office to increase marketing 4 efforts in the South Florida region in light of the new 5 competition coming? 6 MR. MARCUS: Object to form. 7 A. Not that I recall. I mean, there could have 8 been. 9 BY MS. BLAIR: 10 Q. Do you recall having any conversations as 11 the CEO of Good Samaritan about increasing marketing 12 efforts in the South Florida region in or around or 13 between April of 2022 and present in light of the new 14 competition coming to the area? 15 A. I would say that the conversations I recall 16 were more around branding. And obviously there was a 17 budget put out there for branding, but it's not a 18 budget I'm really aware of. 19 Q. And when you say "around branding," are you 20 referring to branding Palm Beach Health Network? 21 A. Correct. 22 Q. And what do you recall about the efforts to 23 brand the Palm Beach Health Network? 24 A. You know, the creation of a logo, tag line, 25 commercials, videos, things of that nature.

Page 42 1 Q. Was part of Good Samaritan's budget 2 earmarked for that additional branding effort? 3 A. I'm not really sure. That's why I was 4 thinking that there's a different -- there was a 5 separate budget allocated that would really be separate 6 from what we would do with our budget at the hospital. 7 Q. Do you recall if there was a marketing 8 campaign to promote Palm Beach Health Network in or 9 around April of 2022 when the branding occurred? 10 A. Yeah, I don't recall the date, but I know 11 there was -- like I said, there's a commercial. 12 There's, you know, collateral, changing the logo, 13 things like that. 14 Q. What is collateral? I don't know what that 15 means. 16 A. Like anything about our network, our 17 hospital, whether it's something that you would mail 18 out to the community, things that you would hand out 19 that talk about your business. 20 Q. Are you now called like Good Samaritan, part 21 of the Palm Beach Health Network? I mean, is that how 22 you brand yourselves now? 23 A. Yep. 24 Q. And so as part of that branding effort, do 25 you consider Good Samaritan to be tied from a branding	Page 44 1 A. Correct. 2 Q. What type of data does she track for the 3 network as a whole? 4 A. I'm not really sure what she does on her 5 day-to-day basis. I just know my interactions with her 6 with our quality meetings and going over our score 7 cards that have anything to do with infection, 8 mortality, things of that nature. I mean, I'm not sure 9 what she tracks on her day-to-day job. 10 Q. Does she produce quality and safety reports 11 for the network as a whole? 12 A. I mean, I'm not sure what she might send out 13 to chief nurse officers, but so we have monthly 14 meetings where we go over our, you know, score cards. 15 She normally, you know, chairs those types of meetings. 16 Q. And you -- when you refer to "score cards," 17 what are you referring to? 18 A. So the quality balanced scorecard basically 19 is what it is. 20 Q. And what does that look like? 21 A. It has a bunch of different measures on it. 22 It has emergency room measures on it, how long a 23 patient is waiting. It has mortality. It has 24 infections, transfer acceptance rate. 25 Q. Are those called the quality reports?
Page 43 1 perspective to the other four hospitals that are part 2 of the Palm Beach Health Network? 3 A. I consider us together, yes. And the whole 4 point is really to show that there are so many services 5 that we provided throughout the community. 6 Q. And when you say "so many services we 7 provide throughout the community," you're referring to 8 healthcare services? 9 A. Correct. 10 Q. Are there any other services that are 11 provided? 12 A. I mean, other than employment... 13 Q. Just want to make sure I understood. 14 We talked earlier a little bit about 15 Regina West. And she is -- I want to make sure I get 16 this right. She is the Palm Beach Health Network group 17 quality director, correct? 18 A. Yes. 19 Q. And there is no Palm Beach Health Network 20 group quality -- or, sorry -- Palm Beach Health Network 21 group chief quality officer, correct? 22 A. No. 23 Q. So she would be the highest ranking 24 individual with respect to quality at the Palm Beach 25 Health Network?	Page 45 1 A. They're -- I would say they're the standard 2 score card that really gathers a lot of information on 3 one score card, but there are all types of quality 4 things that -- you know, data, other score cards, but 5 this is the main one that as leadership we review. 6 Q. Do you know if those documents were produced 7 in this litigation? 8 A. I'm not sure if the balanced scorecard was. 9 Probably. 10 Q. I'll show you some -- 11 A. I'm pretty confident. 12 Q. I'll show you some document later today. 13 A. Okay. 14 Q. Maybe I've seen them and I'm just not 15 calling them the score card. 16 A. Okay. 17 Q. And speaking of documents, were you involved 18 in connection with gathering documents to produce in 19 this litigation? 20 A. Yes. 21 Q. And what did you do to gather documents to 22 produce? 23 A. I believe specifically for me it was mostly 24 emails and helping with like governing board minutes. 25 Q. Did you ask anyone else at the

Page 46 1 Good Samaritan organization to gather documents? 2 A. I did. 3 Q. Who were those people? 4 A. Amy Travland, who is the director of medical 5 staff. She keeps all the minutes for the Med Exec 6 Committee. 7 Q. Anyone else? 8 A. Laura Feak, she's my AA. She gathered like 9 governing board minutes because she's the one that 10 obviously does them. I had conversations with 11 Erin Britt who's the quality director. 12 Q. Did you ask Erin Britt to gather her emails? 13 A. Yes, it was emails, and I think there may be 14 was a request for like monthly QIPSC minutes or 15 something, so and then she started working with 16 Gina West and they gathered everything and had their 17 own thing they were doing. 18 Q. And for the record what is QIPSC? 19 A. It's Quality Improvement Patient Safety 20 Committee. 21 Q. And who is on the QIPSC? 22 A. Most leaders in the hospital, risk 23 management, infection control, CNO. I attend quite 24 often. There's a few doctors that are on it as well. 25 Our vice chief is on it. Nick Sama, director of	Page 48 1 patient safety or patient quality are shared at these 2 QIPSC meetings? 3 A. All of them, like down to SSIs, any 4 infection, incident reports, grievances from patients. 5 I would essentially say that mostly everything that's 6 reviewed there is around patient safety. I look at all 7 of this as patient safety, every measure. 8 Q. And what did you do to prepare for your 9 deposition here today? 10 A. I had some meetings with my attorneys, 11 reviewed -- reviewed documents that we discussed. 12 Q. Do you recall what documents you reviewed? 13 MR. MARCUS: Objection. I'm going to 14 instruct the witness not to answer that. 15 MS. BLAIR: You're going to instruct the 16 witness not to answer about documents -- 17 MR. MARCUS: Documents. 18 MS. BLAIR: -- she reviewed in 19 preparation -- 20 MR. MARCUS: She can talk generally, yeah. 21 MS. BLAIR: -- for her deposition? 22 MR. MARCUS: Well, she's talking about 23 conversations with her attorney. 24 MS. BLAIR: I don't know want to know about 25 conversations with your attorney.
Page 47 1 orthopedic services is on it. It's a good group of 2 people. 3 Q. How often do you meet? 4 A. Once a month. 5 Q. And do you go over the score card at these 6 meetings? 7 A. Yes, I think it's typically on there. 8 Q. What else do you do at these meetings? 9 A. Go over blood transfusions, falls, 10 infections. Risk management normally goes through her 11 like list of any like grievances. Infection control is 12 there so they'll go over their surveillances. You 13 know, there's a whole list of Like Joint Commission 14 stuff that you have to review and then other stuff. If 15 they have a PI committee or something, they'll go over 16 things like that. 17 Q. Are there meeting minutes that are produced 18 from these QIPSC meetings? 19 A. There should be. 20 Q. Are there agendas for these QIPSC meetings? 21 A. Yes. 22 Q. What types of -- and I'm really focused on 23 like patient safety type of documents, infection 24 control. 25 What type of documents in the area of	Page 49 1 MR. MARCUS: Well, that's what she just 2 said, so... 3 MS. BLAIR: Oh. I'll rephrase the question. 4 BY MS. BLAIR: 5 Q. What documents did you review in preparation 6 for your deposition? 7 A. I reviewed quality documents. Mostly 8 quality documents. Actually, they all encompass things 9 to do with patient safety, quality, CMS. 10 Q. So CMS documents? 11 A. Yeah. 12 Q. And what kind of -- 13 A. Data. 14 Q. Oh, CMS data. 15 A. Yeah. 16 Q. Do you remember for what years? 17 A. What's out there now and where we are today 18 because, as you know, it's a lagging indicator. It's 19 some of data is three years old. 20 Q. And when you say "quality documents," what 21 do you mean by "quality documents"? 22 A. Like QIPSC, tracking of infection control 23 documents. 24 Q. When you say "QIPSC," are you referring to 25 agendas or minutes?

Page 50 1 A. Yeah, like maybe looking at one of the 2 months. 3 Q. Did you look at any emails? 4 A. I did, yes. 5 Q. Do you recall any specific emails you 6 reviewed? 7 A. Anything that I was supposed to give really 8 to the attorneys that related to Leapfrog. 9 Q. And I don't want to know any discussions you 10 had with your attorneys, but so your memory is that in 11 preparation for your deposition you reviewed emails 12 that had to do with Leapfrog? 13 A. Mine. 14 Q. Your emails? 15 A. Yeah. 16 Q. Any emails stand out in your mind that you 17 reviewed in preparation for this deposition? 18 A. What do you mean by "stand out" in my mind? 19 Q. Can you recall any specific email that you 20 reviewed? 21 A. Oh, that I -- I mean, yes. 22 Q. Which ones? 23 A. An email about getting statements out or 24 like to governing board members. 25 Q. And those would have been statements about	Page 52 1 Q. My first question is, do you understand 2 you're here today to testify not only individually but 3 also in your capacity as the corporate representative 4 of Good Samaritan Medical Center? 5 A. Yes. 6 Q. And while we made -- do you understand that 7 your attorneys and I have had multiple conversations 8 about limiting what your testimony would be here today 9 in your capacity as the corporate representative of 10 Good Samaritan? 11 A. Yes. 12 Q. Okay. And do you understand that this 13 document is a result of the negotiations that your 14 counsel and I have had with respect to the limitations 15 that would be on your testimony as the corporate 16 representative of Good Samaritan? 17 A. Okay. 18 Q. And I understand you've seen a document like 19 this previously, correct? 20 A. Correct. 21 Q. Okay. And you are prepared to testify on 22 the topics that you just read through here today? 23 A. Yes. 24 Q. And when we talked about your preparation, 25 how many times did you -- I don't want to know what you
Page 51 1 your Leapfrog grade was going to be an F or a D? 2 A. Well, more like there are emails to me about 3 the F. 4 Q. Any other emails that you can recall that 5 you reviewed in preparation for your deposition? 6 A. Other than some emails that I reviewed with 7 the attorneys. 8 Q. I'm going to mark this as Exhibit 1 now that 9 I have a copy. 10 (Defendant's Exhibit Number 1 for i.d.) 11 BY MS. BLAIR: 12 Q. Ms. Montgomery, I've handed you what we've 13 now marked as Montgomery Exhibit 1, which is titled -- 14 and it's long -- "Amended Notice of Taking in Person 15 Videotaped Deposition of Sheri Montgomery, Individually 16 and Pursuant to Rule 30(B)(6) to Good Samaritan Medical 17 Center, Inc." 18 Do you see this? 19 A. I do. 20 Q. And full disclosure, this was just updated, 21 I think, over the weekend with your attorneys. So can 22 you just take a look at this? And I'm going to ask if 23 you've seen this version before, which you may not 24 have. 25 A. Okay.	Page 53 1 said with your attorneys, but how many times have you 2 met with your attorneys to prepare for your deposition? 3 A. Probably five times maybe. 4 Q. And when was the first time? 5 A. Maybe a couple months ago maybe. I don't 6 know. 7 Q. Okay. You can set that aside. I just want 8 to make sure for the record we all understand you're 9 here both in your individual capacity and on behalf of 10 Good Samaritan. And I will try to make sure that my 11 questions are clear. Right now I'm just asking you 12 questions as Sheri Montgomery. 13 But from time to time I might -- may ask you 14 to clarify your question both in your individual 15 capacity and in your capacity as the corporate 16 representative for Good Samaritan? 17 Is that okay? 18 A. Yes. 19 Q. And if at any time you have a question about 20 whether or not I'm asking that in your capacity as an 21 individual or as a corporate representative of 22 Good Sam, please ask me for that clarification. 23 Otherwise, for purposes of this record, I will try to 24 make that clear. 25 Is that fine?

Page 54 1 A. Yes. 2 Q. We talked earlier about -- 3 MR. MARCUS: Kim -- 4 MS. BLAIR: Yeah. 5 MR. MARCUS: -- we've been going over an 6 hour. Is this a good time to take a break 7 before you get into your -- 8 MS. BLAIR: Oh, sure, yeah, go ahead. 9 MR. MARCUS: Can we go off the record? 10 THE VIDEOGRAPHER: We're going off the 11 record. The time is 10:16 a.m. 12 (A recess was taken from 10:16 a.m. to 10:25 a.m.) 13 THE VIDEOGRAPHER: We are back on the 14 record. The time is 10:26 a.m. 15 BY MS. BLAIR: 16 Q. Ms. Montgomery, before we went off the 17 record, we were talking about what I've now marked as 18 Exhibit A [sic]. 19 And for the record, I just want to be clear, 20 and counsel reminded me of this, that late last night I 21 had an agreement with Mr. Lee Crain from Gibson Dunn 22 that I would withdraw topic number 10, and so that will 23 be stricken from Exhibit Number 1. 24 I know there's no question, but I wanted to 25 put that on the record.	Page 56 1 A. Definitely at the local level, so they're 2 similar or, if not, the same because. We try to 3 operate as a network and have similar structures. 4 Whether the corporate office is part of 5 that, that's a possibility. 6 Q. Okay. It's a possibility, but you don't 7 know for sure? 8 A. I'm not a hundred percent. 9 Q. Do you know whether Good Samaritan's 10 hospital safety plan has been produced in this 11 litigation for 2003 [sic], 2004 [sic] and 2005 [sic]? 12 MR. MARCUS: Object to form. 13 A. I'm not 100 percent, to be honest. I 14 believe so. 15 MR. MARCUS: Did you mean 2023, 2024, 2025? 16 MS. BLAIR: Oh, see, I should be reading 17 this realtime. I'm too old for that. Yeah, let 18 me rephrase the question. I'll just go one by 19 one. 20 BY MS. BLAIR: 21 Q. Do you know whether the Good Samaritan 2023 22 hospital safety plan has been produced in this 23 litigation? 24 A. I'm not 100 percent. 25 Q. And same question with respect to the 2024
Page 55 1 A. Oh. 2 Q. No question. I just wanted you to know that 3 and counsel to know that. 4 Going back to Regina West, does she create 5 hospital safety plans for Good Samaritan? 6 A. I mean, she may be involved with that piece 7 of it. I'm not sure. 8 Q. Does Good Samaritan have a hospital safety 9 plan? 10 A. It does. 11 Q. And how often is that hospital safety plan 12 created? 13 A. Annually. 14 Q. And, to your knowledge, who creates that for 15 Good Samaritan? 16 A. I think it's really reviewed -- this is my 17 thoughts -- you know, at the corporate level and then 18 the local level and for all hospitals so that we all 19 have similar structures. 20 Q. Is there a hospital safety plan specific to 21 Good Samaritan? 22 A. Yes. 23 Q. And to the best of your understanding as you 24 sit here today, that safety plan is first reviewed at 25 the corporate level and then at the local level?	Page 57 1 Good Samaritan Hospital safety plan. 2 A. I'm not 100 percent. 3 Q. And same question with respect to 2025. 4 A. I'm not 100 percent. 5 MS. BLAIR: Thank you, Counselor. I 6 appreciate that. 7 BY MS. BLAIR: 8 Q. In your conversations as the CEO of 9 Good Samaritan, have you ever had any discussions with 10 Ricky Ramirez regarding nurse retention? 11 A. I'm sure we have. 12 Q. Can you tell me just generally about the 13 market for nursing in South Florida? 14 A. You mean as regards to what exactly? 15 Q. Yeah. Is it difficult to hire nurses in 16 South Florida? 17 A. I mean, I would say that in today's 18 environment it's better than it was, you know, but it's 19 still a challenge. There's a lot of nurses wanting to 20 do remote work, for example, and not be in a hospital, 21 so, you know, when individuals leave an organization 22 oftentimes, it's for that type of balance or work from 23 home. There's more of that these days, so... 24 Q. With respect to Derek Collins, he's the 25 chief strategy officer for Palm Beach Health Network?

Page 58 1 A. Yes. 2 Q. And is he affiliated with a specific 3 hospital? 4 A. No. 5 Q. As the chief strategy officer, do you know 6 what his duties are? 7 A. He's just really with market analysis, 8 business planning, you know, service line development 9 and things of that nature. 10 Q. Does he provide reports to the hospitals 11 that make up Palm Beach Health Network regarding the 12 competitive position of the hospitals in the South 13 Florida market? 14 A. He supplies market share data. 15 Q. And what is that market share data that he 16 supplies? 17 A. Essentially it's our primary service area 18 for all five hospitals, and then it will show by, like 19 service line, and it will show like all the hospitals 20 in that area that may have -- are in our PSA that what 21 their volumes are by service line, what the population 22 is, things of that nature. 23 Q. And when you say "PSA," what do you mean by 24 PSA? 25 A. Primacy service area.	Page 60 1 compare. 2 Q. Does this document that he or his people put 3 out, does it have a name? 4 A. I believe it's just, you know, we all just 5 know it as the market share data. 6 Q. Do you know whether or not that document has 7 been produced in this litigation? 8 A. I don't know. 9 Q. Did you review that document in preparation 10 for your deposition today? 11 A. I did not. 12 Q. Does he put out -- other than this document 13 that you know as the market share data, does he put out 14 any other documents analyzing your competitive position 15 in the geographic area? 16 A. Most of it is that market share data. I 17 mean, if you individually ask him for something, he'll 18 produce that data to you. If you ask for a specific, 19 you know, service line for your hospital, they can 20 produce that data for you. 21 But, for the most part what he sends out is 22 market share data which has all the hospitals on it. 23 Q. Do you know what system he uses to get the 24 data that shows the market share? 25 A. I think it's called Trilliant potentially.
Page 59 1 Q. And what is the primary service area for 2 Good Samaritan? 3 A. It's like 14 different zip codes. It's by 4 zip codes. 5 Q. Okay. And so he creates, if I am 6 understanding, he creates a document that will show by 7 service lines all the hospitals in the area and the 8 different volumes by service line? 9 A. (Nodding head). 10 Q. Okay. So -- 11 A. I mean, he doesn't do it personally. 12 Q. Understood. He's got people, right? 13 What -- 14 A. Or a system or whatever. 15 Q. What does that document look like? 16 A. Essentially it's a, I want to say like a bar 17 graph or whatever that shows, you know, various years, 18 and then it will show neurology, for example. And it 19 will show over those years, you know, what the volume 20 and market share is of that population in the PSA 21 basically. 22 Q. Does it compare your hospital to, let's say, 23 your competitors in terms of volume and market share? 24 A. I mean, all the hospitals are there if they 25 have volume in that service line, you know, so you can	Page 61 1 Q. Do you know what Good Sam's market share was 2 in 2024 -- well, strike that. 3 Do you know what Good Sam's market share was 4 in 2023 for its primary service lines? 5 A. In 2023? Not off the top of my head. I'd 6 have to look at a document. 7 Q. I'd show you one if I had it. 8 Do you know what Good Sam's market share was 9 for its primary service lines in 2024 for the South 10 Florida area? 11 A. I really don't because they're like -- the 12 document that's provided, I'd have to say just for 13 Good Samaritan, not for the Palm Beach Health Network, 14 so for the Palm Beach Health Network, that would be 15 lower than if I looked at just primary service area for 16 Good Sam, to be honest. I look at data that's more 17 specific to Good Sam, my own volume at Good Samaritan. 18 Q. Okay. And when you look at the volume at 19 Good Samaritan, what documents are you looking at? 20 A. They're produced documents that are out of 21 the financial system that we have called S2K or an 22 Excel document that's produced by like the CFO. 23 Q. So at any time did you do a comparison of 24 Good Sam's market share for 2024 versus 2025? 25 A. I'm sure it was probably produced for

Page 62 1 business planning or something. 2 Q. As you sit here today, do you know what the 3 difference was in market share for Good Samaritan's 4 primary service lines between the -- the difference 5 between 2024 and 2025? 6 A. In 2025. Actually, the '25, probably is not 7 available. 8 Q. Okay. Then do you know -- that's a good 9 point. 10 Do you know what the difference is -- did -- 11 do you know what the difference in the market share is 12 for Good Samaritan between 2024 and 2023 as you sit 13 here today? 14 A. So I believe it was down, and I know that 15 it's down in my financials 5 percent. 16 Q. Okay. So it's down from -- I want to make 17 sure I understand. So your memory is that when you 18 looked at 2023 compared to 2024, the market share is 19 down? 20 A. I -- no, '23 to '24? No, should not be down 21 because my financials are up. But, again, I don't have 22 the report. So it should be up. But '25 from what I 23 have on my financials, which we don't have, market 24 share data because I think it's six months in a lag, I 25 am down 5 percent.	Page 64 1 A. I believe. 2 Q. And same thing with OBS, you believe those 3 are down? 4 A. Yes, observations. 5 Q. Have you seen any documents showing you that 6 the -- all five hospitals which make up the Palm Beach 7 Health Network are down? 8 A. So we get monthly statements that have 9 financials for the network and then -- or the group and 10 then volume. I mean, I don't necessarily hone in on 11 all of the other hospitals. We're all in the same 12 report. But from conversations and closed calls I know 13 that admits and OBS are -- have been down and, you 14 know, a lot of the hospitals have been struggling. I 15 personally know mine, obviously, at Good Samaritan 16 because that's where I'm living my day to day. 17 Q. And so these market share data reports, 18 they're monthly? 19 A. The market share data, no. 20 Q. Okay. How often does the market share data 21 report come out? 22 A. Every six months. Don't hold me to that, 23 but it should be every six months. Now did I receive 24 it every six months? It might be seven months or eight 25 months, but because the data is available every six
Page 63 1 Q. And when you say "I am down 5 percent" -- 2 A. Good Samaritan is down 5 percent and 3 admissions and OBS year over year, year to date. 4 Q. 5 percent in admissions and OBS? 5 A. Observations cases, which is essentially a 6 patient and you're in the hospital that stays two to 7 three days. Under observation it's called. 8 Q. Okay. That makes sense. 9 And you said Good Samaritan is down 5 10 percent and admissions and OBS year over year to date? 11 A. Yes. 12 Q. What's the "year over year" mean? 13 A. So looking at last year, year to date 14 compared to this year, year to date. 15 Q. Got it. 16 A. Through August. 17 And in emergency room visits, 2 percent. 18 Q. 2 percent emergency room visits are down? 19 A. Yes. Yes. 20 Q. Do you have any understanding of Palm Beach 21 Health Network as a whole, whether admissions are down? 22 A. Admissions specifically? I'm not sure. 23 Q. What about emergency -- 24 A. I believe so. 25 Q. You believe so?	Page 65 1 months because I think it's claims data that it pulls 2 from, so it's not out there as soon as you want it to 3 be. 4 Q. And then the report you talked about that 5 you look at every month about admits and OBS -- 6 A. Yes. 7 Q. -- who creates that report? 8 A. Michelle Cartwright. 9 Q. And what -- do you know where the data comes 10 from that monthly report that Michelle Cartwright puts 11 out? 12 A. Yep, the financial system. 13 Q. That's the S2K? 14 A. Yes. 15 Q. Do you know whether or not those monthly 16 reports regarding revenue were produced in this 17 litigation? 18 A. I'm not sure. 19 Q. And am I right that you look at -- well, I 20 don't want to ask if I'm right. 21 Are you looking at revenue to determine that 22 admits and OBS, observations are down, or are you 23 looking at actual numbers of admits and observations? 24 A. Actual numbers. 25 Q. And when you were talking about the

Page 66 1 5 percent, is that revenue is down by 5 percent or the 2 numbers of admits and observations are down? 3 A. The volume. 4 Q. In the documents or monthly reports that 5 Michelle Cartwright puts out, does that show you, since 6 it comes from the financial system, is that showing you 7 financially whether the numbers are down or, again, 8 just the number of visits? 9 A. There's a tab for EBITDA and there is a tab 10 for volume. 11 Q. Okay. And is it your understanding for 12 Good Sam -- not your understanding. 13 Is Good Sam's EBITDA down for 2020 -- year 14 to date 2024 to 2025? 15 A. It is not. 16 Q. Is revenue down year to date for 17 Good Samaritan year to date 2024 to 2025? 18 A. It is not. 19 Q. What about does Ricky Ramirez provide you 20 with any monthly reports regarding nursing retention? 21 A. It doesn't really come from him, but we do 22 have group meetings where he'll go over various things 23 in the group meeting, and I believe retention is one of 24 them, but it would really be the CHRO. 25 Q. Do you do -- well, do you know if	Page 68 1 A. Right, if it's... 2 We have initiative now for retention 3 essentially, so I would say year to date we're doing 4 better because we're highly focused on that indicator 5 for sure. 6 Q. And Shannon Wills, she's the human -- she's 7 the group chief human resources officer for Palm Beach 8 Health Network, correct? 9 A. Correct. 10 Q. Do you know if she keeps any metrics on 11 nurse turnover -- much better word -- of the network as 12 a whole? 13 A. Definitely. 14 Q. Do you get those reports? 15 A. Yes. 16 Q. And what do those reports look like? 17 A. We'll cover like total turnover for total 18 employees, nursing turnover and then first-year 19 turnover, first-year RN turnover. 20 Q. First-year RN. 21 Do you know if turnover has increased from 22 2024 to 2025 year to date for the health network as a 23 whole? 24 A. I don't know 100 percent. 25 Q. But these reports that Shannon Wills puts
Page 67 1 Good Samaritan's human resource office does exit 2 interviews for nurses that are leaving? 3 A. They do. 4 Q. And do you retain that information on the 5 exit interviews? 6 A. Yes. 7 Q. Do you know if any reports are produced by 8 Good Samaritan that sort of breaks down the reasons why 9 nurses are leaving? 10 A. Yes. 11 Q. And who produces those reports? 12 A. The CHRO, Kevin. 13 Q. Kevin whose last name I cannot pronounce. 14 A. Me neither. I struggle. 15 Q. Have you ever had to as the CEO of 16 Good Samaritan raise the issue of nurse retention to 17 the corporate level? 18 A. No, I wouldn't ever. It's not really the 19 structure. 20 Q. Do you have any understanding as to whether 21 or not nurse retention has gone down from year to date 22 from 2024 to 2025? 23 A. You mean turnover? 24 Q. Yes, I guess that's what I mean, turnover. 25 I guess turnover would be up, right?	Page 69 1 out may be able to tell me, correct? 2 A. Definitely. 3 Q. Would you characterize Good Samaritan as 4 having issues relating to difficulty retaining nurses? 5 A. "Issues." I would say that turnover is a 6 focus for us. I think turnover is difficult in this 7 industry, period, for the reasons earlier that I was 8 discussing. People -- 9 And here's a perfect example. For the 10 operating room, we're 24/7. You have to take call. 11 You may get called in at 2:00 o'clock in the morning 12 for emergency service or emergency room, or I mean, an 13 operating room procedure. 14 We have nurses now that want to go work for 15 a surgery center that's Monday through Friday, they're 16 done at 5:00. So all of those, you know, stressors of 17 working in a hospital, it's very different than working 18 in a surgery center, and there are surgery centers 19 popping up everywhere, so that's a good example of how 20 people are wanting to move to things that are not 21 necessarily a hospital environment, so... 22 Q. Lisa Cook does marketing, correct? 23 A. Yes. 24 Q. And she does marketing for Good Samaritan 25 specifically?

Page 70 1 A. She works with my manager, so, I mean, she 2 might help with specific things. I mean, she does help 3 with specific things for Good Sam, but she normally 4 works with the manager. 5 Q. And who is the manager? 6 A. Nancy Morales. 7 Q. And what kind of marketing initiatives does 8 Good Sam have? 9 A. I would say it's mostly service line 10 specific, you know, our bariatric service line or, you 11 know, orthopedics, you know, the various, you know, 12 accolades that we receive, we make sure that we get 13 that out in the community so they understand the 14 quality. 15 Q. What about Erin Britt? She was recently 16 identified in Good Samaritan's amended Answers to 17 Interrogatories. And I know you talked about her 18 previously. She's an -- on the quality side? 19 A. Yes, she's the quality director. 20 Q. Okay. And she reports -- who does she 21 report to? 22 A. Colleen Thielk. 23 Q. And do you know why she was recently 24 identified in Good Samaritan's Amended Answers to 25 Interrogatories?	Page 72 1 And you see it says, "Identify every individual not 2 identified in your Rule 26(a) disclosures with 3 knowledge of your Complaint," et cetera. 4 Do you see that? 5 A. Oh, yeah. 6 Q. And then the original answer is on page 4, 7 and the amended answer starts at the bottom of page 4. 8 Do you see where it says "amended answer"? 9 A. Yes. 10 Q. And in the amended answer we'll see on 11 page 5, Erin Britt is identified as the quality 12 director. Do you see that? 13 A. Yes. 14 Q. And so she was not identified in the 15 original Answers to Interrogatories. I'm just curious 16 as to why she's coming up now, if you know. 17 A. I believe Gina was the quality director at 18 Good Sam at one time. Now, Erin is. 19 Q. And do you know when Gina was the director 20 at Good Sam, when she stopped being? 21 A. My thoughts are probably three years ago -- 22 Q. Okay. 23 A. -- four years, somewhere around there, three 24 years. 25 Q. So just so I understand like the structure
Page 71 1 A. I'm not really sure I understand the 2 question. So what do you mean by she was identified as 3 the amended? 4 Q. Sure. I can just mark that if I can find 5 it? 6 MS. BLAIR: Can you mark this as Exhibit 2? 7 (Defendant's Exhibit Number 2 for i.d.) 8 MR. MARCUS: Just on the Exhibits, the first 9 Exhibit you had marked as 1 and then I think you 10 referred to it as A. 11 MS. BLAIR: Oh, I did? 12 MR. MARCUS: We're going to go with numbers? 13 MS. BLAIR: Yes, numbers. Yes. I even have 14 my own chart here. I apologize if I did that. 15 MR. MARCUS: No worries. 16 BY MS. BLAIR: 17 Q. Ms. Montgomery, I've now put in front of you 18 what we've marked as Exhibit 2 to this deposition, 19 which are Good Samaritan's Amended Answers to 20 Interrogatories, do you have that in front of you? 21 A. I do. 22 Q. And if we look at page 4. Or I'm sorry. It 23 starts on 4 and goes to 5. And it actually starts on 3 24 so, I apologize. 25 The question on 3 is interrogatory number 2.	Page 73 1 here, Erin Britt reports to Colleen Thielk, right? 2 A. Right. 3 Q. And three years ago did Regina West have the 4 same job as Colleen Thielk does now? 5 A. No. 6 Q. Okay. Did Regina West ever have the same 7 job at Colleen Thielk? 8 A. No. 9 Q. So three years ago -- and, again, I'm not 10 holding you to the three years, but at some point 11 Regina West was the quality director at Good Samaritan? 12 A. Correct. 13 Q. And now she is just at the network level; is 14 that fair? 15 A. That's fair. 16 Q. And how long has Erin Britt been -- 17 A. I believe. 18 Q. How long has Erin Britt been in this 19 position of quality director at Good Samaritan? 20 A. I'm going to go with six months. 21 Q. Okay. 22 Do you know was Erin Britt employed by 23 Good Samaritan prior to six months ago? 24 A. Yes. 25 Q. And what was her position six months ago, if

Page 74 1 you know? 2 A. She was the director of surgical -- two 3 south, a nursing unit. 4 Q. Okay. 5 A. A surgical nursing unit. 6 Q. Is Erin Britt's background nursing? 7 A. Yes. 8 Q. She's an RN? 9 A. Yes. 10 Q. Okay. Is Colleen Thielk a former nurse as 11 well? 12 A. She is. 13 Q. And what about Regina West, is she also a 14 nurse? 15 A. Yes. Where, I'm not sure. I think I've 16 always known her in a quality capacity. 17 Q. And how long has Colleen Thielk been at 18 Good Samaritan? 19 A. About maybe going on two years, I think, 20 maybe. 21 Q. And did she come from another Palm Beach 22 Health Network hospital? 23 A. She did not. 24 Q. Is there any like prohibition about going 25 between hospitals with your job?	Page 76 1 A. Really myself and the board members get 2 together and try to make sure there's diversity amongst 3 the board and, you know, from attorneys to fire rescue 4 people to, you know, Palm Beach Atlantic president. So 5 as their terms come up, we think about people in the 6 community that could add a value to our board. And, 7 you know, it's a collaborative meeting, so they like to 8 give a lot of input. 9 Q. How many -- how many board members are 10 there? 11 A. I think there's twelve, something like that. 12 Q. Twelve? 13 A. I think so. 14 Q. Is there a chairman of the board? 15 A. Yes. 16 Q. Are there any other positions on the board? 17 A. Like there's a treasurer, but I'd say it's 18 mostly the chairman and a treasurer. 19 Q. Are there subcommittees on the board? 20 A. Not really. 21 Q. Is there a quality patient subcommittee of 22 the board? 23 A. Not a subcommittee. It's all reviewed in 24 our board meetings. 25 Q. How long are the terms of your board
Page 75 1 A. No. 2 Q. Okay. I just noticed several of you have 3 worked at different ones. I was just curious. 4 So I want to talk a little bit about how the 5 board works for each of these hospitals. Does 6 Good Samaritan have its own board of directors? 7 A. We do. 8 Q. Is there a board of directors for the 9 Palm Beach Health Network? 10 A. There is not. 11 Q. And each -- to your knowledge, do each of 12 the five hospitals -- I'm struggling over here. 13 Sorry. 14 To your knowledge, do each of the five 15 hospitals have their own board of directors? 16 A. They do. 17 Q. And is the board of director position at 18 Good Samaritan a paid position? 19 A. They receive a stipend for the meetings. 20 Q. Do you know what the stipend is? 21 A. I think like \$200 or something minimal. 22 Q. So not significant? 23 A. Um-hum. 24 Q. How are board members selected for 25 Good Samaritan's board of directors?	Page 77 1 members? 2 A. Two years. 3 Q. Are they staggered terms? Do you know what 4 I mean when I say that? 5 A. Yeah, I know what you mean, but I'm thinking 6 they're not. I'm not sure. I'll have to get back to 7 you on that. 8 Q. That's fine. You don't have to get back to 9 me. If you don't know, you don't know. Sounds like a 10 true CEO. 11 A. Yeah. 12 Q. Do you know, are there term limits for 13 sitting on your board? 14 A. You can go off the board for a year. Like 15 the chamber, I'm on the board of Chamber. I go off for 16 a year, but I can come back if, you know, they want me 17 to come back. 18 Q. So after two years your board members cycle 19 off the board? 20 A. Right. 21 Q. Who was on the board in 2024? Well, strike 22 that. 23 Who was the chairman of the board in 2024? 24 A. Patrick Franklin. 25 Q. And what is Patrick Franklin's background?

Page 78 1 A. He's the CEO of the Urban League. 2 Q. And who were there twelve members of board 3 in 2024? 4 A. I don't know. I'd have to go and look. 5 Q. Are the members that were on the board -- 6 well, let me ask this. 7 Is the board annually like from January 1 to 8 December 31? 9 A. Yes. 10 Q. In 2024, were there certain members of the 11 board that were more active than others? 12 A. No, I'd say they're all very active and they 13 attend the meetings. It's very rare for them to miss 14 meetings. 15 Q. How often do they meet? 16 A. Once a month. 17 Q. Do you report to the board? 18 A. I would say there's a more of a 19 collaborative thing but I guess in some ways. 20 Q. What type of reports do you give to your 21 board regarding patient safety? 22 A. There's the risk plan. Risk does a whole, I 23 think probably every quarter I think they report; so 24 does quality, go over our report card, how we're doing. 25 Compliance is every quarter he presents to the board.	Page 80 1 have to approve all the MEC medical staff 2 credentialings. They see the financials. 3 We bring employees that, you know, that we 4 like to recognize, you know, whether it's a Tenet hero 5 or a good catch employee, we'll bring employees 6 sometimes to the governing board as well to allow them 7 the opportunity to thank the employees. 8 Q. The board has no control over the 9 compensation of any of the directors of Good Samaritan, 10 do they? 11 A. They do. 12 Q. Are you involved in the search for board 13 members when it occurs? 14 A. Yeah, I would say there's -- we have a 15 committee that gets together with some of the board 16 members, and we talk about, you know, people in the 17 community who we think would maybe add value, and then 18 we, you know, interview and meet with them. 19 Q. Have you ever had any trouble recruiting 20 board members for the Good Samaritan board? 21 A. Well, recently one of the board members 22 that, you know, she's part of helping recruit, you 23 know, as we have new board members, you know, had 24 concerns about recruiting new board members because of 25 our safety rating and F.
Page 79 1 Q. When you say -- 2 A. Which would include -- 3 Q. Oh, I'm sorry. 4 A. -- down to like HIPAA compliance things, 5 ethics calls, you know, any outliers in contract 6 compliance, as you can imagine, all the compliance 7 stuff. 8 Q. When you say "report card," what are you 9 referring to? 10 A. The balanced scorecard. 11 Q. And the balanced scorecard is what we talked 12 about earlier when you were talking about the score 13 card? 14 A. Correct. 15 Q. So the board sees that every month, the 16 balanced scorecard? 17 A. I think every quarter. 18 Q. And when you said "risk plan," what are you 19 referring to? 20 A. All the risk indicators. Like, you know, 21 every quarter they'll report. The Joint Commission has 22 a requirement, too, whether it's, you know, falls, 23 grievances, how many grievances you've had, things of 24 that nature, any behavioral issues that you may have 25 with physicians. They get all the medical staff. They	Page 81 1 Q. And I'll show you that document because I 2 think I have it. 3 Is that one of the documents you reviewed in 4 preparation for your deposition today? 5 A. It is. 6 Q. I'll mark this as 3. 7 (Defendant's Exhibit Number 3 for i.d.) 8 BY MS. BLAIR: 9 Q. Ms. Montgomery, I am handing you what we've 10 now marked as Exhibit 3. And this is an email. 11 Obviously the oldest email is on the bottom from 12 Judy Goodman to you dated December 10th, 2024 at 13 9:46 a.m. Do you see that in front of you? 14 A. Yep. 15 Q. And in or around December 10th, 2024, your 16 email address was sheri.montgomery@tenethealth.com, 17 correct? 18 A. Yes. 19 Q. And I'm not going to ask you that for every 20 email I say to you today. Is it okay for purposes of 21 this deposition that if that email address 22 sheri.montgomery@tenethealth.com is on an email, is it 23 safe to say that was your email in or around that time? 24 A. Yes. 25 Q. Okay. And that first email, first tell me

Page 82 1 who is Judy Goodman? 2 A. She's a member of the board. 3 Q. And what is her background? 4 A. She's a retired attorney. 5 Q. Do you know what firm she worked at? 6 A. I don't. 7 Q. And if you look at her email, it looks like 8 she's talking about Kara Coniglio McClure, Gail's 9 granddaughter. Do you see that? 10 A. Yes. 11 Q. Who is Gail? 12 A. I'm not -- I'm not sure who Gail is. 13 Q. Okay. She also mentions the name 14 Ted Cooney. Do you see that? 15 A. Yes. 16 Q. And then another name is Christina Matthews 17 McFarland. Do you see that? 18 A. Yes. 19 Q. And those three names in looking at this 20 email, does that refresh your recollection that she was 21 providing names of potential future board members for 22 Good Samaritan? 23 A. Yes. 24 Q. And then she says, this line here, she says, 25 "However, it's hard to recruit right now when this	Page 84 1 A. No. 2 Q. Okay. So what is the -- when were the new 3 board members, if any, going to start on the 4 Good Samaritan board? 5 A. It would be next -- it would be in January. 6 Q. Of '26? 7 A. Yes. 8 Q. Okay. So is this email from Judy Goodman 9 sort of like an early email discussing who might fill 10 open positions in January of 2026? 11 A. Right, because we all talk about it, and 12 throughout the year they think about who would be good 13 and then let's try to see if we can meet with them, 14 who's going to come off the board, that kind of stuff, 15 so... 16 Q. Got it. 17 A. Yeah. 18 Q. So the board as constituted in December of 19 2024 is the same board for Good Samaritan as we sit 20 here today, same board members? 21 A. Correct. 22 Q. Okay. Have you spoken to Kara McClure, 23 Ted Cooney or Christina McFarland about potentially 24 serving on the board? 25 A. I have not.
Page 83 1 story appeared this morning." 2 Do you see that? 3 A. I do. 4 Q. And she's referring to a story in the 5 Stet's -- that's all caps, S-t-e-t -- Stet blog, 6 correct? 7 A. Correct. 8 Q. Are any of these three people that are 9 mentioned in this email, Kara McClure, Ted Cooney or 10 Christina McFarland, are they currently on the 11 Good Samaritan board? 12 A. They are not. 13 Q. Did the -- did new members of the 14 Good Samaritan board come on to the board in January of 15 2025? 16 A. No. It was all last year, the year before. 17 Q. 2023? 18 A. No. You said 2025, right? 19 Q. No, 2024. 20 A. Oh, I thought you said January 2025. 21 Q. Oh, I think I did say 2025, or at least 22 Barbie wrote it down that way so I apologize. Yes. So 23 I guess let's go back. 24 Were you recruiting in December of 2024 for 25 a new board to start in January of 2025?	Page 85 1 Q. Do you know if Judy Goodman has? 2 A. I'm not sure if she has, honestly. 3 Q. Other than this email, which we've now 4 marked as Exhibit 3, are you aware of any other emails 5 from a board member about difficulties in recruiting 6 for the Good Samaritan board? 7 A. I am not. 8 Q. Do you anticipate difficulties in recruiting 9 for the Good Samaritan board for January of 2026? 10 A. Potentially, but my true thoughts are I have 11 a really solid board, and they could probably explain 12 to the new candidates that the F is not -- it's a false 13 grade and explain what we have explained to them about 14 the survey. And there could be potential that it 15 wouldn't be a problem. 16 Q. And new board members could look at this 17 lawsuit as well, right, and make their own conclusions? 18 A. They could. 19 Q. I've seen emails in this -- and I'm going to 20 show you some later today, but I've seen emails in this 21 litigation that refer to H/O. Is that referring to 22 Tenet home office? 23 A. Probably. I'd have to see the email. 24 Q. Okay. 25 A. I mean, it could be another acronym, but not

Page 86 1 one I can think of right now. 2 Q. Okay. I've also seen references to the 3 acronym ELT. Do you know what that refers to? 4 A. My guess would be executive leadership team. 5 I would have to see the email. That's what I know that 6 acronym could be, but it could -- if it was a quality 7 email, it could be something related to quality or 8 clinical. 9 Q. And I'll show you those emails as well. And 10 that was my understanding. 11 So is executive leadership team a phrase 12 that is used at Tenet Healthcare? 13 A. I think so. I think it's -- yeah. 14 Q. And in your mind as the CEO of 15 Good Samaritan, who would comprise the executive 16 leadership team of Tenet Healthcare? 17 A. Of Tenet Healthcare? 18 Q. Of Tenet Health. 19 MR. MARCUS: Object to form. 20 A. Lisa -- you know, the officers, I guess, you 21 know, Lisa Foo, Saum, Judy Chabot and Ernest Franklin. 22 BY MS. BLAIR: 23 Q. Who is Judy Chabot? 24 A. She's the chief nurse officer. 25 Q. And who is Ernest Franklin?	Page 88 1 Leapfrog or anything like that? 2 A. Not really. 3 Q. Do you know whether or not there is a 4 quality department at Tenet Healthcare corporate? 5 A. I mean, I'm sure -- there's a lot of people 6 on our quality call, so I'm assuming there is like 7 infection control people, quality people that our group 8 people report up to, but the way our structure is, is 9 we're really on the group level, so I have issues, it's 10 Maggie. Maggie is the person that has a connection to 11 corporate. 12 Q. Got it. 13 A. I'm not saying the corporate people aren't 14 involved on a quality call like the CMO, but our group 15 leads kind of interact, if that makes sense. 16 Q. That makes sense. 17 A. So they would know the structure a little 18 more than I probably would at the corporate level. 19 Q. And is Tenet divided into regional 20 divisions, if you know? 21 A. Yes. 22 Q. And what division does the Palm Beach Health 23 Network fall into? 24 A. I guess in the eastern division. 25 Q. And judging by --
Page 87 1 A. Chief medical officer. 2 Q. Anyone else -- and Saum is the CEO we 3 discussed earlier, right? 4 A. Right. 5 Q. And Lisa Foo is the CFO? 6 A. No, COO. 7 Q. COO. Is there a CFO of Tenet Healthcare? 8 A. Yeah, Sun. Something Sun. 9 Q. Do you know if there's a chief quality 10 officer of Tenet Healthcare at large? 11 A. I don't know if there would be a chief but 12 maybe like a vice president of quality or something, 13 but they would report to Ernest probably. 14 Q. Do you know who the director, if that's the 15 right phrase, would -- of quality at Tenet Healthcare 16 would be that reports to Dr. Franklin? 17 A. No. I know there's someone that Gina speaks 18 to and reaches out to, so I don't -- I don't know. 19 Q. Do you know if there's anybody at 20 Tenet Healthcare that oversees hospital ratings issues? 21 MR. MARCUS: Object to form. 22 A. I don't know. 23 BY MS. BLAIR: 24 Q. Is there anybody at Good Samaritan that 25 oversees hospital ratings like Healthgrades™ or	Page 89 1 A. I don't get division reports anymore, so I'm 2 not a group person, so I don't really get all that 3 information anymore. 4 Q. Well, that answers my next question, so 5 thank you. 6 Are there any documents that are put out by 7 Tenet home office about -- well, strike that. 8 Does Tenet Healthcare on the corporate level 9 have a mission statement for its hospitals? 10 MR. MARCUS: Object to form. 11 A. Yes. 12 BY MS. BLAIR: 13 Q. And is that mission statement reproduced to 14 the hospitals like either in email form or written form 15 to the various hospitals that are Tenet hospitals? 16 A. I mean, I don't really know if it's verbatim 17 over the years. I mean, I'm not really sure. I can't 18 answer that question. 19 Q. If you had to summarize the Tenet mission 20 statement, what would you say it is? 21 A. To provide quality care treating every 22 patient the same essentially but to provide quality 23 care. 24 Q. And as the CEO of Good Samaritan hospital, 25 what would you say is the most important principle for

Page 90 1 Good Samaritan? 2 A. To provide quality care to all patients in 3 our community. 4 Q. So consistent with the Tenet Healthcare 5 mission, correct? 6 A. Yes. 7 Q. In your mind as the CEO of Good Samaritan 8 hospital, do you make a distinction between quality and 9 patient safety? 10 A. To me, patient safety encompasses the 11 quality, risk management, infection control. It is all 12 the same because at the end of the day zero harm is our 13 goal. They're all intertwined and related to one 14 another. 15 THE VIDEOGRAPHER: Can we go off the record 16 for a media change? 17 MS. BLAIR: Sure. 18 THE VIDEOGRAPHER: This ends media one. 19 We're going off the record. The time is 11:17. 20 (A recess was taken from 11:17 a.m. to 11:17 a.m.) 21 THE VIDEOGRAPHER: We're back on record. 22 The time is 10:17 a.m. -- 11:17 a.m. 23 BY MS. BLAIR: 24 Q. Ms. Montgomery, right before the break for 25 the video change you said that "Zero harm is our goal,"	Page 92 1 Q. Right. But this is how you -- 2 A. It's a personal thing, yes. 3 Q. But you as the CEO of Good Samaritan 4 interpret it that way? 5 A. Correct. 6 Q. And so do you see patient safety more 7 encompass -- more encompassing than quality? 8 MR. MARCUS: Object to form. 9 A. They're all intertwined, so... 10 BY MS. BLAIR: 11 Q. Yeah, and I don't disagree. I'm just trying 12 to understand. 13 So I thought patient safety includes -- so 14 I'm just in my mind. 15 A. Yeah. 16 Q. Patient safety includes quality, risk 17 management and infection control, correct? 18 A. Yeah. I could be missing a piece or two, 19 but, yes. 20 Q. Of course. 21 A. Yes. 22 Q. But patient safety is the umbrella under 23 which you would put quality, risk management and 24 infection control? 25 A. I would.
Page 91 1 correct? 2 A. Correct. 3 Q. Is that the goal of the Palm Beach Health 4 Network as well, or is that just Good Samaritan's goal? 5 A. I'm sure, but it should be every hospital's 6 goal, so... 7 Q. And when you say "zero harm," does that 8 include reducing preventable errors? 9 A. Everything. 10 Q. So that's "yes" -- 11 A. Yes. 12 Q. -- it would include that as well? 13 A. (Nodding head). 14 Q. And so would you agree with me that patient 15 safety is the most important principle for a hospital? 16 A. Yeah, the quality, yes. 17 Q. Well, you said "the quality," and I want to 18 make sure. I thought I wrote down you said, patient 19 safety equals quality plus risk management plus 20 infection reduction, correct? 21 A. Yes, they're all quality. So we would put 22 it under an umbrella of safety if... 23 Q. That's fair. 24 A. Some others may not interpret that the same 25 way.	Page 93 1 Q. And would you agree with me that patient 2 experience is an important factor for a hospital to 3 consider? 4 A. It is. 5 Q. And would you agree with me that it's 6 important for a hospital to prevent hospital-acquired 7 infections? 8 A. I would agree with that. 9 Q. And would you agree with me that it's 10 important that patients have positive outcomes when 11 they leave a hospital? 12 A. Yes, I agree. 13 Q. And would you agree with me that it's 14 important that hospitals have processes in place to 15 make sure that patients suffer zero harm at a hospital? 16 A. Yes. 17 Q. And would you agree with me that it's 18 important that patients be free from medication errors 19 at a hospital? 20 A. Yes. 21 Q. And do you consider that to be part of 22 patient safety, freedom from medication errors? 23 A. I would. 24 Q. And is it important to a hospital that its 25 patients feel as if they were receiving high quality

Page 94 1 care from the hospital staff while they were admitted 2 to the hospital? 3 A. Say that again. 4 Q. Yeah. Would you agree with me that it's 5 important to a hospital that the patients receive high 6 quality care from the hospital staff while they're 7 admitted at a hospital? 8 A. Yes. 9 Q. And that's part of the patient experience 10 that we talked about earlier, correct? 11 A. Patient experience, obviously, is important, 12 right. 13 What -- another piece of what's important is 14 trying to get the patients to complete a survey so you 15 have a true understanding of what all the patients 16 experience is or at least a good amount of patients. 17 And that's where, I think, a lot of hospitals struggle 18 is getting patients to complete surveys so we truly 19 understand what they think. 20 Q. Does the hospital, Good Samaritan, go and 21 look at Facebook comments, TikTok comments, Instagram 22 comments, social media comments, Yelp reviews, Google 23 reviews outside of the CMS patient safety surveys to 24 determine what the patient experience really is at 25 Good Samaritan?	Page 96 1 report to at Good Samaritan? 2 A. They don't report to anyone at 3 Good Samaritan. 4 Q. At what level is this team operating? 5 A. I don't know. 6 Q. Is it at the Palm Beach Health Network 7 level? 8 A. I don't know if it's a Tenet Healthcare that 9 they hired someone or, you know, it's -- it probably 10 is, I would say. So I'm not sure who they report to. 11 I just know we're notified so we can follow up, one, if 12 it's a patient grievance, you know, so it goes to risk 13 management or just so we're aware. 14 Q. Do you get reports from this team about 15 social media posts regarding patient experience at 16 Good Samaritan? 17 A. Not -- no, they're just emails of, you know, 18 a review or a post. 19 Q. So someone would email someone at 20 Good Samaritan and say, Here's what's being posted 21 about Good Samaritan right now? 22 A. Yeah. And it could just be something 23 positive that we want to, you know, tell the staff that 24 we received this positive review or something of that 25 nature or if it's something we want to follow up on.
Page 95 1 A. Yes, currently we're rolling out and have, 2 we hired a patient experience liaison for a couple 3 things: One, to push Google reviews as well because if 4 you can get a patient to give feedback on the spot, 5 they normally are more willing to do that, so you can 6 capture a lot more than the mailed surveys that do go 7 to the patient. 8 And our percentage has been low so we're 9 trying to move it to where more patients will fill out 10 the HCAHPS survey to improve our overall results. 11 But our Google reviews, I think, is at a 4.0 12 right now. But I get emails on all of them, so I 13 review them. 14 Q. So when did you hire the patient experience 15 liaison? 16 A. Probably six months ago or so. 17 Q. Prior to hiring the patient experience 18 liaison who at Good Samaritan was reviewing social 19 media posts related to patient's experiences at 20 Good Samaritan? 21 A. I think it goes to the CNO. There's a team 22 that monitors patient experience stuff or social media 23 posts, so it goes to a group of people. 24 Q. Do you know that team that monitors social 25 media posts about patient experience, who do they	Page 97 1 Q. Do you know if those documents have been 2 produced in this litigation? 3 A. I have no idea. 4 Q. Are those documents shared with the board as 5 they relate to Good Samaritan, are they shared with the 6 board? 7 A. No. Patient experience is shared with the 8 board but not like emails of, you know, say, we get a 9 Google review, we have five-star Google reviews 10 employees get, like I mentioned before, we take those 11 employees to the governing board. We've had employees 12 that got five-star reviews to the governing board so 13 they're aware and they have opportunity to thank the 14 staff. 15 Q. And you used a phrase "governing board." Is 16 that what you refer to -- 17 A. The board. 18 Q. The Good Samaritan board? 19 A. Yeah, they're called the governing board. 20 Q. And if I've seen emails where it just says 21 "GB," is that referring to governing board, emails from 22 you? 23 A. Probably. I don't know what else I would 24 use GB for. I'd have to see the email, but... 25 Q. Sure. I'm just trying to interpret some of

Page 98 1 things I saw. 2 A. Yeah, I would say GB is governing board. 3 Q. And if I see a reference in emails to 4 governing board, that would -- that you've written -- 5 A. Yeah, normally I type governing board out, 6 so that's why it's throwing me a little. 7 Q. And governing board is the Good Samaritan 8 board of directors, the one that we discussed that 9 Judy Goodman is on, correct? 10 A. Correct. 11 Q. Okay. Does Good Samaritan believe in being 12 transparent with its patients about its safety record? 13 A. Yes. 14 Q. And as the CEO of Good Samaritan, do you 15 believe that's important to be transparent with 16 patients about Good Samaritan's safety record? 17 A. I do. 18 Q. Do you agree with me that it's important 19 that the governing board have transparent data about 20 Good Samaritan's patient safety? 21 A. I do. 22 Q. What is the Med Exec? 23 A. They really govern the medicine of the 24 hospital. It's physicians that are leaders in the 25 organization, chief of surgery, chief of orthopedics,	Page 100 1 is also chief of cardiology at the hospital. 2 Q. And when you say "at the hospital," you mean 3 Good Samaritan? 4 A. Good Samaritan. 5 Q. What specific reports related to patient 6 safety are provided to the Med Exec on a regular basis? 7 A. Everything to do with falls to grievances 8 to, I mean, there's a quality report, which is the 9 score card which goes over mortality, infections, 10 lending of stay in the emergency room. Risk management 11 reports out to the MEC. I mean, they review a lot, and 12 they're on par to -- you know, they're on committees. 13 Some of them attend QIPSC, for example. They're pretty 14 involved on a lot of things. Surgery committees. 15 Chair of surgery goes to the surgery committees. 16 There's committees after committees. 17 Q. Do they interact with the governing board? 18 A. They do. So Dr. Meyer is -- attends 19 governing board. All the chairs of the MECs are 20 nonvoting members of the governing board. The 21 vice chair attends as well the governing board. 22 Q. The vice chair of the Med Exec? 23 A. (Nodding head). 24 Q. And who is the vice chair? 25 A. Dr. George Gurdock.
Page 99 1 you know, chief of medicine, chief of anesthesia. 2 They're all like basically chairs of certain service 3 lines or committees like things, you know. 4 And they review peer review things. They 5 review all the credentialing information so that the 6 chair of credentialing reports out an MEC. They really 7 govern the medicine and bylaws of, you know, the 8 medical staff essentially. 9 Q. Are they interested in patient safety data? 10 A. They are. 11 Q. And are they provided patient safety data? 12 A. They are. 13 Q. And the Med Exec, is there one for each 14 hospital, or does it sit over the whole Palm Beach 15 Health Network? 16 A. Each hospital has their own. 17 Q. And is there one for the Palm Beach Health 18 Network? 19 A. No. 20 Q. How often does the Med Exec meet? 21 A. Monthly. 22 Q. And who chairs the Med Exec? 23 A. Keith Meyer. 24 Q. And who is Keith Meyer? 25 A. He is a cardiologist at the hospital, but he	Page 101 1 Q. Can you spell his last name? 2 A. G-u-r-d-o-c-k. 3 Q. What sort of things does the board vote on? 4 A. I mean, they basically reports -- all 5 reports come through them, whether it's the safety 6 plan, emergency management plan, you know, the quality 7 plan. 8 Q. Do they vote on filing lawsuits on behalf of 9 Good Samaritan? 10 A. They do not. 11 Q. Who makes the decision on whether or not 12 Good Samaritan should file a lawsuit? 13 MR. MARCUS: Object to form. 14 A. Maybe someone at the corporate office. I'm 15 not sure. 16 BY MS. BLAIR: 17 Q. I want to talk a little bit about your -- 18 what Good Samaritan views as its competitors in the 19 South Florida region. And I will refer you to that 20 Exhibit 2 and specifically interrogatory 19, which is 21 on page 27. 22 And you'll see that question says, "Identify 23 all hospitals, medical centers or health systems that 24 you consider to be your direct competitors within the 25 relevant geographic market during the time period

Page 102 1 covered by the Complaint." 2 Do you see that? 3 A. Okay. Yes. 4 Q. And the answer, after all of the objection, 5 appears on page 28. And we have to read both the 6 answer and the supplemental answer. 7 And if you see the answer there, it says, 8 "HCA Florida JFK Hospital," correct? 9 A. Yes. 10 Q. And where is HCA Florida JFK Hospital 11 located? 12 A. Physically? Like Congress Avenue. I 13 mean -- 14 Q. Oh, no, like what town. 15 A. Oh. I think they're considered Lake Worth, 16 I think. 17 Q. Lake Worth. How far is Lake Worth from 18 Good Samaritan? 19 A. Not far. HCA is probably, I don't know, 20 five miles. I'm guessing. 21 Q. Oh, five miles? 22 A. I'm just guessing. 23 Q. And the next one here is HCA Florida Palms 24 West Hospital. Do you see that? 25 A. Yes.	Page 104 1 Q. And then if you look at the supplemental 2 answer, you talk about Cleveland Clinic, correct? 3 A. Yes. 4 Q. Now, in looking through, do you know if 5 that's Cleveland Clinic Martin South Hospital or 6 Cleveland Clinic Martin North Hospital that you're 7 referring to here? 8 A. So Cleveland Clinic -- well, one, they're 9 building a hospital in West Palm, but, two, they have 10 outpatient imaging centers in West Palm. They have 11 physicians' offices in West Palm, so does NYU Langone. 12 Q. In your supplemental answer you're referring 13 to the West Palm Cleveland Clinic facilities? 14 A. Correct. 15 Q. Okay. And then the same with NYU Langone, 16 you're referring to whatever facilities Langone 17 currently has here? 18 A. Yes, right. But Cleveland Clinic can, you 19 know, now that they are local, see patients and send 20 patients to Cleveland Clinic Weston, so that's how they 21 capture our market, I would say. 22 Q. Okay. Cleveland Clinic Weston? 23 A. Yeah. 24 Q. Where is that located in? 25 A. In Weston.
Page 103 1 Q. Where is that located, town-wise? 2 A. It might be considered Palms West. I'm not 3 really sure. 4 Q. Oh, is that a town? 5 A. It's probably Loxahatchee, but there might 6 be a little section that's considered Palms West. 7 Q. And forgive me. I'm not from here so I 8 don't know. 9 A. That's okay. 10 Q. How far is Loxahatchee from Good Samaritan? 11 A. Ten miles maybe? I mean, I'm just really 12 guessing. 13 Q. Yeah, I understand. I'm just trying to 14 guess a sense of the region here. 15 What about Jupiter Medical Center, where is 16 that located? 17 A. In Jupiter. 18 Q. How far is Jupiter from Palm Beach? 19 A. I'd say Jupiter is 11 miles. 20 Q. And then the next one here is Wellington 21 Regional Medical Center. What town is that located in? 22 A. In Wellington. 23 Q. And how far is Wellington? 24 A. Maybe eight miles, maybe ten. I'd say 25 they're all around ten.	Page 105 1 Q. How far away is that? 2 A. An hour probably. Or probably, maybe an 3 hour and a half, but so they have a hospital there that 4 they send patients, you know, and they're wanting to 5 build a hospital, obviously, in West Palm. 6 Q. Okay. I just want to run through a few 7 hospitals to make sure. And we talked about this 8 earlier. You don't consider any of the other four 9 hospitals in the Palm Beach Health Network to be 10 competitors of Good Samaritan? 11 A. I don't. 12 Q. So if a patient chooses to go to Delray over 13 Good Samaritan, you don't consider that to be competing 14 with Good Samaritan, correct? 15 A. Not really. I mean, I don't think that a 16 patient would do that. I mean, they probably, they're 17 really out of my PSA, Delray, so I wouldn't really look 18 at them as a competitor. 19 Q. Are any of the other four hospitals that are 20 plaintiffs in this litigation within your PSA? 21 A. Yes. 22 Q. Which ones? 23 A. St. Mary's. 24 Q. So same question, then, if a patient chooses 25 to go to St. Mary's over Good Samaritan, do you

Page 106 1 consider that to be competition with Good Samaritan? 2 A. No. And they have like very different 3 service lines than we do, so they don't have an 4 oncology hospital. They're trauma. I'm not trauma. 5 They have, you know, a level III NICU and RIPIT clinic. 6 I don't. So they're very different service lines than 7 what we have. 8 Q. Does Jupiter medical have different service 9 lines than what you have? 10 A. Yeah, like -- well, they only have 11 open-heart that we don't have, but essentially we have 12 the same service lines. 13 Q. And same question with HCA Florida JFK 14 Hospital, do they have different service lines than you 15 have? 16 A. Did you say JFK North? 17 Q. JFK -- oh, HCA Florida JFK Hospital. 18 A. Okay. 19 Q. Am I not saying that right? 20 A. No. That's okay. I thought you said 21 "north." 22 So JFK has open-heart. We do not. So there 23 are some differences, right, but... 24 Q. Okay. What about Wellington Regional 25 Medical Center, do they have the same service lines as	Page 108 1 within your PSA? 2 A. I've never heard of them, so I'm thinking 3 no. 4 Q. Okay. What about Florida Medical Center? 5 A. They are not in my PSA. 6 Q. What about Universal Health Services, the 7 Alan B. Miller Medical Center, do you consider that to 8 be a competitor? 9 A. So it hasn't opened yet. 10 Q. Will you consider that to be a competitor 11 when it opens? 12 A. Yes, probably because I think it's only -- 13 it's probably in my PSA. I'd have to really look at 14 their zip code but a slight competitor. 15 Q. Okay. What about Florida Coast Medical 16 Center in Port St. Lucie? 17 A. It's not a competitor. 18 Q. Okay. Would you agree with me that the 19 population of Palm Beach has at least a significant 20 portion of which are what we call snowbirds? 21 A. Well, some of the snowbirds we've been 22 seeing are staying actually and not going away as much, 23 but there are definitely a good amount of snowbirds in 24 Palm Beach County. 25 Q. Has Good Samaritan performed any studies
Page 107 1 you do? 2 A. Pretty much. 3 Q. Do you consider Kindred Hospital to be a 4 competitor? 5 A. No, that's a long-term acute care hospital. 6 Q. Okay. What about Baptist Health Bethesda, 7 do you consider them to be a competitor? 8 A. Baptist Health Bethesda, they're really 9 removed from my PSA for the most part. They could be a 10 competitor to Delray Medical Center. 11 Q. How are they removed from your PSA for the 12 most part? 13 A. Because, you know, their zip code is not in 14 my PSA. 15 Q. Got it. What about Baptist Health 16 Boca Raton, is that in your PSA? 17 A. It is not. 18 Q. What about Broward? 19 A. No. 20 Q. This is probably my lack of geography, and I 21 apologize. 22 Holy Cross Hospital, is that within your 23 PSA? 24 A. It is not. 25 Q. What about HCA Florida Woodmont, is that	Page 109 1 about the transient nature of the Palm Beach population 2 when it comes to healthcare services -- 3 MR. MARCUS: Object to form. 4 BY MS. BLAIR: 5 Q. -- in light of -- 6 MS. BLAIR: Sorry. 7 BY MS. BLAIR: 8 Q. -- in light of what I'm calling the snowbird 9 nature of the population? 10 MR. MARCUS: Same objection. 11 A. So Good Sam is a little different, I would 12 say. The transient nature would be Palm Beach Island, 13 not necessarily West Palm. 14 So in the summer are we a little slower than 15 we are in the winter? Yes, you know. But it would 16 maybe be more impactful, that analysis, to like a 17 Delray Medical Center. 18 But we do have the impact of snowbirds. I 19 think we all do. You can get into a restaurant now. 20 When we're in season, it's a challenge. 21 BY MS. BLAIR: 22 Q. And what about have you done any -- would 23 you agree that the wealth of many of the residents in 24 Palm Beach County, at least, allows them to travel for 25 elective health services?

Page 110 1 MR. MARCUS: Object to form. 2 A. I would say a small amount of people have 3 that wealth. 4 BY MS. BLAIR: 5 Q. Have you performed any studies to see 6 whether or not people in your area, geographic area 7 choose to go, let's just say, back to New York if 8 they're from New York, for elective procedures as 9 opposed to stay in the Palm Beach area for them? 10 A. I have not done any study. 11 Q. Do you know if Tenet Healthcare has? 12 A. I don't know. 13 Q. Do you know if Palm Beach Health Network 14 has? 15 A. I don't know. 16 Q. What were the discussions at Palm Beach 17 Health Network in or around the summer of 2024 18 regarding all of these new entrants into the healthcare 19 arena in Palm Beach County? 20 A. The end of the summer of '20 -- 21 Q. Just generally the summer of 2024. 22 A. What was the discussion of the Palm Beach 23 Health Network about? 24 Q. Yeah. Might be a terrible question. 25 So I assume there were some -- well, you're	Page 112 1 Q. Mount Sinai as well, correct. 2 From 2022 to 2024, did the hospitals in the 3 Palm Beach Health Network perform any studies to 4 determine whether or not these new healthcare 5 facilities like Cleveland Clinic, like Langone, like 6 what's going to be the Universal Health Services, did 7 you do any studies to discuss what impact that might 8 have on your market share? 9 A. I would say that we have -- so Cleveland 10 Clinic announced they're going to build a hospital, 11 right, so clearly we are looking at more data now of 12 how that could impact you. But, you know, UHS 13 obviously, opening another hospital, the more beds that 14 come into a community, obviously, is going to affect a 15 hospital. 16 I don't think there was a specific analysis 17 that was done that looked at these not-for-profits that 18 I'm aware of and how it's going to impact us because 19 the not-for-profits have been here for a long time. 20 Q. Do you recall any discussions -- well, you 21 keep saying "a long time." I want to make sure we 22 understand. What's a long time to you? 23 A. Well five plus years, not like they just 24 showed up in the last year or two. 25 Q. Do you recall any discussions at any time
Page 111 1 aware that in -- we just talked about, for example, 2 Universal Health Services hasn't even opened in Palm 3 Beach, correct? 4 A. Correct. 5 Q. And as I understand the newspaper articles 6 I've read, it appears that in the summer of 2024 7 NYU Langone is coming, Cleveland Clinic is starting to 8 come. Were there discussions from a branding 9 perspective and/or marketing perspective at the 10 Palm Beach Health Network about combating a potential 11 decrease in market share as a result of new healthcare 12 facilities coming into the geographic area? 13 A. They've been here for a while, not just in 14 2024, so all the -- the not-for-profits have been in 15 Downtown West Palm for a long time because of 16 Palm Beach Island. 17 Q. Okay. And so am I wrong that NYU Langone 18 came in 2022? 19 A. I thought you said 2024. 20 Q. I was asking about 2024. 21 A. Oh. Yeah, it might be. But they've had 22 doctors, NYU Langone has had physicians here since I 23 remember, like a good period of time. 24 Q. From 2022 to 2020 -- 25 A. Mount Sinai as well.	Page 113 1 with the other hospitals that make up the Palm Beach 2 Health Network about the potential impact of these new 3 healthcare facilities coming to Palm Beach, whether it 4 was five years ago, three years ago, yesterday? Do you 5 recall any conversations with the other hospitals about 6 the potential impact of those new entrants into the 7 healthcare market here? 8 A. Of course, yes. 9 Q. And what do you recall about those 10 discussions? 11 A. I'll just give you an example. Erik, the 12 CEO of Gardens, and I discussed UHS, them opening and 13 what impact it may have on our staff that live in that 14 area. So his hospital, Palm Beach Gardens is very 15 close to that hospital. 16 I have staff that live north of 17 Good Samaritan, Port St. Lucie, Jupiter, so if they're 18 opening a brand new hospital and they need 300 nurses, 19 how that would impact us. 20 Q. What about any discussions about competing 21 for patients with those hospitals? 22 A. I mean, not specifically about patients. I 23 mean, we have really solid service lines and what we 24 do. That hospital is not offering a service line that 25 our hospitals don't offer. I would say it's really

Page 114 1 more about the employees, physicians. 2 Q. Do all of the -- since you guys are a health 3 network, do all of the physicians at Good Samaritan 4 also have privileges at the other four hospitals and 5 vice versa? 6 A. No. 7 Q. Why not? 8 A. Because they're -- we have all different 9 governing bodies and different MECs and bylaws. Every 10 hospital has their own bylaws. 11 Q. Do you know if there's any overlap between 12 privileges at different hospitals? 13 A. Yes. 14 Q. And do you have any understanding of what 15 the percentage is of that overlap, how many doctors 16 have privileges at one or more hospitals in the 17 Palm Beach Health Network? 18 A. I don't. I don't know. 19 Q. Would you say it's more than 50 percent? 20 MR. MARCUS: Object to form. 21 A. No. 22 BY MS. BLAIR: 23 Q. No, you would not know or, no, you -- 24 A. No, it would not be more than 50 percent, in 25 my opinion.	Page 116 1 reason for this rebranding was because of -- this is 2 not my words -- new entrants into the healthcare 3 market. 4 MR. MARCUS: Object to form. 5 BY MS. BLAIR: 6 Q. Do you have any memory of discussions with 7 the other five hospitals in or around April of 2022 8 about that was the purpose of organizing under the 9 umbrella of Palm Beach Health Network? 10 A. Absolutely not. 11 Q. Okay. What did you believe the purpose of 12 rebranding under Palm Beach Health Network was? 13 A. To show our identity and that we have all 14 these hospitals, we're the largest employer in Palm 15 Beach County, so, one, we want to demonstrate that. We 16 have the most -- you know, we see the most patients in 17 Palm Beach County. We wanted to put our network out 18 there that how we work together. 19 As you mentioned before, we have people that 20 are moving from one hospital to another hospital 21 because they're training at one hospital and being 22 promoted and going to the next hospital, so it's good 23 for recruitment for people to see that we have a really 24 solid organization where you have opportunities to 25 maybe start out at Delray Medical Center as a nurse and
Page 115 1 Q. Okay. Do you know if it would be more than 2 25 percent? 3 MR. MARCUS: Object to form. 4 A. I would be guessing. 5 BY MS. BLAIR: 6 Q. I don't want you to guess. 7 Was there ever a written strategic plan at 8 any time, a written strategic plan for Palm Beach 9 Health Network about how they were going to compete 10 with the new entrants into the healthcare system in 11 Palm Beach? 12 A. The new entrants of -- 13 Q. These other hospitals that we've been 14 talking about. 15 A. All right. There's only one, but, I mean, 16 absolutely. I'm sure that Erik, because of Gardens, is 17 the one that would be impacted more because of the 18 geographical location. 19 Q. I want to make sure. So I understood from 20 articles I've read, and please tell me if I'm wrong, 21 that in April of 2022 your five hospitals rebranded as 22 Palm Beach Health Network, correct? 23 A. Correct. 24 Q. And these articles -- and I know you weren't 25 quoted, but these articles talk about part of the	Page 117 1 end up as the CNO or something at another one of our 2 hospitals. So it's about showing our quality, all the 3 things that we can provide in a network. We have two 4 trauma hospitals. You know, giving us an identity that 5 we're all connected. Like Baptist Health, you know, 6 they do the same thing. It's a -- it's what 7 organizations do, so... 8 Q. Right. 9 A. It wasn't like there's new entities coming 10 in, we need a brand. 11 Q. Right. And as I understand our discussion 12 earlier today, all five of these hospitals have been 13 part of Tenet system for almost over a decade by 2022, 14 correct? 15 A. Yes. 16 Q. And this situation with people training at 17 one hospital and going to a different hospital, that 18 had been happening for at least a decade, correct? 19 A. Sure. 20 Q. So I guess my question is, why in April of 21 2022 was the decision made to rebrand as Palm Beach 22 Health Network? 23 A. Like the reasons that I mentioned. And we 24 have more of a structure now, now that Maggie is there, 25 so she's a lot of the reason. She came in. She has a

Page 118 1 lot of great ideas. And we really became more Palm 2 Beach. We were part of ten hospitals at one time, all 3 in Broward and in Miami. So when we became a group, it 4 just, it ended up, I guess, fostering into that. We 5 have become more of a group now -- 6 Q. Okay. 7 A. -- where we hadn't really in the past. 8 Q. So the timing of it was coincidental? 9 MR. MARCUS: Object to form. 10 A. I would say the article you read was 11 probably from the Palm Beach Post and it's the editor's 12 thoughts of why that happened. I am not aware that 13 this idea came from, we need to combat, you know, the 14 Cleveland Clinics and things like that. It's just 15 advancing and developing our brand and our network. 16 BY MS. BLAIR: 17 Q. Okay. And so in or around April of 2022, to 18 your knowledge, was there a strategic plan for 19 marketing the Palm Beach Health Network? So April of 20 2022 when you rebranded, was there a written strategic 21 plan for marketing the health network that you were 22 part of? 23 A. I don't recall it, but there probably, you 24 know, was because, you know, we have commercial, so 25 obviously funding has to go to that. You know, there	Page 120 1 MR. MARCUS: Object to form. 2 A. I'm not really sure. It could be both. You 3 know, the Palm Beach Health Network is still getting 4 out there. It takes a long time for a brand to stick 5 or for people to start understanding. And you know, it 6 takes a long time. 7 BY MS. BLAIR: 8 Q. That's fair. 9 Do you know if anyone at the Palm Beach 10 Health Network level has done any studies to see if the 11 Palm Beach Health Network brand is sticking with the 12 residents of this area? 13 A. I may have just recently saw a document. 14 Q. And what is your memory of -- well, what is 15 this document you may have recently saw? 16 A. I mean, I reviewed it with the attorneys. 17 Q. Did you review it in preparation for your 18 deposition here today? 19 A. Yes. 20 Q. What was it? 21 A. I had not seen the document before, but it 22 was maybe like a Net Promoter Score. I didn't have all 23 the details behind like who did the study or -- and I 24 think it was like Palm Beach Health Network awareness 25 maybe.
Page 119 1 was the logo, like I said, so obviously there had to 2 have been money set aside. I just don't recall like it 3 being reviewed with me or something. 4 Q. Okay. But you're sure that there was no 5 discussion about, we're doing this in order to compete 6 with new healthcare entities that are coming into the 7 market? 8 A. This is what I would say. Could there have 9 been a discussion when we're discussing all of the 10 positive reasons that branding can, you know, your 11 awareness of your institutions that are out there? I 12 can't say three years ago if that was not talked about. 13 I just cannot. 14 Q. So in 2024, is your view as the CEO of 15 Good Samaritan that the brand in 2024 is really the 16 Palm Beach Health Network as opposed to Good Samaritan 17 as an individual hospital? 18 MR. MARCUS: Object to the form. 19 A. It's Good Samaritan, part of the Palm Beach 20 Health Network. 21 BY MS. BLAIR: 22 Q. Do you believe that the patients in this 23 geographic area think of Good Samaritan as part of the 24 Palm Beach Health Network brand or as Good Samaritan 25 standing alone?	Page 121 1 Q. Okay. 2 A. Like maybe a year over year. 3 Q. Maybe a year over year, is that what you 4 said? 5 A. Right, correct. 6 Q. And what is your memory in reviewing that 7 document of what the Net Promoter Score was of 8 Palm Beach Health Network? 9 A. My memory, when I looked at it for literally 10 one minute, all I can say is that there was more 11 awareness. 12 Q. More awareness than the year before? 13 A. Correct. 14 Q. And was that document that you looked at 15 granted only for a minute or more, comparing 2025 to 16 2024 or 2024 to 2023, do you recall? 17 A. I don't recall. 18 MR. MARCUS: Is this a good time to take a 19 break, Counsel? 20 MS. BLAIR: Sure, yeah. 21 THE VIDEOGRAPHER: We're going off the 22 record. The time is 11:57 a.m. 23 (A recess was taken from 11:57 a.m. to 12:43 p.m.) 24 THE VIDEOGRAPHER: We are back on record. 25 The time is 12:43 p.m.

Page 122 1 BY MS. BLAIR: 2 Q. Ms. Montgomery, I want to just talk a little 3 bit about -- and we touched on this earlier, about how 4 Good Samaritan benchmarks itself against its 5 competitors. Do you understand what I mean by 6 "benchmark"? 7 A. Well, why don't you tell me. That way we're 8 on the same page. 9 Q. Sure. Do you ever -- does Good Samaritan 10 have any data or analysis where it looks like, for 11 example, its CAUTI scores versus the hospitals that you 12 consider to be your competitors or your HCAHPS scores 13 with CMS, do you have any -- how do you do that? Or 14 let me strike that. 15 Do you do that? Do you have data where you 16 benchmark how is Good Samaritan doing in different 17 patient safety categories versus your competitors in 18 the area? 19 A. So the balanced scorecard, I believe it's on 20 there. It might be all of Tenet or the national 21 average, whatever the goals are. And you have access 22 to all the data, so if I wanted to look at 70 plus 23 hospitals or whatnot, I could. 24 I personally don't go out there and look at 25 Good Samaritan to, you know, many other hospitals other	Page 124 1 A. No, that's more like market share data. 2 Q. The score card, is that generated from 3 internal Tenet data? 4 A. I don't know exactly where it pulls from. 5 It's called Kaleidoscope is where we get the 6 information from. Where it pulls from, you know, the 7 background, I'm not sure. 8 Q. Okay. Kaleidoscope just like the word? 9 A. Is the tool. 10 Q. Are you familiar with Vizient? 11 A. No. 12 Q. Do you know if Good Samaritan has ever had a 13 contract with Vizient? 14 A. Not that I'm aware of. 15 Q. What about Premier, do you know what Premier 16 is? 17 A. No. 18 Q. So I guess the follow-up question is, do you 19 know if Good Samaritan has ever had a contract with 20 Premier? 21 A. Not that I'm aware of. 22 Q. What about Healthgrades™, does 23 Good Samaritan have a contract with Healthgrades™ to 24 review its data? 25 A. Yes.
Page 123 1 than, you know, the tools that are provided to me. 2 Q. And when you say you could, for example, 3 look at 70 other hospitals, are those the 70 Tenet 4 hospitals? 5 A. Correct. 6 Q. And when you say the tools -- you could if 7 you looked at the tools that are provided to you, what 8 tools would those be? 9 A. That's what I'm saying is it's mostly, you 10 know, like the report card that has the 70 hospitals on 11 it. But I personally haven't gone out there to go look 12 at Good Sam and compare it to other hospitals, per se, 13 or did some analysis. 14 Q. Do you know if Tenet Healthcare does that? 15 A. I don't know. I mean, I'm -- 16 Q. Do you know if Palm Beach -- 17 A. I don't know. 18 Q. I'm sorry. 19 Do you know if Palm Beach Health Network 20 looks at how the five hospitals in the Palm Beach 21 Health Network compare to the competitors in various 22 areas of patient safety? 23 A. I'm not really sure. 24 Q. And you mentioned Trilliant earlier. Is 25 that where the score card comes from?	Page 125 1 Q. And is that an annual contract? 2 A. I'm not really sure if it's annual or not. 3 I don't really do that piece at all. 4 Q. Who does do that piece? 5 A. I would say the group level. 6 Q. And by group level, you mean Palm Beach 7 Health Network? 8 A. Right. 9 Q. Would Gina West know about that? 10 A. Yeah, she would probably know more about it, 11 but the contracting would, you know -- she wouldn't 12 sign a contract, per se. 13 Q. Who would sign the contract at the group 14 level? 15 A. Probably Michelle Cartwright. 16 Q. So is it your understanding that any 17 contract with Healthgrades™ would be at the group level 18 and not at the Good Samaritan level? 19 A. I really don't know if it's individual or 20 how it works. 21 Q. Do you know how much Good Samaritan pays for 22 its contract with Healthgrades™? 23 A. I don't. 24 Q. Do you know how much Palm Beach Health 25 Network pays for its contract with Healthgrades™?

Page 126 1 A. I'm not sure, but I think they pay for -- I 2 think Healthgrades™ has the data for everybody, I'm 3 sure. When I was the group CFO, I want to say it might 4 have been like 50,000 to 100 or something of that 5 nature. 6 Q. Okay. But that's a guesstimate, my word? 7 A. Yeah, I mean, yeah. 8 Q. But to the best of your knowledge, the -- 9 Good Samaritan either individually or through the Palm 10 Beach Health Network still participates in 11 Healthgrades™ via contract? 12 A. Yes. 13 Q. What about are there any other services that 14 you know of that Good Samaritan contracts for to 15 provide data related to quality or patient safety? 16 A. That provides data specifically? 17 Q. Correct. 18 A. Not that I can think of right now. 19 Q. Does Good Samaritan engage in any contracts 20 with any vendors to provide consulting services with 21 respect to improvement of patient safety or quality? 22 A. Not that I can think of. 23 Q. Does the Palm Beach Health Network engage in 24 any contracts with vendors to provide consulting 25 services for patient safety or quality?	Page 128 1 third-party vendor to collect HCAHPS data; is that 2 true? 3 A. I mean, I don't know if it's a requirement, 4 but it could be. 5 Q. Okay. 6 A. Sounds right. 7 Q. Does Press Ganey provide any services to 8 Good Samaritan outside of collecting data relating to 9 the HCAHPS? 10 A. They recently were at our hospital. One of 11 the representatives came and met with the CNO. And 12 this champion I was telling you about, I think, did 13 some rounding and, you know, probably gave 14 recommendations of how to get higher participation 15 rates and things of that nature. 16 Q. Do you know -- strike that. 17 We talked a little bit about the hospital's 18 brand before the lunch break as well as the brand of 19 Palm Beach Health Network. Do you recall that? 20 A. Yes. 21 Q. I was told in this litigation that your 22 attorneys would be producing brand marketing documents. 23 Do you know, can you describe for me what type of brand 24 documents exist? 25 MR. MARCUS: Just object to form.
Page 127 1 A. I mean, if they do, I'm not really sure. I 2 can't think of anything right now. 3 Q. Do you know if -- you mentioned earlier a 4 patient experience champion that you were looking to 5 hire or did hire. Do you recall that? 6 A. Right. 7 Q. Is that a consultant or is that a direct 8 employee of Good Samaritan? 9 A. No, she's an employee. 10 Q. I've seen references in some of documents to 11 Press Ganey. Are you familiar with what Press Ganey 12 is? 13 A. I am. 14 Q. Does Good Samaritan utilize the services of 15 Press Ganey? 16 A. We do. 17 Q. Do you pay for those services? 18 A. I'm not really sure. I mean, they do all 19 our patient satisfaction HCAHPS distribution and 20 reports. I would think there would be a payment, but I 21 don't know. 22 Q. And I understand -- and my understanding may 23 be wrong because I'm not in the healthcare field -- but 24 that CMS does not allow -- or strike that. 25 I understand CMS requires hospital to have a	Page 129 1 A. Brand marketing like as in the Palm Beach 2 Health Network? 3 BY MS. BLAIR: 4 Q. Or Good Samaritan. I don't know what they 5 are, so I'm just trying to ask you, do you know what 6 brand documents would exist? 7 A. I mean, my thoughts would be the rollout of 8 our brand, the Palm Beach Health Network. It could 9 encompass a lot of things related to the brand and our 10 impact on the community, things like that. 11 Q. Your -- you, Good Samaritan and the other 12 plaintiffs, have produced an expert report from a man 13 named Mr. Chakurda. Have you read this expert report? 14 A. I have not. 15 Q. Have you ever spoken with Mr. Chakurda 16 regarding what his expert opinions were going to be in 17 this matter? 18 A. I have not. 19 Q. Do you understand that Mr. Chakurda is a 20 brand marketing expert? 21 A. I don't know that. 22 Q. Did you have an understanding before you 23 came here for your deposition today that you had hired 24 a brand marketing expert to opine in this litigation? 25 A. I read it somewhere in a document. That was

Page 130 1 just -- 2 Q. And I don't want to know what you read 3 because it's probably through your attorney. 4 A. -- to the best of my knowledge. 5 Q. And in that report Mr. Chakurda says, 6 "Hospital systems have dedicated marketing 7 departments." 8 Would you agree with that statement? 9 A. Correct. 10 Q. And does Good Samaritan have a dedicated 11 marketing department? 12 A. Yes. 13 Q. Okay. And he says that, "The marketing 14 departments are responsible for advertising website and 15 digital communications, competitive intelligence, 16 patient outreach and media relations." 17 So my question is, I'm going to break that 18 down, do you know whether or not the Good Samaritan 19 marketing department is responsible for advertising for 20 Good Samaritan? 21 A. They are. 22 Q. And do you have specific advertisements for 23 Good Samaritan that are separate and apart from 24 Palm Beach Health Network? 25 A. Yes.	Page 132 1 A. She doesn't have any. 2 Q. What about competitive intelligence? Is the 3 Good Samaritan marketing department in charge of 4 overseeing competitive intelligence? 5 A. I would have to have that really explained 6 to me of what that entails to answer that 7 appropriately. 8 Q. Do you have any understanding as you sit 9 here today how you, Sheri Montgomery, understand the 10 term "competitive intelligence"? 11 A. Yeah, I would say really understanding our 12 environment, our competitors, what they are doing, kind 13 of understanding their market that they're going after 14 as well, I would say. 15 Q. And as I understand our conversation earlier 16 this morning, that's done at the Palm Beach network 17 level, competitive intelligence; is that fair? 18 A. Well, I would say that information is shared 19 from the marketing, group marketing person with the 20 marketing managers. They meet all the time. 21 What I'm referring to, the marketing manager 22 is expected to know those things that I just referred 23 to. 24 Q. And who's the Good Sama marketing manager? 25 A. Nancy.
Page 131 1 Q. Does your marketing department oversee the 2 website for Good Samaritan? 3 A. Yes. 4 Q. And same question with respect to digital 5 communications. Does Good Samaritan have a department 6 that oversees digital communications? 7 A. Yes. 8 Q. And what do you understand the digital 9 communications to be for Good Samaritan? 10 A. Like anything that's digital and social 11 media and all of those things. 12 Q. Does Good Samaritan have social media pages? 13 A. Yes. 14 Q. And do you know who at Good Samaritan 15 oversees the social media pages? 16 A. Marketing. 17 Q. But who specifically, do you know? 18 A. Nancy -- 19 Q. Morales? 20 A. -- Morales. 21 Q. Is Nancy Morales in charge of overseeing the 22 website as well? 23 A. Yes. 24 Q. How many direct reports does Nancy Morales 25 have?	Page 133 1 Q. Okay. 2 A. Yeah. Morales. 3 Q. That's her title? 4 A. Yes. 5 Q. And there's a marketing manager at each of 6 the five hospitals, correct? 7 A. Yes. 8 Q. What about patient outreach, does the 9 marketing department at Good Samaritan engage in 10 patient outreach? 11 A. They do. 12 Q. How do they engage in patient outreach? 13 A. Many different ways. I mean, one could be 14 like direct mail or, say, we're having a health fair. 15 We just recently had one at one of our emergency rooms 16 where you're doing blood pressure screening, things 17 like that. She reaches out to patients and 18 communities. 19 Q. Does she reach out for patient experience 20 feedback outside of the HCAHPS process? 21 A. She'll do like patient testimonials, so I 22 would say, yes. 23 Q. Do you know how she figures out which 24 patients she would reach out to for a patient 25 testimonial?

Page 134 1 A. Sometimes it's a Google review. Sometimes 2 it's a physician that has said, "This patient had a 3 great outcome." 4 Q. What about media relations, does the 5 Good Samaritan marketing department engage in media 6 relations? 7 A. Yes. 8 Q. And what does that mean to you? 9 A. I would say that she really works -- we 10 actually have a media relations person, and they work 11 together on anything that's to do with releases, like 12 new technology at the hospital, you know. If we're 13 first in the community to offer a new technology, she's 14 going to be part of writing that release along with the 15 public relations individual. 16 Q. Okay. And who's your public relations 17 individual? 18 A. Andrew Lofholm. 19 Q. And I've seen his name in several of the 20 documents that have been introduced with this. So he 21 was also involved with the press releases surrounding 22 the filing of the lawsuit that we're all here for today 23 as well, correct? 24 A. Yes. 25 Q. And that would be part of his job as the	Page 136 1 Q. Prior to January of 2025, did Good Samaritan 2 have any programs in place to increase patient 3 experience scores? 4 A. I mean, yes. 5 Q. And what programs did you have in place 6 prior to January of 2025 to increase patient experience 7 scores? 8 A. Leadership rounding, which includes, you 9 know, we even include our ancillary directors and 10 leadership rounding, which is non, non-nurses basically 11 in the leadership rounding. The CNO actually does 12 leadership rounding. It interviews patients to see 13 what their experience has been. 14 Q. So to the layperson I don't know what 15 leadership rounding is. Can you explain that to me? 16 A. Yeah. Essentially leaders in the 17 organization, like your nurse managers or your nurse 18 directors, we will pair them up with an ancillary 19 individual, which an ancillary person is the imaging 20 director, for example, and we have them go out and 21 round on patients not in their unit, so obviously 22 outside of their units because you really want, you 23 know, unbiased, I guess, you know, and sometimes other 24 people can see things that you wouldn't see, so we have 25 them go out and round on patients, get their feedback.
Page 135 1 media relations person? 2 A. Yeah. 3 Q. And would you agree that Mr. Chakurda's 4 statement where he says, "Hospital systems have 5 dedicated marketing departments responsible for 6 advertising, website and digital communication, 7 competitive intelligence, patient outreach and media 8 relations" -- I can't talk today -- "all with the aim 9 of increasing, enhancing a hospital's patient outreach 10 and media relations all with the aim of increasing and 11 enhancing a hospital's brand." 12 That's a mouthful. 13 MR. MARCUS: Object. 14 BY MS. BLAIR: 15 Q. My question is, do you agree that your 16 marketing department engages in all of these efforts to 17 increase and enhance the hospital's brand? 18 A. I'd agree with that. 19 Q. And we talked about this before. You don't 20 know as you sit here today what Good Samaritan's 21 marketing budget is, correct? 22 A. I do not. 23 Q. Do you know if Palm Beach Health Network has 24 a separate marketing budget? 25 A. I'm not quite sure. I'm not quite sure.	Page 137 1 All of that is logged. And if there are things that 2 they're bringing up, you know, patients are bringing 3 up, say it's food related, you know, my breakfast was 4 cold this morning, following up on all those types of 5 things, so... 6 Q. And how would -- 7 A. And that's a huge thing to do. 8 Q. How are they logged, these rounding? You 9 said they're logged. 10 A. Yeah, they log them. They go around and 11 they have their notepad. It's not electronic. I don't 12 know if they put it in an Excel spreadsheet. We have 13 them do that on Stoplight Reports now, and they follow 14 up on all of those items. 15 Q. Is there some sort of document that's 16 generated from all of this leadership rounding from the 17 logging of notes? 18 A. There is now what we call it a Stoplight 19 Report, a leadership Stoplight Report. So and I 20 believe patient experience is on there along with 21 employee rounding that is on the Stoplight Reports, but 22 it's an Excel opportunity. 23 Q. And you said there is now. When did that 24 first go into place? 25 A. Probably -- probably six months ago

Page 138 1 probably. 2 Q. Okay. So nothing from before November of 3 2024, fair enough? 4 A. It might have been because we had a rollout 5 on -- it might have been in November that we started 6 looking at turnover for staffing and then came up with 7 this whole, we should have a Stoplight Report where 8 we're logging trends and, you know, build like log 9 trends for employees and bring it to us so we can start 10 taking action on things. 11 Q. Are these stoplight reports something that 12 would have been discussed at a board meeting? 13 A. A governing board meeting? 14 Q. Yes. Is there another kind? 15 A. No, I guess not. 16 Q. Okay. 17 A. I don't think so. I don't know. We might 18 have mentioned, Hey, that we're starting to do this, 19 you know, to address turnover and things of that 20 nature. It could have been. 21 Q. Do you know whether or not those Stoplight 22 Reports have been produced in this litigation? 23 A. I don't know. 24 Q. Would these Stoplight Reports have been 25 discussed at a Med Exec meeting?	Page 140 1 litigation which is from SEIU1199 that lists out, you 2 know, different complaints nurses have given to their 3 union. And I'm just curious, do you look at those in 4 the context of not the nurse complaint but in the 5 context of patient experience? 6 A. I mean, I don't know really of employees 7 coming back -- other than the employees that are 8 involved in the meetings and improved patient 9 experience what you're really referring to. 10 Q. Sure. And I guess from a hypothetical 11 standpoint, let's say a nurse says, "I started my 12 shift, and I realized this patient hadn't been toileted 13 in, you know, four hours, and that's a problem." 14 Is that kind of complaint from the nurse 15 then translated into a discussion about patient 16 experience? 17 MR. MARCUS: Object to form. 18 A. I mean, depends on who it was -- who that 19 information was given to. If it was a leader of a 20 department, then it would be. If it was, you know, an 21 incident report that's investigated, why did that 22 happen. 23 BY MS. BLAIR: 24 Q. And Press Ganey, they provide -- do you know 25 what the document looks like when they provide you
Page 139 1 A. I'm not sure. 2 Q. I'm just trying to figure out where's the 3 best place for me to figure out when these Stoplight 4 Reports started document-wise? 5 A. They probably started around November when 6 we started talking about Stoplight Report. I would say 7 it was probably November. 8 Q. Of 2024? 9 A. Yeah. 10 Q. Okay. 11 A. Um-hum. But, you know, there's also with 12 patient experiences there's Press Ganey provides 13 comments like actual comments that patients will leave, 14 so that's reviewed. You know, and the team works 15 towards where some of the common themes, say if 16 temperature for food is one of them, you know, working 17 with our dietary team to find out, you know, when are 18 you delivering it; what's wrong with the warmers, 19 things of that nature. 20 Q. Do you ever look at complaints from the 21 nursing staff about issues related to patients in terms 22 of evaluating patient experience? 23 A. Give me an example. What do you mean 24 exactly? 25 Q. Well, we've had a document produced in this	Page 141 1 actual comments or common themes related to the patient 2 experience outcomes? 3 A. I do. 4 Q. What's -- 5 A. They're called verbatims. 6 Q. They're called verbatims. Do you know if 7 the verbatims have been produced in this litigation to 8 date? 9 A. I do not. 10 Q. How often do you get verbatims from 11 Press Ganey? 12 A. I'm not really sure. They're not sent to me 13 personally, so I'm not sure. 14 Q. Do you know who they would be sent to? 15 A. Maybe the CNO, patient experience 16 coordinator. 17 Q. Do these verbatims get turned into any sort 18 of comprehensive report, to your knowledge? 19 A. Not to my knowledge. 20 Q. Are these verbatims shared in any way with 21 the governing board? 22 A. Not to my knowledge. 23 Q. Are these verbatims shared in any way with 24 the Med Exec Committee? 25 A. No, not to my knowledge.

Page 142 1 Q. You mentioned -- 2 A. The patient experience scores are. 3 Q. Of course? 4 A. Right. Verbatims is like a way to actually 5 get a comment and dig down. 6 Q. But they -- I thought you told me, and I 7 want to make sure, that they are somehow summarized 8 into some sort of report that goes somewhere. 9 A. They're not summarized by like a theme. 10 They're just here is verbatims for a certain nursing 11 floor, for example. 12 Q. Got it. But those are summarized in some 13 way and provided maybe to the chief nursing officer or 14 the patient experience coordinator, correct? 15 A. Correct. 16 Q. You mentioned earlier that you, 17 Good Samaritan had recently had a health fair at one of 18 its emergency rooms, correct? 19 A. Yes. 20 Q. Does Good Samaritan regularly engage in 21 community sponsorships and philanthropy? 22 A. Sponsorships of what exactly? What do you 23 mean? 24 Q. Well, you know, sometimes hospitals will go 25 and they will sponsor a charity event or something else	Page 144 1 A. Yeah, relationships with physicians? 2 BY MS. BLAIR: 3 Q. Yes, do you -- for example, does 4 Good Samaritan, for example have visits to referring 5 physician offices to sort of promote Good Samaritan and 6 try to increase referrals to Good Samaritan? 7 MR. MARCUS: Object to form. 8 A. I would say that we visit their offices to 9 let them know about our services. 10 BY MS. BLAIR: 11 Q. How often are you going to referring 12 physician offices? 13 A. I am not really sure, but it's not, you 14 know, really -- I'm not going out to the physician 15 offices, so... 16 Q. Do you know who would be? 17 A. Holly -- 18 Q. Who is Holly? 19 A. -- Wadownsky (phonetic). That's another 20 long one. She's a -- she works for the business 21 development team, so she works for Derek. 22 Q. What's Derek's last name? 23 A. Collins. 24 Q. And that's the business development team? 25 A. Yes.
Page 143 1 in the community, a soccer team, I don't know, a little 2 league team. Do you do things like that? 3 A. I'm trying to think of an example of a 4 sponsorship that we've done. I mean, we do a lot of 5 community events. A sponsorship. I'm trying to think 6 of one. I know that there are some out there. I just 7 can't think of one off the top of my head. 8 Q. Okay. And Tenet Healthcare is a for-profit 9 institution, correct? 10 A. Yes. 11 Q. Do you know if they have any charitable arm 12 of Tenet Healthcare? 13 A. No, not that I'm aware of. 14 Q. And then you talked about community events. 15 What type of community events is Good Samaritan 16 involved in? 17 A. Health fairs like I spoke about. 18 You know when there's events downtown West 19 Palm, you know, the, like the Susan G. Komen Race, 20 there's a sponsorship right there. We sponsor that, 21 and obviously we attend the race and are there just for 22 giving water and things of that nature, but, yes. 23 Q. What about physician relations, do you 24 engage in physician relations at Good Samaritan? 25 MR. MARCUS: Object to form.	Page 145 1 Q. I think I had it listed as something else. 2 Okay. And the business development team, 3 what kind of business are they trying to development? 4 A. You know, they'll go and visit physicians to 5 say, you know, Hey, did you know Good Samaritan has a 6 bariatric program, that it's accredited, that type of 7 stuff, let them know about the orthopedic service 8 lines, those types of things. 9 Q. Do they go to employers and ask employers to 10 engage with Good Sam on behalf of their employees? 11 A. I know that there's been meetings like that. 12 I mean, that's more Derek's umbrella. 13 Q. Do you know if Derek's team engages with 14 health insurers to try and promote Good Samaritan? 15 A. I'm not aware of that, no. 16 Q. Prior to 2020 -- well, strike that. 17 You talked to me earlier about 18 Healthgrades™, correct? 19 A. Yes. 20 Q. And as I understand it, Good Samaritan has 21 accolades with respect to Healthgrades™ as well, 22 correct? 23 A. Yes. 24 Q. Does Good Samaritan have to purchase 25 accolades in order to be able to use the Healthgrades™

Page 146 1 logo to promote the its award? 2 MR. MARCUS: Object to form. 3 A. I don't really know the details behind the 4 contract. You know, marketing and the CFO probably 5 would be able to explain that a little better than I 6 could. 7 MS. BLAIR: We're going to mark this as 8 Exhibit 4; is that correct? 9 THE STENOGRAPHER: Yes. 10 Can we go off the record for just a second? 11 MS. BLAIR: Yes. 12 THE VIDEOGRAPHER: We're going off the 13 record. The time is 1:14 p.m. 14 (A recess was taken from 1:14 p.m. to 1:16 p.m.) 15 THE VIDEOGRAPHER: We are back on the 16 record. The time is 1:16 p.m. 17 (Defendant's Exhibit Number 4 for i.d.) 18 BY MS. BLAIR: 19 Q. Ms. Montgomery, I've handed you what we've 20 just marked Montgomery Exhibit 4. It's a document. At 21 the top it says "Palm Beach Health Network." Do you 22 see that? 23 A. Yes. 24 Q. Do you know when this document was produced? 25 I don't -- that's a terrible word because I don't mean	Page 148 1 Good Samaritan, at the bottom -- I think I answered my 2 own question -- of the Good Samaritan on the left-hand 3 side it says, "Healthgrades™ Top 10 Percent in the 4 Nation For Spine Surgery 2025." 5 Do you see that? 6 A. I do. 7 Q. So obviously this was after April of 2022, 8 correct? 9 A. I would definitely recollect that that's 10 probably a fact. 11 Q. And in looking at these awards and accolades 12 under the Good Samaritan heading, on page 8924, does 13 this accurately describe the accolades that 14 Good Samaritan currently has? 15 A. I think there's potentially more, but I'd 16 have to look at my updated list. 17 Q. Okay. And if we look at that first 18 bullet -- well, let's look under -- do you see that 19 it's all caps, it says "services"? Do you see that 20 right above "awards and accolades"? 21 A. Yes. 22 Q. Is this your -- you referred earlier in the 23 deposition to like lines of service. Is this the 24 description of your lines of service? 25 A. Right.
Page 147 1 "produced" in a legal sense. 2 Do you know when this document was created? 3 A. I do not. 4 Q. In looking at this document, do you have any 5 recollection of seeing this before? 6 A. This first page doesn't look familiar to me. 7 Q. What about the second page? 8 A. Yes. 9 Q. Okay. And, for the record, this document -- 10 and we refer to this, Ms. Montgomery at the bottom 11 right-hand corner as Bates labels, so, for the record, 12 this is PBHN followed by five zeros 8923 through 8924. 13 Do you see those numbers on the bottom? 14 A. 8923, yes. 15 Q. Okay. And if I turn to this -- well, let me 16 ask this. 17 Does it refresh your recollection in any 18 way? Was this the brand rollout document for 19 Palm Beach Health Network in or around April of '22? 20 MR. MARCUS: Object to form. 21 A. I mean, I don't recall. 22 BY MS. BLAIR: 23 Q. And I'll just tell you -- I'm not trying to 24 be tricky. If we look at 8924, 8924, which is the 25 second page of your Exhibit, if you look at	Page 149 1 Q. Okay. And then going to the award and 2 accolades, you say, "Designated Breast Imaging Center 3 of Excellence By the American College of Radiology," 4 correct? 5 A. Correct. 6 Q. Do you pay for anything related to the 7 American College of Radiology for this designation? 8 A. I believe we do. Typically any accrediting 9 body that comes into your organization, one, they're 10 bringing in their expertise and their pathways that 11 they're sharing with you, and, two, they're coming into 12 your organization for like three or four days and going 13 through all your pathways and making sure that 14 everything that, you know, to be accredited that that 15 is happening. So I would say in many of these there is 16 a fee to get accredited because it's a lot of 17 information they're giving to us, and then they're 18 coming and verifying all of that and working with us 19 and our organization. 20 Q. How much -- and let's just take this first 21 bullet point, for example. How much time does 22 Good Samaritan have to dedicate to the accreditation 23 from the American College of Radiology for this 24 designation? 25 A. How much time?

Page 150 1 Q. Time. 2 A. I don't really know about the time, per se, 3 for imaging, but for, you know, bariatrics and 4 orthopedics, I mean, it's a ton of time, a lot of 5 people, a lot of resources. 6 Q. How many -- oh, sorry. 7 A. Go ahead. 8 Q. How many FTEs do you have dedicated to 9 engaging in these types of accreditation reviews? 10 A. I wouldn't say that really it is that 11 because it's an entire team, but for, say, orthopedics, 12 it's a large undertaking. We had an FTE assigned to 13 tracking everything and kind of organizing all the 14 meetings and things of that nature. 15 For those large accreditations, you do 16 assign a point person, but I wouldn't necessarily say 17 that, oh, one person is assigned to just doing 18 accreditations. So it's many FTE's involved in the 19 process. 20 Q. Okay. So is there like a person in the 21 marketing department, let's say, that kind of oversees 22 the coordination of these accreditations? 23 A. In the marketing, no. 24 Q. Who generally would be involved? I know 25 it's a team, but who generally are the types of FTE's	Page 152 1 There's registries like for bariatrics that you have to 2 log all the data and send them all the results. It 3 takes a tremendous amount of hours to implement all the 4 standards to become accredited. I can't even give you 5 an amount of the hours but a very long time. 6 Just for orthopedics it took us probably a 7 year to prepare. 8 Q. Like one person every day to prepare? 9 A. Yeah. Always doing something for it, 10 pathways, having meetings. There's just -- it's an 11 undertaking for sure. 12 Q. Okay. And that would be sort of the same 13 for all of those accreditations, including like let's 14 look at just like the first one on here, Healthgrades™ 15 five-star rated for colorectal surgery, do you see that 16 one, the third bullet point? 17 A. Yes. 18 Q. Is that the same, you would dedicate 19 somebody for a whole year to get ready for that, or is 20 that different than an accreditation? 21 A. That's different than an accreditation. 22 Q. Okay. How long do you think it would take 23 for the -- to complete and engage in the Healthgrades™ 24 rating for colorectal surgery, for example? 25 A. So the way I would -- I look at it a little
Page 151 1 that you would dedicate to -- and I understand they're 2 not full time, but dedicate to an accreditation 3 process? 4 A. So for bariatrics we have a bariatrics 5 coordinator. She is a full-time individual that does 6 everything for the bariatric program and does the 7 accreditation. 8 For orthopedics, we have a service line 9 individual that does all of those things. There's 10 always like a clinician involved in all of those, you 11 know, duties that need to be done, but there's always 12 one person assigned to kind of be the gatekeeper of 13 everything. 14 Q. Okay. And for the bariatric accreditation, 15 let's just stick with that, do you have any just 16 general understanding of how many hours go into the 17 accreditation process for your bariatric accreditation? 18 I'm trying to find which one it is here. I 19 apologize. I don't see it on here maybe? 20 A. Yeah, it might be not on here. Let's see. 21 You could go into breast. We have bariatrics. 22 But, you know, for breast or bariatric, so 23 many hours by so many people, including physicians, to 24 get accredited for COC, for our breast center, for 25 bariatrics. I mean, data has to be submitted to them.	Page 153 1 differently, the two. But Healthgrades™ I would say 2 that it's not really an accreditation, but it's our 3 outcomes so ensuring our best practices are there so 4 that our colorectal surgery patients have the best 5 outcomes. So I can't really say that it's 6 Healthgrades™ is saying, Hey, you have to meet all 7 these standards like a Joint Commission would. 8 Q. Okay. So -- 9 A. They don't give accreditations. They give 10 awards based on outcomes. 11 Q. So the designated Breast Imaging Center of 12 Excellence by the American College of Radiology, that's 13 more like an accreditation process; is that fair? 14 A. That's correct. 15 Q. Okay. 16 A. But it's outcomes too or they wouldn't give 17 you their accreditation. 18 Q. Okay. I just -- I'm just learning as I go. 19 So like bullet point two talks about 20 accredited by the American College of Surgeons, but 21 bullet point one just says designated. I'm trying to 22 figure out which ones of these would fall into the 23 category of accreditations that you just described that 24 are like a year-long difficult process and which ones 25 don't?

Page 154 1 A. I would say they all fall under an 2 accreditation except Healthgrades™. 3 Q. Okay. And even like the second to the last 4 bullet point", Only Hospital in South Florida to Be 5 Recognized With the America's 100 Best For Spine and 6 Outpatient Orthopedic Excellence Awards," that's like 7 an accreditation? 8 A. That's Healthgrades™. 9 Q. Oh, that is Healthgrades™? 10 A. Um-hum. 11 Q. The second to last bullet point? 12 A. Yeah. 13 Q. Okay. So going back to Healthgrades™, if 14 you look at that bullet point again on Exhibit 4, it 15 says Healthgrades™. Do you see that, like every time 16 it says "Healthgrades," it says "™"? 17 A. Yes, I see it. It's very little. 18 Q. Do you know whether or not you have to pay 19 Healthgrades™ in order to use its trademark in your 20 promotional materials like this? 21 A. I think so. 22 Q. Okay. In reviewing the Palm Beach Health 23 Network Web page, it had these various patient review 24 portals. And one of them they talk about is vitals. 25 Are you familiar with vitals?	Page 156 1 hospitals and/or doctors? 2 A. Not really. 3 Q. Do you know whether Healthgrades™ provides 4 Good Samaritan or Palm Beach Health Network with 5 metrics regarding patient satisfaction? 6 A. I am not aware of that. 7 Q. You mentioned earlier the Google reviews for 8 Good Samaritan, do you recall that? 9 A. Yes. 10 Q. And I think you told me Good Samaritan 11 currently has four-star Google review, correct? 12 A. Correct. 13 Q. Do you pay for any Google analytics to be 14 run so that you can see how patients are interacting 15 with your Web page? 16 A. I'm not sure if they do that at the group 17 level or marketing or something. 18 Q. Do you know whether or not Good Samaritan 19 pays for Google ads for Good Samaritan? 20 A. No. 21 Q. I noticed on some of the -- all of the 22 Google reviews, I think, there were responses to each 23 and every one on behalf of Good Samaritan. Do you know 24 who responds to those Google reviews? 25 A. It's the same entity that was really hired
Page 155 1 A. So it was a patient review? 2 Q. It has a Web page saying "Patient Review 3 Portals." And, again, this is on the Palm Beach Health 4 Network website, not on Good Samaritan? 5 A. Okay. 6 Q. Are you familiar with the Palm Beach Health 7 Network Web page for patient review portals? 8 A. The only thing -- the portals that I am 9 aware of that my website now links Palm Beach Health 10 Network is like either where you can get your patient 11 record. Is that what you're -- 12 Q. No, I'll just tell you. It lists Vitals, 13 WebMD, Rate MDs, doctor.com, Healthgrades, Google, 14 Yelp. So these are, as I see them, places that 15 Palm Beach Health Network is encouraging patients to go 16 to to review its services? 17 A. Oh, I see. Okay. 18 Q. Are you familiar with that page? 19 A. It's not ringing a bell. 20 Q. All right. Okay. And I didn't see it on 21 the Good Samaritan Web page so I just was curious 22 whether you knew anything about that. 23 A. Doesn't ring a bell. 24 Q. Do you understand that Healthgrades™ has a 25 patient review portal that patients can go to to rate	Page 157 1 to notify us, so I'm not really sure. I think it's our 2 business center that we have. 3 Q. So it's not a third-party contractor? 4 A. I'm not really sure, to be honest. 5 Q. If Good Samaritan gets a bad Google review, 6 does that get elevated to you as the CEO of 7 Good Samaritan? 8 A. It does. 9 Q. And what do you do with bad Google reviews? 10 A. Well, there's many people on the email, 11 including the CNO, but -- and risk management. They 12 investigate all of them. 13 Q. And how does -- what form does the 14 investigation take? 15 A. It depends. I mean, if it's something where 16 it's a billing complaint, for example, then the 17 director of revenue analysis will be notified. She 18 will do her investigation, reach back out. They close 19 the loop if you can identify who the patient is. 20 Sometimes you can't. 21 Q. Do you -- does Good Samaritan use Google 22 reviews to compare itself to its competitors? 23 A. We really use the Google reviews to get 24 immediate feedback from the patients. Like I stated 25 before, it's, you know, difficult to get participation

Page 158 1 in a paper survey, so we encourage the patients to give 2 us their feedback realtime. 3 I wouldn't say that I go out and say, Hey, 4 I'm this and someone else is that. I want to be 5 five-star, so that's our goal. 6 Q. Is there one platform that Good Samaritan 7 believes is the most important platform to consumers 8 when evaluating patient experience? 9 A. Evaluating patient experience. There's so 10 many ways you can get information these days to 11 evaluate things. People, you know, sometimes use -- my 12 point is like 10 percent of people, I think, or maybe 13 it's 12 percent, fill out the survey for us. That's 14 not where I want it to be. I'd rather -- you know, 15 statistically it's better when you have 25 to 35 16 percent. 17 You know, experts will even tell you that 18 you get a more solid feel, I think, of an organization. 19 Typically people don't fill out surveys unless they're 20 not happy, at least immediately, you know. Even 21 restaurant reviews, if you look at them, you know, 22 normally you leave a restaurant and it was wonderful. 23 No one goes out and, "Oh, this restaurant was 24 wonderful." It's that "The service was horrible and 25 the meal was cold" or something that somebody wants to	Page 160 1 BY MS. BLAIR: 2 Q. Okay. This is going to be a group Exhibit 3 so it's going to take me a minute. 4 MS. BLAIR: Can you mark this as group 5 Exhibit 5? Thank you. 6 (Defendant's Exhibit Number 5 for i.d.) 7 BY MS. BLAIR: 8 Q. Ms. Montgomery, I am handing you what we've 9 now marked as group Exhibit 5. And I'll submit to you 10 what is before you now are printed out as of 11 9-13-2025 -- you can see that in the top left corner -- 12 the CMS scores for Good Samaritan Medical Center. And 13 this first page, two pages -- well, one through four 14 you'll see at the bottom left, is the overall star 15 rating and patient survey ratings. 16 Do you see that? 17 A. Yes. 18 Q. And then the second is the breakdown of the 19 overall star ratings. And then the third is the 20 breakdown of the patient survey ratings. Do you have 21 all three of those in front of you? 22 A. I do. 23 Q. Okay. And I just want to make sure for my 24 record I understand when you're talking about HCAHPS, 25 is that the patient survey rating that we see in this
Page 159 1 put out a review, unfortunately. 2 So we try to encourage everyone to give the 3 feedback, you know, positive or negative because we do 4 want to know. 5 Q. But there's not one rating system, WebMD or 6 doctors.com or Google that you look at more than any 7 others? 8 A. No. I mean, HCAHPS is important to me, so 9 if I'm going to look at anything, our efforts are to 10 increase our participation in HCAHPS. That is the goal 11 so we can really get a solid understanding of our 12 opportunities. 13 Q. And HCAHPS, just for the record, that's 14 through CMS, correct? 15 A. Yes. 16 Q. And that, as we talked earlier, Press Ganey 17 is the vendor for CMS that Good Samaritan has to 18 collect those HCAHPS scores? 19 A. Yes. 20 Q. To you as the CEO of Good Samaritan, what is 21 the most important patient ratings service available? 22 MR. MARCUS: Object to form. 23 A. Important? What is important to me is that 24 we improve our HCAHPS and get our patients to respond 25 to HCAHPS.	Page 161 1 group Exhibit 5? 2 A. Yes. 3 Q. Okay. And that would be the third document 4 in my group Exhibit, correct? 5 A. Yes. 6 Q. And the patient survey rating as of 7 9-13-2025 was one star, correct? 8 A. Correct. 9 Q. And the number of completed surveys is 822, 10 correct? 11 A. Yes. 12 Q. And do you understand is that 822 in a year? 13 A. That is my understanding. 14 Q. And the survey response rate was 15 percent, 15 correct? 16 A. Yes. 17 Q. Looking at this document, and, again, I'm 18 talking about the third document in group Exhibit 5 19 which is the patient survey rating, do the numbers and 20 percentages that you see on here comport with your 21 understanding of Good Samaritan's current patient 22 survey rating? 23 A. Actually, we have improved because I think 24 these are from maybe 2023. So there has been some 25 improvement in some of these questions.

Page 162 1 Q. And I think you testified earlier that the 2 reason some of this data I printed out just on 3 September 13th, 2025 is lower is because of publicly 4 available CMS data lags, correct? 5 A. It does lag. 6 Q. So the data that you may have at 7 Good Samaritan internally as of September 13th, 2025 8 would be more up to date than what I, the layperson, is 9 able to pull off of CMS, correct? 10 A. Correct. 11 Q. Do you have -- 12 A. And I think this is only Medicare patients, 13 too, unfortunately not all patients, but -- 14 Q. Correct. 15 A. -- yeah. 16 Q. But these were the HCAHPS scores that you 17 were just -- 18 A. Right. 19 Q. -- testifying about, correct? 20 And would you agree for me for at least 21 patient scores, it appears that Good Samaritan lags in 22 both the national average and the Florida average in 23 every category except one where it is even with the 24 Florida average? 25 MR. MARCUS: Object to form.	Page 164 1 Q. And it's one star, correct? 2 A. Yes. 3 Q. And do you know whether or not in June of 4 2024 Good Samaritan's overall CMS star rating was 5 one star? 6 A. I believe so. 7 Q. And if you look at the first page of my 8 group Exhibit, it says here at the bottom of the first 9 page, "The overall star rating is based on how well a 10 hospital performs across different areas of quality, 11 such as treating heart attacks and pneumonia 12 readmission rates and safety of care," correct? 13 A. Yes. 14 Q. And if you turn to the next page, it says 15 here that, "The patient survey rating measures 16 patient's experiences of their hospital care. Recently 17 discharged patients were asked about important topics, 18 like how well nurses and doctors communicated, how 19 responsive hospital staff were to their needs and the 20 cleanliness and quietness of the hospital environment." 21 Do you see that? 22 A. I do. 23 Q. And is that your understanding of what the 24 CMS patient survey rating is rating? 25 A. Yes, that is some of the questions for sure.
Page 163 1 A. That's what it appears. 2 BY MS. BLAIR: 3 Q. And do you know what the publicly available 4 CMS data was for -- I'm sorry. That's a terrible 5 question. 6 Do you know what the publicly available 7 patient survey rating was for Good Samaritan in or 8 around June of 2024? 9 A. Do I actually know the scores you're saying 10 in June? 11 Q. No, the stars. I apologize. 12 A. Oh, okay. The patient safety -- or, I mean, 13 patient experience, is that what you said? 14 Q. Patient survey rating as it's described. 15 A. Okay. In 2024? Similar, I believe. 16 Q. And if we turn to the second -- 17 A. I don't know. 18 Q. -- document in my group Exhibit, 19 Good Samaritan Medical Center, the overall star rating, 20 that's the page you have in front of you, right, it's 21 one of two pages? 22 A. Okay. 23 Q. This is the CMS overall star rating, 24 correct? 25 A. Yes.	Page 165 1 Q. And just for the record, is one star the 2 best or the worst? 3 A. The worst. 4 Q. And if we turn to the back of first document 5 in this group Exhibit page 4 of 4, you'll see this on 6 the back, "Consider this when choosing a hospital," do 7 you see that? 8 A. I do. 9 Q. And do you see under that it says, "Guide to 10 Choosing a Hospital PDF," do you see that? 11 A. I do. 12 Q. Have you ever read that document? 13 A. I have not. 14 Q. Do you have any understanding of whether or 15 not CMS instructs patients to review these star ratings 16 before they choose a hospital? 17 A. I don't know. I'd have to read the "Guide 18 to Choosing a Hospital." 19 Q. Would it surprise you if CMS tells patients 20 to look at their star ratings before choosing a 21 hospital? 22 MR. MARCUS: Object to form. 23 A. No. 24 BY MS. BLAIR: 25 Q. Have you ever had any discussions with

Page 166 1 Tenet Healthcare corporate home office about improving 2 Good Samaritan's CMS ratings? 3 MR. MARCUS: Object to form. 4 A. With corporate, I have not. 5 BY MS. BLAIR: 6 Q. Have you had any discussions with Palm Beach 7 Health Network about improving Good Samaritan's CMS 8 star ratings? 9 A. Yes. 10 Q. When did those discussions occur? 11 A. I would say specific discussions with CMS 12 star ratings, more recently. However, we have 13 discussions about everything that's on Medicare's CMS. 14 You know, there's like five domains, I believe, in CMS. 15 And those are things we work towards all the time. And 16 most of those domains are already on our balanced 17 scorecard. So, yes, we strive for CMS, but some of 18 those domains are already on our balanced scorecard 19 anyways. It's not like we don't strive to do those 20 things already. 21 Q. What is the highest CMS star rating 22 Good Samaritan has ever received? 23 A. I've only been there five years, so two 24 stars. 25 Q. And in what year was Good Samaritan a	Page 168 1 lagging. It's not like the information is not there, 2 you know, so, you know, if a patient wanted to get -- 3 it depends on what you're talking about out of the five 4 categories. There's a lot. There are 62 measures or 5 something in CMS score card. 6 Q. Right. And you would agree with me that CMS 7 evaluates things other than patient safety as well, 8 correct? 9 A. Correct. 10 Q. Do you know whether Good Samaritan tracks 11 its -- tracks how it's doing in hospital-acquired 12 infections as compared to competitors? 13 A. So on the balanced scorecard there's 14 targets. I believe those targets are national averages 15 or something. I'm not quite sure. I didn't develop 16 the scorecard, so... 17 Q. Who did develop the scorecard that we keep 18 talking about? 19 A. I'm not really sure. 20 MS. BLAIR: I'm going to show you a document 21 that we'll mark as Exhibit 6. 22 (Defendant's Exhibit Number 6 for i.d.) 23 BY MS. BLAIR: 24 Q. Ms. Montgomery, I've handed you now what 25 we've marked as Montgomery 6 to this deposition. This
Page 167 1 two-star CMS rated hospital? 2 A. I believe '21 and '22 maybe. 3 Q. Do you have any understanding of why the CMS 4 star rating declined in 2023, 2024, 2025? 5 A. So my understanding -- I haven't done a 6 complete analysis -- is patient experience was a big 7 driver. I'd have to look at what years are encompassed 8 in those patient experience. It's always a struggle 9 with CMS is everything is so lagging. We're always 10 trying to look at our current data and continue to 11 improve, but it takes a while as you improve to change 12 this. 13 Q. And would you agree with me that the CMS 14 data that is publicly available is that lagging data 15 that you were just discussing? 16 A. Is it lagging data? 17 Q. Yeah, so the publicly available CMS data 18 would be that lagging data that you were just 19 discussing, correct? 20 A. I'm almost positive most of it is lagging. 21 Q. And the only way for anyone other than CMS 22 to have access to current CMS data would be directly 23 from the hospitals themselves, correct? 24 A. I'm sure they can get a lot of the 25 information from CDC. I'm not sure why Medicare is	Page 169 1 is a document that was produced in discovery just a 2 couple of days ago. 3 A. Okay. 4 Q. Is this the scorecard you keep talking 5 about? 6 A. No, but this data goes into the scorecard. 7 Q. Okay. What is this document that we're 8 looking at that we've now marked as Exhibit 6? 9 A. This is probably something from -- these 10 might be quality updates. Yeah, these are the quality 11 updates that are sent out to the CNO and myself. 12 Q. Okay. 13 A. I'm not sure who else gets it as well. 14 Q. And if you look at like the bottom of the 15 first page of this Exhibit, for I think it's the bullet 16 point C, and just below there's this chart that's sort 17 of grayed out? 18 A. Um-hum. 19 Q. And it says, "the BSC target." What's BSC 20 stand for? 21 A. Balanced scorecard. 22 Q. Okay. So that's a reference to the 23 scorecard that you've been talking about today? 24 A. Correct. 25 Q. Okay. And the target is 15 or less C. diff

Page 170 1 infections for the year; is that correct? 2 A. Correct. 3 Q. And this looks like through for 2024 you had 4 15, correct? 5 A. Correct. 6 Q. Okay. So that's how I read that. 7 So the BSC that you've been referring to 8 today, that would have targets for patient safety and 9 quality? 10 A. Yes. 11 Q. And then who puts together these quality 12 updates? 13 A. Erin Britt. 14 Q. Okay. And who is she preparing this for? 15 A. Myself, the CNO. I'm not sure if it's 16 Gina West. 17 Q. And do you see them in this form when they 18 come to you? 19 A. You mean like this? 20 Q. Yes. 21 A. Yes. 22 Q. Okay. And if you look at the last page of 23 this document, it refers to PROMs data collection. 24 What's PROMs? 25 A. It's the new standard that you have to have	Page 172 1 just trying to understand documents that I have. 2 So this is not the scorecard that you keep 3 talking about, correct? 4 A. It is not. 5 Q. Okay. Thank you. 6 Is -- in order to get the accolade you get 7 for Healthgrades™, is there a survey that has to be 8 completed? 9 A. I don't believe so. I believe they pull 10 everything from the outcomes and data. I don't believe 11 so. 12 Q. And do you know whether or not participation 13 in Healthgrades™ is tied to any contract or payment 14 from Good Samaritan? 15 MR. MARCUS: Object to form. 16 A. Is it tied to any contract meaning? 17 BY MS. BLAIR: 18 Q. Healthcare contract or employer contract 19 or -- 20 A. Oh. 21 MR. MARCUS: Same objection. 22 A. Not to my knowledge. 23 BY MS. BLAIR: 24 Q. Is it tied to any payment -- or I'm sorry. 25 Strike that.
Page 171 1 for orthopedic patients. I think it was rolled out by 2 Medicare. It's a bunch of different data you have to 3 submit. It's new. Wasn't anything you had to do 4 before. 5 Q. Okay. And above that, the bullet point, 6 what's "GBC extraction"? 7 A. Global business center. 8 Q. Okay. And then the third indented bullet 9 point says "PCI." What's PCI? 10 A. It's a medical term. You'd have to Google 11 it. I don't know the -- 12 Q. Okay. 13 A. It's -- where is it at on here? 14 Q. It's under "GBC extraction," and it's the 15 third indented bullet point, "PCI, no cases extracted 16 since Q4 '23," "P" as in "Paul"? 17 A. I know. What page are you on? 18 Q. The very last page, quality. 19 A. Oh, sorry. I was totally on the wrong page. 20 THE STENOGRAPHER: Just read it to yourself 21 or out loud, one or the other. 22 THE WITNESS: Okay. I'll read it to myself. 23 A. I'm not quite sure. 24 BY MS. BLAIR: 25 Q. That's okay. Again, not a memory test. I'm	Page 173 1 Is it tied to any local regulatory 2 requirement? 3 MR. MARCUS: Object to form. 4 A. Not to my knowledge. 5 BY MS. BLAIR: 6 Q. Is participation in Healthgrades™ approved 7 by Tenet home office? 8 A. I'm not sure. 9 Q. Do you know whether or not participation in 10 Healthgrades™ needs to be improved by Tenet Healthcare 11 home office? 12 A. I don't know that either. 13 Q. Is engagement -- is positive -- strike that. 14 Are accolades given to Good Samaritan from 15 Healthgrades™ tied to your compensation in any way? 16 A. No. 17 Q. Do you know whether or not Good Samaritan 18 participates in U.S. News & World Report hospital 19 rankings? 20 A. I'm not sure. 21 Q. Do you know whether or not the hospital 22 participates in the Lown Hospital, L-o-w-n, hospital 23 rating system? 24 A. I'm not aware of that. 25 Q. Have you ever heard of that before I said it

Page 174 1 to you? 2 A. I have not. 3 Q. Is your compensation tied in any way to how 4 well Good Samaritan does on its CMS star ratings? 5 A. No. 6 THE VIDEOGRAPHER: Can we go off record for 7 a media change? 8 MS. BLAIR: Sure. 9 THE VIDEOGRAPHER: This ends media two. 10 We're going off the record. The time is 11 1:56 p.m. 12 (A recess was taken from 1:56 p.m. to 2:11 p.m.) 13 THE VIDEOGRAPHER: This begins media three. 14 We're back on the record. The time is 2:11 p.m. 15 BY MS. BLAIR: 16 Q. Mrs. Montgomery, right before the break I 17 was asking about your compensation, whether your 18 compensation was tied to participation in certain types 19 of -- or on performance with respect to the hospital 20 ratings. 21 Do you recall that? 22 A. Yes. 23 Q. And if you could turn to what we previously 24 marked as Exhibit 2 and specifically interrogatory 25 number 18 on page 27, now I'm curious if whether the	Page 176 1 previous answer was that it's not related to ratings by 2 third-party ratings organization; is that true? 3 A. I think you asked me is my compensation 4 related to CMS star rating, I think, is what you said. 5 Q. So let me ask it more general. Thank you. 6 Let me ask it in a more general and I'll break these 7 down because there are multiple things here. 8 Is your compensation, your compensation tied 9 to patient safety in any way? 10 A. Yes. 11 Q. How? 12 A. The balanced scorecard. 13 Q. All right. 14 A. So there's patient safety things on the 15 balanced scorecard. 16 Q. Okay. What about union worker contracts, is 17 it tied to that? 18 A. No. 19 Q. What about ratings by third-party ratings 20 organizations? 21 A. No. 22 Q. Okay. So the -- and this question was not 23 only with respect to your compensation but other 24 executive leadership officers. Do you see that? 25 A. Or any other executives, yes, I do.
Page 175 1 word "not" is missing in this answer is going to be my 2 question. 3 Once you get there, let me know. 4 So you see at the top of the page? 5 A. 27? 6 Q. Yes, at the top of page interrogatory 18 7 says, "State whether the compensation of your chief 8 executive officer" -- which would be you -- "or any 9 other executive level leadership officer is tied to or 10 related in any way to your hospital's performance on 11 patient safety, union worker contracts or your 12 hospital's ratings by third-party ratings 13 organization, ratings publications." 14 Do you see that? 15 A. I do. 16 Q. And the amended answer says, "Plaintiffs' 17 performance on patient safety union worker contracts or 18 ratings by third-party ratings publications is related 19 in some way to the compensation of the plaintiff's 20 chief officer or other executive level officers." 21 Do you see that? 22 A. Yes. 23 Q. Is that a true statement? 24 A. Yes. 25 Q. Okay. So it may, then, be that your	Page 177 1 Q. Are there any other executive level 2 leadership officers whose performance is tied to the 3 balanced sheet, the balanced scorecard you mentioned? 4 A. Right, yes, my administrative team. 5 Q. And who's on your administrative team? 6 A. The CNO, CFO, COO, CHRO. 7 Q. Anyone else? 8 A. No. 9 Q. And so just so my record is clear, the 10 answer to this question relates solely to patient 11 safety and specifically the balanced scorecard that 12 we've been discussing here today, correct? 13 A. Yes. 14 Q. And that balanced scorecard that I've not 15 seen, can you tell me what -- again, you may have 16 already, and I apologize -- what is on that balanced 17 scorecard? 18 A. There are a lot of measures on it, but 19 HCAHPS HAI's, HAI's are on there, transfer acceptance 20 rate is on there, ODE ratio is on there. There's an ED 21 indicator on there. It might be -- I'm not sure which 22 one it is but something related to the emergency 23 department. Might be left without being seen or 24 something of that nature. 25 What else is on there?

Page 178 1 I think SSI is on there. Adjusted 2 admissions is on there. EBITDA. I think that's the 3 majority. 4 Q. Okay. And I know what -- for the record, 5 HAI's are hospital-acquired infections, correct? 6 A. Yes. 7 Q. Transfer acceptance rates, what are those? 8 A. We have a transfer center for our network 9 accepting -- the goal is 85 percent accepting of the 10 transfers. 11 Q. Okay. I don't even know what that means so 12 I'll try to break it down. 13 There's a transfer center for your network? 14 A. Yeah. So basically the transfer from any 15 other hospital into our organization, you know, they 16 manage that whole process and reaching out to us to see 17 if we have the services, can we accommodate the 18 patient, things like that. 19 Q. And is that transfer acceptance from within 20 these five hospitals only or other hospitals as well? 21 A. It can be, yeah, it's everyone. 22 Q. Does Good Samaritan accept transfers from 23 Jupiter? 24 A. Yeah, we have. 25 Q. Do you accept transfers from any of the	Page 180 1 patient that we're making every effort to ensure we can 2 accommodate a patient being transferred. 3 Q. And are you -- is Good Samaritan a level I 4 trauma center? 5 A. It is not. 6 Q. Okay. So that doesn't count like accepting 7 patients, going on bypass, for example? 8 A. Trite. Trauma centers are different. 9 They're the only two in the county, so... 10 Q. When you talk about O to E ratios, what does 11 "O to E" stand for? 12 A. Expected over observed, length of stay. 13 Q. Got it. And so is that measure measuring 14 whether or not you are discharging patients in a timely 15 manner? 16 A. You could look at it that way. It's really 17 just a measure of Medicare gives you an amount of time 18 a patient should be in a hospital, you know, for a 19 certain DRG, and are we meeting that. 20 Q. Got it. The ED indicator, emergency 21 department, correct? 22 A. Yes. 23 Q. And that, what is that measuring, to the 24 best of your knowledge? 25 A. I think it's the left without being seen,
Page 179 1 other four hospitals in the Palm Beach Health Network? 2 A. I mean, we can. It just depends, you know, 3 if you have a certain service and someone else doesn't 4 have it. 5 Q. Would that, if you transferred, let's just 6 say a patient from Delray into Good Samaritan, would 7 that be part of the 85 percent transfer rate you're 8 trying to get to? 9 A. Internal? Yeah, it is. 10 Q. Okay. And can you not accept patients? Is 11 that -- 12 A. Yes. 13 Q. I guess I'm -- 14 A. Yes. 15 Q. So it's measuring whether or not 16 Good Samaritan has put into place processes that it can 17 accept patients from other hospitals, is that what that 18 rate is measuring? 19 A. Yes. And that we, you know, we're making 20 sure that we have the coverages for services. You 21 know, sometimes it's the patient -- might be a patient 22 request to, and it might not have anything to do with 23 the service, for example, that they request a different 24 hospital, so that would be part of transfers. But it's 25 just making sure that when we're requested to take a	Page 181 1 WL -- or LWBS, I think, is what's on the balanced 2 scorecard or it might be how long it took to see a 3 patient once they hit the emergency room -- 4 Q. Got it. 5 A. -- you know, like the length of stay. It's 6 one of two of those measures. 7 Q. And SSI, what does that stand for? 8 A. Surgical site infection. 9 Q. And that's different than HAI, right? 10 A. Yes. 11 Q. Adjusted admission, what does that mean? 12 A. It takes admissions plus outpatient, the 13 volume and -- it's a calculation, put it that way. 14 Q. Okay. 15 A. Basically it's admissions and outpatient 16 visits combined together but equating an outpatient 17 visit to an admission, so it's relatable. 18 Q. That makes sense. And then HAI is your, I 19 assume you're looking at CAUTI and CLABSI? 20 A. Yes. 21 Q. Anything else? 22 A. C. diff, MRSA. 23 Q. And those are all things that are on our -- 24 are measured by the CMS as well, correct? 25 A. Correct.

Page 182 1 Q. And I want to talk briefly about prior to 2 2020 -- prior to 2020, Good Samaritan participated in 3 the Leapfrog survey, correct? 4 A. I wasn't there, but I believe the network 5 did before 2020. 6 Q. And -- 7 A. I don't -- 8 Q. I'm sorry. Go ahead. 9 A. Go ahead. 10 Q. Do you have any understanding of whose 11 decision it was for the network to participate in the 12 Leapfrog survey? 13 A. To participate? 14 Q. Correct. 15 A. I don't know. 16 Q. And who was the CEO of Tenet Healthcare 17 prior to 2020? 18 A. Saum. He was still the CEO. 19 Q. He was? 20 A. Um-hum. 21 Q. He did not become the CEO in 2021? 22 A. I don't -- no, because I went to Good Sam in 23 2020 and he was the CEO then. 24 Q. Do you know when Saum became the CEO of 25 Tenet Healthcare?	Page 184 1 Q. No, I mean -- yes, that was a terrible 2 question. 3 Like children's hospitals can do the survey, 4 correct? 5 A. I don't know that. 6 Q. Okay. So there's the hospital survey on the 7 one hand, and then there's the hospital safety grades 8 on the other hand. Do you understand that? 9 A. The safety grades as in the F? 10 Q. Correct. 11 A. (Nodding head). 12 Q. You understand that? 13 A. I do. 14 Q. Do you have an understanding of how many 15 measures on the hospital safety grade exist? 16 A. 22. 17 Q. And do you understand that not all of those 18 measures come from the Leapfrog survey? 19 A. I understand that. 20 Q. So with that understanding, I'm talking 21 about just participating in the survey, because do you 22 understand that all hospitals are graded whether they 23 participate in the survey or not? 24 MR. MARCUS: Object to form. 25 A. I am aware.
Page 183 1 A. Probably in 2019, '18. I'm not sure. 2 Q. Okay. And so while Saum was the CEO of 3 Tenet Healthcare, your understanding is that these five 4 hospitals participated in the Leapfrog survey, correct? 5 A. I believe so. 6 Q. And do you have an understanding that the 7 Leapfrog survey is separate and distinction from the 8 hospital ratings program? 9 MR. MARCUS: Object to form. 10 A. What do you mean? 11 BY MS. BLAIR: 12 Q. Well, do you understand there's a survey -- 13 Well, let's go back to the beginning. 14 There is a Leapfrog Hospital Survey, 15 correct? 16 A. Correct. 17 Q. Have you seen that survey before? 18 A. I have. 19 Q. And it's like three, 400 pages, correct? 20 A. Yes. 21 Q. And lots of different types of hospitals can 22 engage in the Leapfrog Hospital Survey. Do you have an 23 understanding of that? 24 A. You mean many hospitals participate in the 25 survey, is that what you mean?	Page 185 1 BY MS. BLAIR: 2 Q. Okay. Now, I was focusing just on 3 Good Samaritan. Do you know when Good Samaritan 4 started participating in the Leapfrog Hospital Survey? 5 A. I don't. 6 Q. Do you know whether or not when 7 Good Samaritan did participate in the Leapfrog Hospital 8 Survey, whether it ever had to pay a fee to participate 9 in the survey? 10 A. I don't know. 11 Q. Do you know whether or not hospitals today 12 that are participating in the Leapfrog Hospital Survey 13 pay a fee to participate in the survey? 14 A. Pay a fee to Leapfrog? 15 Q. Correct. 16 A. To take the survey? 17 Q. Correct. 18 A. No. 19 Q. Do you know whether or not hospitals pay a 20 fee -- well, strike that. 21 Do you know whether or not hospitals, all 22 acute care hospitals, whether they fill out the survey 23 or not, have access to the information contained in the 24 survey? 25 A. Do they have access, like to the survey?

Page 186 1 Q. Correct. 2 A. Yes. 3 Q. And to the best of your knowledge, Leapfrog 4 does not charge any hospital in the United States of 5 America to access its survey materials, correct? 6 MR. MARCUS: Object to form. 7 A. Not to my knowledge, but... 8 BY MS. BLAIR: 9 Q. Is there a "but" there? 10 A. Not to my knowledge. 11 Q. Do you have an understanding that the 12 Leapfrog Hospital Survey is publicly available on the 13 leapfroggroup.org website to anybody that wants to 14 download it? 15 A. Yes. 16 Q. Do you know whether or not Good Samaritan 17 has ever paid any money to Leapfrog for anything? 18 A. I don't know if they have in the past. 19 Q. Do you have an understanding that at some 20 point in the history of Good Samaritan it received an A 21 grade from Leapfrog? 22 A. Not to my knowledge. 23 Q. To your knowledge, in the history of 24 Good Samaritan hospital has Good Samaritan ever been 25 approached by Leapfrog or solicited by Leapfrog to pay	Page 187 1 for consulting services provided by Leapfrog? 2 A. I don't know if that has ever occurred. I'm 3 not aware of it. 4 Q. Do you know whether or not Leapfrog has 5 consulting services that a hospital can purchase? 6 A. That is my understanding. 7 Q. How did you come to that understanding? 8 A. I don't recall. It's just a general that 9 you can pay Leapfrog for, you know, consulting fees to 10 help you with your grade. 11 Q. Have you -- 12 A. I don't recall who told me that. I don't 13 know. 14 Q. Have you ever done any independent 15 investigation into whether or not that statement is 16 true? 17 A. I have not. 18 Q. And as the corporate representative of 19 Good Samaritan, do you have any idea as to whether or 20 not the statement that Leapfrog charges for consulting 21 services is true? 22 A. Yes. 23 Q. And what is that? 24 A. I would say some of that is true. 25 Q. What is that based on?	Page 188 1 A. Well, I didn't see a document myself, but in 2 conversations with individuals that would know, like 3 quality directors. 4 Q. Which quality director told you that 5 Leapfrog charges for consulting services? 6 A. Gina West. 7 Q. So when I take Gina West's deposition, she's 8 going to testify that she indicated to you that 9 Leapfrog charges hospitals for consulting services? 10 MR. MARCUS: Object to form. 11 A. I would say, yes. 12 BY MS. BLAIR: 13 Q. Do you -- 14 A. There's definitely been conversations with 15 her about the payment to Leapfrog and how it works. 16 Q. What is your understanding of the payment to 17 Leapfrog and how it works? 18 A. You could pay Leapfrog for consulting to 19 help you with your grades. You have to pay Leapfrog if 20 you want to advertise your grade. That is my 21 understanding. 22 Q. And your understanding comes solely from 23 conversations with Gina West? 24 A. I mean, it might not have just been Gina. 25 It's been a general conversation and knowledge that	Page 189 1 people have. 2 Q. And you've done nothing to investigate 3 whether or not that's true? 4 A. What, to go try to find a contract from 5 Leapfrog or something and ask them for their fees? 6 Q. Well, have you ever even looked at their 7 website to see if consulting services are offered? 8 A. I didn't go to look to see if consulting 9 services were offered. I had no reason to doubt what 10 was being -- the general idea of what everybody knows 11 to be. Just never had a doubt. 12 Q. But you signed a declaration under oath 13 that, in fact, Leapfrog charges for consulting services 14 for hospitals to get better grades, correct? 15 A. That's what I was told. 16 MR. MARCUS: Object to form. 17 BY MS. BLAIR: 18 Q. And that sworn statement under oath is based 19 on what you were told, correct? 20 A. Correct. 21 Q. And you were told that by Regina West, 22 correct? 23 A. She is one of the individuals. 24 Q. Who were the others? 25 A. I don't know exactly who they were, but I
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Page 190 1 know we've had conversations about how Leapfrog 2 generates revenue. 3 Q. And you believe the answer to the question 4 as to how Leapfrog generates revenue is by charging for 5 consulting services to help hospitals get better 6 grades? 7 MR. MARCUS: Object to form. 8 A. One of them. 9 BY MS. BLAIR: 10 Q. I want to focus on the consulting services. 11 You testified that you believe the consulting services 12 are that you can pay Leapfrog to help you get better 13 grades. Are there other consulting services, 14 consulting services that you believe Leapfrog charges 15 for? 16 A. I mean, other than helping you with, 17 obviously, all the things that are in the Leapfrog 18 survey, I don't know. 19 Q. And so as you sit here today, you believe 20 that Leapfrog has a program where it will help 21 hospitals get a better grade? 22 MR. MARCUS: Object to form. 23 A. I wouldn't say the motivation is just to get 24 a better grade, but whatever is part of the survey, you 25 know, anything that they can help in those areas, yes,	Page 192 1 Q. So it's your belief that if you don't 2 participate in the Leapfrog Hospital Survey, you will 3 be failed? 4 A. Yes. There are seven measures that are not 5 provided -- information is not provided, and it's 6 35 percent, so you're already starting out with a very 7 bad grade. 8 Q. Are you aware that in the State of Florida 9 there are only ten hospitals that did not participate 10 in the Leapfrog Hospital Survey, and the only Fs that 11 were given were four of the hospitals that are 12 plaintiffs in this litigation? 13 MR. MARCUS: Object to form. 14 A. No. 15 BY MS. BLAIR: 16 Q. Are you aware that there are hospitals that 17 do not participate in the Leapfrog Hospital Survey that 18 received A's? 19 MR. MARCUS: Object to form. 20 A. No. 21 BY MS. BLAIR: 22 Q. Have you undertaken any investigation before 23 filing this lawsuit to determine whether or not that's 24 true? 25 A. Yes.
Page 191 1 that's what I believe. 2 BY MS. BLAIR: 3 Q. And you believe that based on just general 4 conversations you've had with Regina West and others? 5 A. Correct. 6 Q. And other than Regina West, can you name 7 another person that you've had that conversation with? 8 A. I mean, I'm going to say, no, for now 9 because I can't identify necessarily a person. They're 10 just conversations. 11 Q. Okay. Did you ever tell the governing board 12 that Leapfrog charges for consulting services to 13 hospitals so that they can get a better grade? 14 A. I don't believe so. 15 Q. Are you aware that there's an allegation in 16 this Complaint that Leapfrog is a "brazen play [sic] to 17 pay [sic] scheme"? 18 A. I'm aware of that, yes. 19 Q. And what is the "brazen pay to play scheme" 20 in your opinion? 21 A. Well, the pay really is your participation 22 and sharing of data and information. 23 To play is, you have to participate. If you 24 don't participate, you will be failed and receive a 25 failing grade.	Page 193 1 Q. And you don't believe there are any 2 hospitals that don't participate in the Leapfrog 3 hospital surveys that receive anything but an F? 4 MR. MARCUS: Object to form. 5 A. Or a D. It would be highly statistically 6 impossible. Maybe you could get a C, but I highly 7 doubt it. 8 BY MS. BLAIR: 9 Q. If I -- 10 A. Mathematically it doesn't work. 11 Q. If I produced to you evidence that there are 12 hospitals in the United States of America that do not 13 participate in the Leapfrog Hospital Survey that 14 receive an A, would you disagree with that? 15 A. I would be incredibly shocked that that's 16 possible. 17 Q. Okay. If I produced to you -- have you read 18 any of the expert reports from defendants in this 19 matter? 20 A. What do you mean? 21 Q. Well, do you understand that my clients have 22 experts that have produced reports in this matter? 23 A. Oh, okay. 24 Q. Do you dispute there are ten hospitals in 25 the State of Florida that did not participate in the

Page 194 1 Leapfrog hospital safety grade in fall 2024? 2 A. I wouldn't know. 3 Q. Do you dispute that five of those hospitals 4 of the ten received grades of C or better? 5 MR. MARCUS: Object to form. 6 A. So five of the hospitals that did not 7 participate -- 8 BY MS. BLAIR: 9 Q. In the State of Florida. 10 A. -- received an A or a B? 11 Q. No, I said a C or better. 12 A. Oh, a C or better. 13 MR. MARCUS: Same objection. 14 A. Like I stated before, it could be 15 statistically possible to get a C. You would have to 16 be next to perfect of a hospital. I don't know how it 17 would be possible to get an A statistically. 18 BY MS. BLAIR: 19 Q. But if evidence is produced in this 20 litigation that hospitals that don't participate in the 21 Leapfrog Hospital Survey receive A's, you would have no 22 reason to dispute that, correct? 23 MR. MARCUS: Object to form. 24 A. What I would say is that us not 25 participating produced an F and would not have had we,	Page 196 1 BY MS. BLAIR: 2 Q. And we'll get to that. 3 When Leapfrog -- or I'm sorry. 4 When Good Samaritan did participate in the 5 Leapfrog Hospital Survey, do you have any reason to 6 dispute that it accurately reported to the Leapfrog 7 survey? 8 MR. MARCUS: Object to form. 9 A. What do you mean exactly? 10 BY MS. BLAIR: 11 Q. Well, if we look at -- and I'll just mark 12 this now, I guess, Exhibit 7. 13 (Defendant's Exhibit Number 7 for i.d.) 14 BY MS. BLAIR: 15 Q. Ms. Montgomery, I've just now handed you 16 what we've marked as Exhibit 7 which is a copy of the 17 Amended Complaint in this matter. 18 As you'll see at the top of this document, 19 it was filed on August 28th, 2025. Have you seen this 20 document before today? 21 A. I believe so. I've seen so many that look 22 familiar like this. I mean, I think. I've seen so 23 many documents. I can take the time to read through 24 this whole thing. 25 Q. Oh, that's okay.
Page 195 1 so, to me, that's what's really important to me. 2 BY MS. BLAIR: 3 Q. But I thought you said earlier that if you 4 don't participate, you get an F. Is that your belief? 5 MR. MARCUS: Object to form. 6 A. That is my belief that is what happened to 7 our five hospitals. 8 BY MS. BLAIR: 9 Q. And I don't want to talk about just your 10 five hospitals. 11 Do you believe that under the Leapfrog 12 rating methodology as it stands today that if a 13 hospital does not participate in the Leapfrog Hospital 14 Survey, it receives an F? 15 MR. MARCUS: Object to form. 16 A. I didn't say an F. A failing grade. And 17 what I did say earlier is it could be possible that you 18 could get a C if you were a perfect hospital. I don't 19 know how you would get an A. But the bottom line is I 20 would have been a C. I'm an F because I didn't 21 participate. 22 There are seven indicators in there. That's 23 35 percent of the grade that -- and it's a voluntary 24 survey -- that we didn't participate and we got a 25 failing grade.	Page 197 1 A. I don't know if I've seen this exact 2 document. A lot of the language looks the same, so I'm 3 not sure if I read through this whole document. 4 Q. Sure. And let me just go back a little 5 ways. You understand that there was a Complaint filed 6 against Leapfrog on April 30 of 2025, correct? 7 A. Right. 8 Q. Did you have any involvement -- and, again, 9 I don't want to know about any direct communications 10 you had with any of your attorneys, but did you have 11 involvement with reviewing and filing the Complaint 12 before it was filed? 13 A. I think I reviewed things specific to like 14 me and things that I had to approve on, sign off on 15 that was for Good Samaritan. This seems like a larger 16 document than I recall. 17 Q. Okay. And just for the record, there was a 18 Complaint filed on April 30 of 2025. After some 19 discussions between the lawyers and a court appearance, 20 there was an amendment to the Complaint on August 28th. 21 And I want to direct your attention specifically to 22 paragraph 27 of the Amended Complaint. 23 And before I got this Complaint out, I asked 24 you about whether or not Good Samaritan accurately 25 reported its data to the Leapfrog Hospital Survey when

Page 198 1 it participated. And specifically looking at paragraph 2 27 of the Amended Complaint, which, for the record, is 3 identical to former paragraph 55 of the original 4 Complaint, it says "Another way TLG's deceptive methods 5 punish nonparticipating hospitals is by rewarding 6 participating hospitals with grade inflation." 7 Do you see that sentence? 8 A. I do. 9 Q. And then it goes on to say, "The data 10 provided by hospitals that do participate in the TLG 11 Hospital Survey is self-reported, biased and subject to 12 manipulation." 13 Do you see that? 14 A. I do. 15 Q. The next sentence, "The plaintiffs in this 16 case say median responses for hospitals that report 17 their own scores show that those hospitals inflate 18 their performance." 19 Do you see that? 20 A. I do. 21 Q. And so my question is, is it your position 22 that Good Samaritan inflated its performance when it 23 engaged in the Leapfrog Hospital Survey? 24 MR. MARCUS: Object to form. 25 A. It says, "...median responses for hospitals	Page 200 1 measures that are on the Leapfrog Hospital Survey. 2 They are CPOE, BCMA, IPS, which is ICU staffing, and 3 hand hygiene. Do you understand those are the four 4 imputed measures at issue in this litigation? 5 A. I do. 6 Q. And, for the record, CPOE, what does that 7 mean to you? 8 A. Physician order entry. 9 Q. Computerized? 10 A. Computerized. 11 Q. BCMA, what does that mean to you? 12 A. Barcode administration. 13 Q. Hand hygiene, what do you understand that to 14 mean in the context of Leapfrog Hospital Survey? 15 A. Hand washing, hand washing policies, 16 et cetera. 17 Q. And what about IPS or ICU staffing, what 18 does that mean to you in the context of Leapfrog 19 Hospital Survey? 20 A. Critical care trained physicians being in 21 the hospital in your ICU. 22 Q. And what types of -- on behalf of 23 Good Samaritan, what types of information did you 24 provide to be produced in this litigation "sufficient 25 to simulate responses" for those four measures?
Page 199 1 that report their own scores showed that those 2 hospitals inflate their performance." 3 Well, I'm pretty confident we didn't inflate 4 our performance. 5 BY MS. BLAIR: 6 Q. Okay. Do you have any evidence that -- any 7 evidence of a hospital inflating its performance on the 8 hospital, Leapfrog Hospital Survey? 9 A. I do not. 10 Q. And so there are no specific competitors of 11 yours that you are accusing of manipulating the data 12 that they've reported to the Leapfrog Hospital Survey? 13 A. I am not. 14 Q. One of the things that your attorneys agreed 15 to produce in this litigation was documents sufficient 16 to simulate responses for the four measures on the 17 Leapfrog Hospital Survey that we are referring to in 18 this litigation as the imputed measures. Do you have 19 an understanding that that information was requested of 20 Good Samaritan? 21 A. By who? I'm sorry. 22 Q. Your attorneys. 23 A. Okay. Yes. 24 Q. Okay. And when I say "the imputed measures" 25 for purposes of this deposition, I'm referring to four	Page 201 1 MR. MARCUS: Object to form. 2 A. Those four measures. 3 BY MS. BLAIR: 4 Q. What documents did you produce sufficient to 5 simulate? 6 A. I believe that quality produced the 7 documents. But I also did answer based on quality they 8 have systems that track this stuff, CPOE for example. 9 Q. Okay. And when you say quality produced 10 these documents, would that be Regina West? 11 A. Yes, or Erin Britt. 12 Q. Did you attempt to rerun -- did you attempt 13 to -- well, strike that. 14 What did you do as the CEO of Good Samaritan 15 to ensure that the document responses that have been 16 provided in this litigation for those four measures 17 was, in fact, accurate and sufficient to simulate 18 responses to the Leapfrog Hospital Survey from fall of 19 2024? 20 A. I saw them myself. 21 Q. You saw the documents yourself? 22 A. Right. 23 Q. Did you take the survey and match it up to 24 make sure there was sufficient information to answer 25 all the questions on the survey?

Page 202 1 A. Did I take the survey? What do you mean? 2 Q. Yeah, so your hospital gathered documents 3 that are sufficient to simulate, correct? 4 A. Yes. 5 Q. For each of these four measures, correct? 6 A. That is my understanding. 7 Q. And I think you just testified then you 8 reviewed those documents before you provided them to 9 your attorneys, correct? 10 A. Yeah, the CPOE percentage, hand washing 11 percentage, those documents I looked at. 12 Q. Okay. And in trying to figure out whether 13 or not Good Samaritan was producing sufficient 14 information to simulate the responses to the Leapfrog 15 Hospital Survey, did you compare the documents to the 16 questions on the survey itself? 17 A. I did not. 18 Q. When Leapfrog -- I'm sorry. 19 When Good Samaritan participated in the 20 Leapfrog Hospital Survey, do you know whether or not 21 Good Samaritan derived any benefit from participating 22 in the survey? 23 MR. MARCUS: Object to form. 24 A. Not to my knowledge. 25 BY MS. BLAIR:	Page 204 1 A. I would say quality. 2 Q. And quality would be Regina West? 3 A. Yes. 4 Q. And the others you've talked about today 5 that are in quality? 6 A. Right. 7 Q. Would you agree with me that the CPOE 8 measure is distinct to the Leapfrog Hospital Survey? 9 MR. MARCUS: Object to form. 10 A. No, I'm pretty confident that it was rolled 11 out originally by like Medicare, and there's -- they 12 want you to be, I think, 85 percent or something. I 13 can't recall, but... 14 BY MS. BLAIR: 15 Q. Are you aware that to comply with the 16 Leapfrog CPOE standard there is a testing of the system 17 that has to be undergone in realtime? 18 MR. MARCUS: Object to form. 19 A. A testing of the CPOE system? 20 BY MS. BLAIR: 21 Q. Correct. 22 MR. MARCUS: Same objection. 23 A. Like testing it how? What do you mean? 24 BY MS. BLAIR: 25 Q. Well, there's a two-hour test that is
Page 203 1 Q. Do you know whether or not Good Samaritan 2 has ever used at any time the Leapfrog Hospital Survey 3 as a benchmarking tool? 4 A. Not to my knowledge. 5 Q. Do you know whether or not Good Samaritan 6 has ever used the Leapfrog Hospital Survey to inform 7 its own patient safety plan? 8 A. To inform its own? I don't know what you 9 mean by that. 10 Q. Sure. So Good Samaritan has a patient 11 safety plan. We talked about it earlier today, 12 correct? 13 A. Correct. 14 Q. And I think you told me that there would be 15 somebody in the quality department that would -- that 16 would first corporate and then on a local level put 17 together that patient safety plan; is that fair? 18 A. That's fair. 19 Q. Do you know whether or not anyone either at 20 corporate or on the local level looks at the Leapfrog 21 Hospital Survey to figure out what should be in the 22 patient safety plan? 23 A. I mean, not to my knowledge. If that 24 occurs, I'm not aware or I don't recall. 25 Q. Who would know that?	Page 205 1 required to comply with the Leapfrog CPOE standard in 2 which a physician, a quality person and a nurse must be 3 present at, and they give you prompts to test the CPOE 4 system. 5 A. Oh. 6 Q. Are you aware of that? 7 A. No. 8 MR. MARCUS: Object to form. 9 BY MS. BLAIR: 10 Q. Are you aware of whether or not 11 Good Samaritan attempted to complete that test in order 12 to provide sufficient to simulate responses for the 13 CPOE measure in this litigation? 14 MR. MARCUS: Object to form. 15 A. I am not. 16 BY MS. BLAIR: 17 Q. According to your declaration -- well, 18 strike that. 19 You understand that you signed a declaration 20 in this litigation on May 15th, 2025, correct? 21 A. Yes. 22 Q. And that declaration was attached to a 23 motion for preliminary injunction, correct? 24 A. This is a lot of legal -- 25 Q. Oh, sorry.

Page 206 1 A. You know, you'll have to talk hospital 2 language my way. 3 Q. That's fine. I'm trying to learn the 4 hospital language. 5 For what purpose -- for what purpose do you 6 understand your declaration was drafted and signed? 7 MR. MARCUS: And, again, don't refer to any 8 conversations with counsel. 9 MS. BLAIR: Sure. 10 MR. MARCUS: I'm not sure she can answer 11 that question. 12 BY MS. BLAIR: 13 Q. Okay. Do you have an understanding of 14 whether or not your declaration was produced in this 15 litigation? 16 A. Do I have an understanding whether it was? 17 Q. Correct. 18 A. Yes. 19 Q. And do you know whether that declaration was 20 attached to any motions that have been filed in this 21 litigation? 22 A. That is my understanding. 23 Q. Okay. What is your understanding of which 24 motion it was attached to? 25 A. There were so many documents, honestly, that	Page 207 1 I had to review back and forth that, I mean, I would 2 have to see it. 3 Q. Okay. And I can show it to you. 4 Has anybody ever told you that your 5 declaration has been withdrawn in this litigation? 6 MR. MARCUS: And, again, not -- when she 7 asks you that, she's not talking about 8 attorneys. 9 BY MS. BLAIR: 10 Q. Correct, I'm not talking about attorneys. 11 A. Not talking about attorneys meaning what? 12 Q. I don't want to know about anything your 13 attorneys have told you or not told you. 14 A. Oh, Jesus. 15 Q. I can't know that. 16 A. Right. 17 No. 18 Q. Okay. And so as far as you know, that 19 declaration that you signed under oath on May 15th, 20 2025 is still part -- as far as you know, is still part 21 of this litigation, correct? 22 A. That's my understanding. 23 Q. When did Good Samaritan stop participating 24 in the Leapfrog Hospital Survey? 25 A. I think it was 2021, I think.
Page 208 1 Q. Why did Good Samaritan stop participating in 2 the Leapfrog Hospital Survey? 3 A. The first conversations, you know, after 4 COVID about what quality was spending time on and, you 5 know, either the Leapfrog survey was brought up, and it 6 was talked about that it was time-consuming and, you 7 know, there was, you know, didn't really add much 8 value, it wasn't like an accrediting body and that we 9 wanted to spend our time more doing surveys where, you 10 know, Joint Commission, for example. 11 Q. Do you know how much time Good Samaritan was 12 spending in, let's just say the last year it engaged in 13 the Leapfrog survey, in responding to the Leapfrog 14 survey? 15 A. I don't know, but looking at it, it looks 16 time-consuming, you know. 17 Q. Was there ever an FTE assigned to responding 18 to a Leapfrog survey? 19 A. I wouldn't say it's like an FTE. It would 20 be quality, so... 21 Q. Okay. And quality, are they physicians? 22 A. No. 23 Q. And so if you started at Good Samaritan as 24 the CEO in April of 2020, was there one year in which 25 you were the CEO of Good Samaritan in which	Page 209 1 Good Samaritan participated in the Leapfrog Hospital 2 Survey? 3 A. One solid year? 4 Q. Yes. 5 A. Well, if we stopped in '21, I would say 6 there wasn't a solid year probably. 7 Q. Let me ask it a different way because it was 8 a bad question. 9 Do you understand that the Leapfrog Hospital 10 Survey is annual? 11 A. Yes. 12 Q. Do you have a recollection of whether or not 13 when you were the CEO of Good Samaritan whether 14 Good Samaritan completed a Leapfrog Hospital Survey in 15 that year? 16 A. No. It's all kind of muddy. It was a long 17 time ago. I don't remember really. I just remember 18 the subject coming up and it being time-consuming, not 19 adding value, and we were going to spend our time doing 20 other things. 21 Q. Okay. So that's the reason why 22 Good Samaritan stopped engaging in the Leapfrog 23 Hospital Survey, correct? 24 A. Yes. It was a voluntary survey, and after 25 COVID, you know, quality was, as you can imagine, busy

Page 210 1 and needed to do a lot of things so we wanted to spend 2 our energy on like getting certified for orthopedics 3 with Joint Commission and things like that. 4 Q. Okay. And just to make sure, that is 5 also -- is that also the answer for Good Samaritan, as 6 the corporate representative of Good Samaritan the 7 reason why Good Samaritan stopped participating in the 8 Leapfrog Hospital Survey? 9 A. Yes. 10 Q. Was there a directive from Tenet home office 11 to stop participating in the Leapfrog Hospital Survey? 12 MR. MARCUS: Object to form. 13 A. I don't recall that. 14 BY MS. BLAIR: 15 Q. Do you recall whether you were involved in 16 any meetings at the Palm Beach Health Network group 17 level about all five hospitals ceasing participation in 18 the Leapfrog Hospital Survey in or around 2021? 19 A. So these, the conversations was with the 20 group CNO, Libby, about, you know, what we needed to 21 spend the time on in quality, so that would be a group 22 decision. 23 Q. Okay. And did you say Libby? 24 A. Yes. 25 Q. Who is Libby?	Page 212 1 A. No, I don't know anything about that. 2 Q. Do you have an understanding of what home 3 office means about "being tied directly to," "being 4 tied directly to payment or contract"? 5 MR. MARCUS: Object to form. 6 A. I don't. I don't know what else it means to 7 them. 8 BY MS. BLAIR: 9 Q. But you still participate in Healthgrades™ 10 even those it's not connected to payment or contract, 11 correct? 12 A. Correct. 13 Q. What was the reaction -- and I'm talking 14 about in 2021 -- when the five Palm Beach Health 15 Network hospitals made the decision to stop 16 participating in the Leapfrog Hospital Survey? What 17 was the reaction internally at the Palm Beach Health 18 Network to that decision? 19 A. You mean like my hospital? 20 Q. Yes. Were people upset that you weren't 21 going to participate? Were they fine with it? Were 22 they glad? Do you have any memory? 23 MR. MARCUS: Object to form. 24 A. I don't recall it ever being -- there really 25 wasn't a lot of -- what's the word -- focus on Leapfrog
Page 211 1 A. Philippe owe. Libby Flippo, she was the 2 group CNO at that time. 3 Q. So that would be before Ricky Ramirez? 4 A. Right. 5 Q. When does Ricky Ramirez enter the picture 6 for the group? 7 A. When Libby left, which was probably two and 8 a half, three years ago, somewhere around there. 9 Q. Where does Libby work now? 10 A. She's semi-retired. That's my 11 understanding. 12 Q. Do you have a recollection as to whether or 13 not the reasoning -- as to whether or not 14 Tenet Healthcare home office indicated to the 15 Palm Beach Health Network hospitals in or around 2021 16 that participation in the Leapfrog survey would not be 17 supported unless it was tied to a local requirement or 18 payer reimbursement? 19 MR. MARCUS: Object to form. 20 A. I recently read an email stating that. 21 BY MS. BLAIR: 22 Q. And do you have any recollection as to 23 whether that was the position back in 2021 when the 24 five Palm Beach Health Network hospitals stopped 25 participating?	Page 213 1 at all, so I feel like it was a nonevent that I recall. 2 BY MS. BLAIR: 3 Q. Would you agree with me that not a lot of 4 patients know what Leapfrog is? 5 MR. MARCUS: Object to form. 6 A. I would not agree with you, no. I think 7 they're very well aware now. 8 BY MS. BLAIR: 9 Q. Right now today? 10 A. Yes. 11 Q. I would agree with that. 12 Prior, in 2021, do you believe patients were 13 well aware of what Leapfrog is? 14 MR. MARCUS: Object to form. 15 A. I don't really know. I mean, quite frankly, 16 I would say that Leapfrog is out there more in the last 17 two years than they previously have been. You know, 18 you see advertisement for it, you know, a lot more than 19 you did in the past. 20 BY MS. BLAIR: 21 Q. And you would say that's like within in the 22 last two years? 23 A. I would say, last, yeah, couple years. 24 Q. At any time between 2021 when Good Samaritan 25 stopped participating in the Leapfrog Hospital Survey

Page 214 1 and September of 2024, had there been any internal 2 discussions at the Palm Beach Health Network group 3 level about rejoining the Leapfrog Hospital Survey 4 participation? 5 A. I don't recall other than that email that I 6 just recently saw a discussion about participating. I 7 don't recall any. I mean, if it did, I just don't 8 recall. 9 Q. And it wasn't important to you as the CEO of 10 Good Samaritan, the Leapfrog hospital safety grade? 11 A. No, it was not. Our focus is more on the 12 accrediting agencies than the survey. 13 Q. Do you know how much a hospital needs in its 14 budget to comply with the Leapfrog Hospital Survey? 15 MR. MARCUS: Object to form. 16 A. How much they need to budget to complete the 17 survey? 18 BY MS. BLAIR: 19 Q. Correct. 20 A. I don't know. I mean, it looks very 21 time-consuming. I'm sure it would take a few weeks 22 probably to complete, involving a lot of other 23 individuals. 24 Q. Does it take more or less time, in your 25 opinion, than those -- than the work that you talked	Page 216 1 This is an email from Maggie Gill to you 2 dated December 11, 2024. Do you see that? 3 A. I do. 4 Q. And I want to focus on the email from you to 5 Maggie Gill right underneath that top email dated 6 Tuesday, December 10th, 2024 at 8:10 p.m. 7 Do you see that? 8 A. Yes. 9 Q. And you said, "Thank you. I appreciate it. 10 Also, Gina did say they could handle without adding 11 resources as well." 12 Do you see that sentence? 13 A. Yes. 14 Q. And if we look down at the very bottom of 15 this page, the first email in this sequence is from 16 Maggie Gill to Regina West, Ricky Ramirez, 17 Teresa Urquhart and Mohammad Aslam, correct? 18 A. Yes. 19 Q. And it has a CC to Shelly Weiss? 20 A. Um-hum. 21 Q. Who is Teresa Urquhart, U-r-q-u-h-a-r-t? 22 A. She was the CEO at Palm Beach Gardens at the 23 time. 24 Q. Okay. And what about Mohammad Aslam, who is 25 he?
Page 215 1 about earlier with respect to the accreditations? 2 A. If I had to guess what takes more or less 3 time? The accreditations would take more resources. 4 I've never completed the Leapfrog survey myself, so... 5 Q. And you don't recall whether it was 6 completed during your time as the CEO of Good Samaritan 7 in April of 2020? 8 A. I don't know when it's really due. So if it 9 was due during my tenure there, then it was completed. 10 But I just, I don't recall. That was five years ago. 11 Q. Right. And you just don't have a memory of 12 how long that took at that time; is that fair? 13 A. Yes, correct. 14 MS. BLAIR: Can you mark this as Exhibit 8? 15 (Defendant's Exhibit Number 8 for i.d.) 16 BY MS. BLAIR: 17 Q. Ms. Montgomery, I'm now handing you what 18 we've marked as Exhibit 8 to this deposition. And, 19 again, I'm going to refer to this Bates number at the 20 bottom right-hand corner, PBHN, four zeros, 11358. Do 21 you have that in front of you? It's at the bottom 22 right-hand corner. 23 A. Yes. 24 Q. I just want to make sure we're reading the 25 same thing.	Page 217 1 A. I have no idea who that is. I don't know. 2 I'm drawing a blank there. 3 Q. What about Shelly Weiss? 4 A. She's PR for the group. 5 Q. For the group? 6 A. Yes. 7 Q. Does she work at a specific hospital in 8 addition to her group duties? 9 A. No. 10 Q. And you'll see Maggie Gill is saying to you, 11 "Please send me a request to reintroduce Leapfrog 12 reporting, including rationale, imputed score and 13 clippings of negative press and MD feedback." 14 Do you see that? 15 A. I do. 16 Q. And she says, "I will request an exception 17 for PBHN and PMC to start reporting next period," 18 correct? 19 A. Yes. 20 Q. What's "PMC"? 21 A. I wonder if that's another group she has. 22 PMC. Palm Beach Health Network and I'm not sure. 23 Q. Okay. And so in response to that email, you 24 say, "And Gina did say they could handle it without 25 adding resources as well."

Page 218 1 Do you see that? 2 A. Yes. 3 Q. Is that referring to that Gina said they 4 could handle the Leapfrog Hospital Survey without 5 adding additional resources? 6 A. Adding additional FTE's is what that means 7 really, yeah. 8 Q. Okay. So suffice it to say, is your email 9 saying that you don't have to hire a new person in 10 quality to complete the Leapfrog Hospital Survey? 11 A. Correct. 12 Q. Okay. 13 A. That's what I mean. 14 Q. Between 2020 -- or I'm sorry. Between 2021 15 when Good Samaritan stopped participating and the fall 16 of 2024, do you recall having any meetings with the 17 governing board about participating in the Leapfrog 18 Hospital Survey? With the understanding this is from 19 December of 2025. So I'm asking from 2021 to the fall 20 of 2024 before this email, do you recall any 21 discussions with the governing board about 22 participating in the Leapfrog survey? 23 A. I don't. 24 Q. Okay. And same question with respect to 25 discussions with Palm Beach Health Network. Between	Page 220 1 Leapfrog grades? 2 MR. MARCUS: Object to form. 3 A. Were they monitoring? I mean, I know they 4 would get emails of what the grade was going to be, so, 5 I mean, like Gina, I think, specifically would get 6 emails about what the grade is going to be and things 7 like that. Is that what you mean? 8 BY MS. BLAIR: 9 Q. Yes. 10 And do you understand that every score -- 11 well, do you understand that the Leapfrog -- now, I'm 12 not talking about the survey anymore. Now we're going 13 to talk about the safety grade for a minute. 14 Do you understand that the Leapfrog hospital 15 safety grade comes out twice a year? 16 A. Spring and fall. 17 Q. Correct. So you have that understanding? 18 A. I do. 19 Q. Do you have an understanding that twice a 20 year before the Leapfrog hospital safety grade comes 21 out Leapfrog provides a calculator to each and every 22 hospital so that they can calculate their own score? 23 A. They send them a calculator? 24 Q. Correct. 25 A. I don't recall that, but...
Page 219 1 2021 when you stopped participating to the fall of 2 2024, do you recall any conversations with Palm Beach 3 Health Network, whoever that may be, about 4 participating in the Leapfrog survey? 5 A. So essentially after we stopped 6 participating and prior to the ratings coming out in 7 that period is what you're -- 8 Q. Correct. 9 A. Do I remember talking to them about 10 participating again? I don't recall ever having that 11 conversation. 12 Q. And it wasn't important to you about 13 participating in the Leapfrog Hospital Survey during 14 that time frame? 15 A. No. 16 Q. Prior -- during the same time period, 2021 17 through the fall of 2024 when the fall of 2024 hospital 18 safety grades came out, do you recall having any 19 conversations with Tenet health system home office, 20 I'll call it, about participating in the Leapfrog 21 survey? 22 A. I don't. I don't recall anything. 23 Q. Do you understand that in that time period, 24 2021 to fall of 2024, the quality personnel at 25 Good Samaritan were monitoring Good Samaritan's	Page 221 1 Q. Okay. Do you have an understanding that at 2 all times since 2021 and before, but at least since 3 2021 that Leapfrog publishes its current scoring 4 methodology on its website for everybody to review? 5 A. I do not. 6 Q. Okay. I want to talk about 7 Good Samaritan's -- I want to focus now a little bit on 8 2023, so this would be the time period before the 9 change in the Leapfrog hospital safety grade 10 methodology. And I think you testified a little bit 11 earlier that Good Samaritan does monitor its CPOE 12 performance regularly, correct? 13 A. Yes. 14 MS. BLAIR: I'll mark this as Exhibit 9 as a 15 group Exhibit. 16 (Defendant's Exhibit Number 9 for i.d.) 17 BY MS. BLAIR: 18 Q. Mrs. Montgomery -- and before we get to this 19 document, I assume Good Samaritan monitors CPOE because 20 it's important to patient safety? 21 A. It is. 22 Q. And can you describe just as a CEO of a 23 hospital how CPOE is important to patient safety? 24 A. Errors. It reduces errors, you know. If 25 the physician is entering an order instead of telephone

Page 222 1 order telling someone who is now going to go, another 2 person go and enter an order, you know, they do it 3 directly into the system and don't do telephone orders 4 or tell the nurse what to put into it, so it obviously 5 should be more accurate for sure. It helps with 6 medication errors, too. 7 Q. Okay. And looking at this group Exhibit, 8 and it's several different CPOE, emails about CPOE, you 9 can just kind of flip through it. I think each one is 10 maybe one or two pages, and they all sort of look the 11 same, and they should be in chronological order. 12 And for my record, can you look at the first 13 page of this starts January 6th of 2023, correct? 14 A. Yes. 15 Q. And I think the last email -- and it's 16 miniature. I apologize. That's how it was produced to 17 me -- is from April 3rd, 2024 the very last one. 18 MR. MARCUS: What's the Bates number of the 19 page we're looking at? 20 MS. BLAIR: PBHN, four zeros, 11428 maybe. 21 I'm not sure if my glasses are strong enough 22 here. 23 MR. MARCUS: Okay. Because I don't have a 24 28. 25 MS. BLAIR: You don't have this tiny page?	Page 224 1 all. I think she was a group lead for informatics, but 2 I'm not 100 percent sure on that. 3 Q. And you see the first line here it says, 4 "Attached is the December CPOE report," correct? 5 A. Yeah. 6 Q. And if we look at the chart that's at the 7 bottom of this page which is Bates number 11534, you 8 see where it says "metric"? 9 A. Yes. 10 Q. And then it's "CPOE percentage all 11 encounters," correct? 12 A. Um-hum. 13 Q. "CPOE percentage inpatient overall," 14 correct? 15 A. Um-hum. 16 Q. And then the "CPOE percentage inpatient only 17 meds Leapfrog," do you see that? 18 A. I do. 19 Q. What was this measuring with respect to 20 Leapfrog? 21 A. That's a good question. 22 Q. Okay. 23 A. I don't know. 24 Q. And would you agree with me if we turn to 25 the next page, we see that again in the chart at the
Page 223 1 MR. MARCUS: The last -- oh, okay. Yeah. 2 MS. BLAIR: Yes, sorry. It's like 3 impossible to read. 4 MR. MARCUS: Yes. It jumps from 32 to 28? 5 MS. BLAIR: Yeah. 6 MR. MARCUS: Okay. 7 BY MS. BLAIR: 8 Q. And that last one in the sequence, 9 Ms. Montgomery, is that from April of 2024? 10 A. It is. 11 Q. Okay. And are these the documents that 12 Good Samaritan compiled in connection with the request 13 for documents related to CPOE sufficient to simulate? 14 A. I don't know. 15 Q. Okay. If we look at, and we can just look 16 at the first one, I think they're all sort of the same, 17 but the very first one is from Rachael Farahmandfar, 18 F-a-r-a-h-m-a-n-d-f-a-r, correct? 19 A. Yes. 20 Q. Who is she? 21 A. Clinical informatics. She's not with the 22 organization any longer. 23 Q. Was she at the home office level or was she 24 at the Palm Beach network level? 25 A. I'm not sure if she was a group person at	Page 225 1 bottom of page 11477, right? It says, "CPOE percentage 2 inpatient meds Leapfrog," correct? 3 A. Yes. 4 Q. And, again, you don't know what this is 5 measuring? 6 A. I'm not sure. 7 Q. And I will submit to you, and you can look 8 at these, but, again, on page 11457 you've got, again, 9 a reference to Leapfrog and on and on. 10 A. Um-hum. 11 Q. Do you have any understanding as you sit 12 here today what that -- how that CPOE percentage was 13 being calculated as it relates to Leapfrog? 14 A. No. 15 Q. Do you know whether or not the -- whoever 16 was running this in informatics was running the test 17 that Leapfrog puts out in its survey to get to this 18 percentage? 19 A. I can't speak to it. 20 Q. Okay. Do you know who I would need to ask 21 to get an answer about what this reference to CPOE 22 percentage inpatient meds Leapfrog refers to? 23 A. Gina West would probably be able to answer 24 that. 25 Q. Okay. And you can set that aside. I'll

Page 226 1 mark this as Exhibit 10. 2 (Defendant's Exhibit Number 10 for i.d.) 3 BY MS. BLAIR: 4 Q. Ms. Montgomery -- 5 Are you freezing? 6 A. I'm freezing in here. 7 THE WITNESS: But I didn't realize you're -- 8 that's so nice of you to write it down for me, 9 the Exhibit Number. 10 BY MS. BLAIR: 11 Q. I've just handed you what we've now marked 12 as Exhibit 10, which is Bates number PBHN, four zeros, 13 11460. And it's sort of weirdly -- oh, and to 46 -- 14 461, is that what you have in front of you? 15 A. 11460. 16 Q. Yes? 17 A. And 11461, yes. 18 Q. Perfect. If we look at this, it's from 19 Regina West to you and others, correct, dated 20 June 13th, 2023. 21 Do you see that? 22 A. Yes. 23 Q. And it's also to Taylor Pool, and we talked 24 about her earlier, correct? She's in the quality 25 department?	Page 228 1 A. No, I really would have to read what I said 2 to really -- 3 Q. Okay. And Judy Goodman, for the record, she 4 was a board member in or around June of 2023? 5 A. Yes. 6 Q. Okay. And then your response to Judy is -- 7 or I'm sorry. Maybe not to Judy. 8 So if we look at the bottom of 11460, you 9 send an email to Regina West, Taylor Pool and, again, 10 Ashley Barquin, right? 11 A. Right. 12 Q. And the substance of your email is on 11461, 13 and you say, "Check out the death rate for patients 14 with serious treatable complications after a surgery. 15 We are higher than the national average and the 16 majority of our peers." 17 Do you see that? 18 A. I do. 19 Q. Do you recall any conversations you had with 20 the governing board regarding the fact that your death 21 rates for patients with serious treatable complications 22 after surgery was higher than the national average and 23 the majority of your peers? 24 MR. MARCUS: Object to form. 25 A. I don't.
Page 227 1 A. She is. 2 Q. And then it's also CC'd to Ashley Barquin, 3 B-a-r-q-u-i-n. Who was Ashley Barquin? 4 A. She was the ACO at that time at Good Sam. 5 Q. Okay. And if you look on the -- the subject 6 of this is "Stet Media Group releases today this data 7 from Medicare compare on death rates outcomes by 8 hospital." 9 Do you see that subject line? 10 A. I do. 11 Q. What is Stet Media Group? 12 A. I don't know exactly what they are. I just, 13 you know, know that they're a media, local media group 14 is my understanding. 15 Q. Okay. And if you look on the next page 16 11461, Judy Goodman is writing to you June 13th, 2023, 17 and she says, "Dear, Sheri, Stet Media Group, all 18 former Post investigative reporters, are digging 19 through Medicare compare info and pulled out these 20 comparisons about staff vaccination rates, death rates, 21 outcomes, et cetera." 22 Do you see that? 23 A. Um-hum. 24 Q. Does this refresh your recollection of what 25 this Stet Media Group article was?	Page 229 1 BY MS. BLAIR: 2 Q. Do you recall whether Taylor Pool or 3 Ashley Barquin got back to you about your question, "Do 4 you know what is driving this? And do we track 5 mortality rates for surgical patients?" 6 A. Well, it looks like that they responded in 7 the email, right? 8 Q. Right. But do you recall conversation? 9 A. I mean, no. I'm sure we had them. 10 Q. Okay. Do you have any specific 11 recollection -- I might have just asked this so I 12 apologize -- of talking to the governing board about 13 this issue? 14 MR. MARCUS: Object to form. 15 A. I don't recall. 16 BY MS. BLAIR: 17 Q. What about any conversations you may have 18 had with Med Exec regarding the issue raised by 19 Judy Goodman in this email and this Stet news report? 20 A. I don't recall. 21 Q. Okay. Do you know if there was any measures 22 put in place at Good Samaritan to address this issue 23 after June of 2023? 24 A. So I would say we constantly, we review all 25 our mortalities all the time, every one of them and

Page 230 1 look for opportunities. A lot of mortalities, like as 2 referenced in here, and things that we have worked on 3 is documenting things that are present on admissions 4 even with infections, for example. 5 So I would say it's obviously a high 6 priority to us all the time any time there is a 7 mortality. And everyone goes through the chart. We 8 have like a three-level review of mortalities. 9 Q. Okay. 10 A. So was it implemented specifically because 11 of this? Not necessarily. We're looking at mortality 12 all the time. 13 I'm sure I was asking what specifically 14 about surgical patients were we an outlier in. 15 Q. Okay. And that would be the job of 16 Regina West, Taylor Pool and their team to sort of 17 monitor that kind of quality information? 18 A. Yeah. I mean, yeah, any mortality, all of 19 them are reviewed immediately by an entire time, so... 20 Q. Okay. And, again, we're still in 2023. And 21 we were talking about that period between 2021 and when 22 the fall safety grades came out in 2024 and about 23 Good Samaritan's position on the Leapfrog Hospital 24 Survey and safety grades during that time. And I want 25 to show you some Exhibits.	Page 232 1 Q. Yes. And if we look at the first page of 2 this Exhibit, it's from Taylor Pool to you dated 3 November 8th, 2023, correct? 4 A. Yes. 5 Q. And the subject is "Quality Weekly Update." 6 Do you see that? 7 A. Yes. 8 Q. And you get quality -- did you -- do you 9 still get quality weekly updates from Taylor Pool? 10 A. No. She is in a different role now. 11 Q. Do you get them from anyone? 12 A. Yes. 13 Q. Who do you get them from now? 14 A. Erin Britt. 15 Q. Okay. You told me that. Sorry. And if we 16 look at this, document specifically starting at 11442, 17 she says, second full sentence, "GSMC scored a C, as 18 did all other hospitals in PBHN." 19 Do you see that? 20 A. Yes. 21 Q. And she says here, "I've attached a Leapfrog 22 calculator that shows our hospital score." 23 Do you see that? 24 A. Um-hum. 25 Q. And I think if you turn to maybe the last
Page 231 1 MR. MARCUS: Do you want to take a break 2 before you get into an new Exhibit? 3 MS. BLAIR: Sure, yeah. 4 MR. MARCUS: Let's do that. 5 THE VIDEOGRAPHER: We're going off the 6 record. The time is 3:28 p.m. 7 (A recess was taken from 3:28 p.m. to 3:51 p.m.) 8 THE VIDEOGRAPHER: We're back on record. 9 The time is 3:51 p.m. 10 BY MS. BLAIR: 11 Q. Ms. Montgomery, right before the break we 12 were talking about how, if at all, Good Samaritan 13 monitored Leapfrog survey measures prior to the fall of 14 2024. And let me show you what we're now going to mark 15 as Exhibit 11. 16 (Defendant's Exhibit Number 11 for i.d.) 17 BY MS. BLAIR: 18 Q. Ms. Montgomery, for purposes of my record, 19 Exhibit 11 is PBHN 11442 at the bottom on the first 20 page. And it ends, this might be -- I can't tell if 21 it's double-sided for you or not, but the last document 22 should be PBHN 11446. Do you have that in front of 23 you? 24 They might be out of order. 25 A. 446? Yes.	Page 233 1 page of your Exhibit is the calculator itself. Mine 2 might be out of order. 3 Do you see that there? 4 A. Yes. 5 Q. And I had asked you a question earlier about 6 whether or not you knew that Leapfrog freely provides a 7 calculator to every hospital whether they participate 8 in the survey or not for them to calculate their grade. 9 Does this refresh your recollection that, in fact, 10 Leapfrog does provide that calculator? 11 A. So I'm not really sure if I was necessarily 12 aware this calculator was from Leapfrog, but, yes, I 13 understand. 14 Q. And if you see here the last sentence of 15 that or the second to last sentence of that first full 16 paragraph Taylor says, "Most of the measures include 17 data from 2020 through 2022." 18 Do you see that? 19 A. Yes. 20 Q. Do you understand that to be a reference to 21 the fact that the CMS data that we discussed earlier 22 today is lagging? 23 A. Yes. 24 Q. And then you see here she says, "Our biggest 25 opportunities for Leapfrog reporting period are as

Page 234 1 follows:" 2 And she has one, two, three, four, five, 3 six, seven bullet points, correct? 4 A. Yes. 5 Q. And then right below this bullet point she 6 says, "The measures with the greatest negative impact 7 on our grade are PSI 90." 8 Do you see that? 9 A. Um-hum. 10 Q. What do you understand PSI 90 to be? 11 A. It is a composite score of like 10 or 11 12 measures. I think they're all the PSIs added together 13 and there's a composite score is my understanding. 14 Q. And the PSI comes from CMS, correct? 15 A. Correct. 16 Q. All right. And she then says, "I put all of 17 the outcome quality measures at the mean, and it was 18 not enough to move us to a B." 19 Do you see that? 20 A. Yes. 21 Q. What do you understand her to mean "the 22 outcome quality measures"? 23 A. "Of all the outcome quality measures..." 24 "Of all the outcome quality measures..." 25 I would say it's putting all the quality	Page 236 1 A. I'm sure at the time I would say, yes, if 2 that's what she provided when we had the C. 3 Q. Okay. And, well, in fact, in 2023, you were 4 not -- you were not engaging in the Leapfrog Hospital 5 Survey, correct? 6 A. Right, we weren't. 7 Q. Right. And my question was very inartful so 8 I apologize. 9 Do you understand that of these measures 10 that are listed on the calculator several of them come 11 from CMS; whereas, others would come from the Leapfrog 12 Hospital Survey? 13 A. Yes. 14 Q. And so my question is, do you understand 15 that the first three measures listed here, CPOE, BCMA 16 and ICU physician staffing, would, if Good Samaritan 17 had participated in the survey, have come from 18 Good Samaritan survey results? 19 A. Right. 20 Q. And do you understand that Good Samaritan 21 was getting 100 out of 100 points on those measures 22 even though it wasn't participating, correct? 23 MR. MARCUS: Object to form. 24 A. For 2023? 25 BY MS. BLAIR:
Page 235 1 measures in the scorecard at the mean. 2 Q. Okay. And did you understand or do you 3 understand as you look at this Exhibit here today that, 4 in fact, the -- these bullet points that Taylor has 5 listed, the, what did I say, seven points, were below 6 the mean? 7 A. I don't know, but she's saying our biggest 8 opportunity are these areas. 9 Q. And if we look at the calculator that is 10 attached, and I believe it's the last page of your 11 Exhibit, if we look at, do you see where it says 12 "Process Structural Measures" on left column? 13 A. Yes. 14 Q. And if you look at the first three of those 15 measures, computerized -- it's CPOE, BCMA and IPS, ICU 16 physician staffing. Do you see that? 17 A. I do. 18 Q. And at this point in time Good Samaritan was 19 given 100 points out of 100 points for those measures, 20 correct? 21 A. Okay. 22 Q. Did you understand that these three measures 23 came from the hospital survey? 24 A. On this scorecard? 25 Q. Correct.	Page 237 1 Q. Correct. 2 A. It looks that way if this is the report 3 card, yes. 4 Q. And then we look a few lines down, do you 5 see hand hygiene? 6 A. Yes. 7 Q. And, in fact, Good Samaritan was getting 8 100 percent on hand hygiene on this scorecard, correct? 9 A. Yes. 10 Q. And in '23, Good Samaritan was not 11 participating in the Leapfrog Hospital Survey, correct? 12 A. That's right. 13 Q. And you understand, though, that 14 Good Samaritan was, nevertheless, receiving a perfect 15 score for hand hygiene, even though it didn't 16 participate in the survey? 17 A. They were what? 18 Q. Receiving a perfect score for hand hygiene, 19 correct? 20 A. Yes. 21 Q. Do you understand how that score was being 22 calculated in November of 2023 with respect to CPOE, 23 BCMA, ICU physician staffing and hand hygiene to give 24 Good Samaritan a 100? 25 A. Do I understand what Leapfrog did?

Page 238 1 Q. Correct. 2 A. My understanding is, from what I was -- what 3 was told to me is that they took previous information 4 and carried it forward maybe for several years. That's 5 my understanding, but... 6 Q. Have you ever been told that the way that 7 score was being calculated at a perfect score for 8 nonparticipating hospitals was by assigning 9 nonparticipating hospitals the mean score of its 10 cohorts? 11 MR. MARCUS: Object to form. 12 A. Tell me that again. Say it again. 13 BY MS. BLAIR: 14 Q. Sure. Did you ever have an understanding 15 that the way this grade was being calculated was that 16 Leapfrog would look at Good Samaritan's cohorts, like 17 hospitals, hospitals like Good Samaritan and then 18 assign Good Samaritan as a nonparticipating hospital 19 the median score -- or I'm sorry -- the mean score of 20 that cohort in order to calculate its score for the 21 four imputed measures? 22 MR. MARCUS: Object to form. 23 A. So for the imputed measures, not here? 24 BY MS. BLAIR: 25 Q. Well, those are the imputed measures,	Page 240 1 Q. Ms. Montgomery, I'm now handing you what 2 we've marked as Montgomery Exhibit 12. And if we look 3 at this, this is, again, an email from Taylor Pool to 4 you. This one is dated April 29th, 2024, subject line, 5 "Weekly Quality Update." 6 Do you see that? 7 A. Yes. 8 Q. And, again, if we read this first full 9 paragraph, the second -- or, I'm sorry -- the third 10 sentence says, "Additionally, preliminary Leapfrog 11 grades have been released. We will remain a C." 12 Do you see that? 13 A. Yes. 14 Q. Does this refresh your recollection that 15 Good Samaritan was monitoring its Leapfrog grades and 16 monitoring them closely, correct? 17 MR. MARCUS: Object to form. 18 A. Yeah, as I stated before, I believe they 19 send emails to the quality directors informing them or, 20 you know, that the grades are coming out in the fall 21 and spring, I believe. 22 BY MS. BLAIR: 23 Q. Okay. And Taylor says to you here, the last 24 sentence of this, of the first full paragraph, "The top 25 five measures that had the greatest negative impact on
Page 239 1 correct, we just talked about them, the first three? 2 A. Yeah, but -- yeah, but that's not what the 3 scores are now. So in this scorecard, you're saying -- 4 because there's a difference now -- 5 Q. Correct. 6 A. -- than here. 7 Q. Right. So I want to stick with in 2023 -- 8 A. Right. 9 Q. -- did you understand that those perfect 10 scores, the 100s, were being generated by giving 11 nonparticipating hospitals the mean score for their 12 cohorts? 13 "Cohorts." 14 A. No, that was not my understanding. 15 Q. Okay. So your understanding was that that 16 score was coming from past surveys? 17 A. That's what I was told at one point. 18 Q. Did you ever have a conversation with 19 Taylor Pool as to how you were getting -- or how 20 Good Samaritan was getting 100s for those four imputed 21 measures in or around 2023? 22 A. I mean, I don't recall. 23 (Defendant's Exhibit Number 12 for i.d.) 24 MS. BLAIR: We'll mark this one as 12. 25 BY MS. BLAIR:	Page 241 1 our Leapfrog grade as follows:" 2 And the first four are all patient 3 experience measures, and the last is outcome falls and 4 trauma. 5 Do you see that? 6 A. Yes. 7 Q. And then she says in the first full, or 8 second full paragraph, "Moving these five measures to 9 the national mean would increase our letter grade to a 10 B." 11 Do you see that? 12 A. I do. 13 Q. Do you recall whether or not in around April 14 of 2024 you were interested in moving Good Sam's 15 Leapfrog safety grade up? 16 A. I don't recall honestly. 17 Q. Who is Michelle Thoman, T-h-o-m-a-n. I've 18 not seen her name before. 19 A. She was the COO at Good Sam. 20 Q. Okay. And she is not still the COO at 21 Good Sam? 22 A. No. 23 MS. BLAIR: Can you mark this one as 13? 24 (Defendant's Exhibit Number 13 for i.d.) 25 BY MS. BLAIR:

Page 242 1 Q. Ms. Montgomery, again, I've handed you what 2 we've now marked as Exhibit 13, which is PBHN 11409 3 through 11411. Again, this is an email from 4 Taylor Pool. And this is just days later after what 5 we've marked as Exhibit 12 to you, "Subject: Weekly 6 quality update." 7 And she writes, "In order to reach the mean 8 in patient experience measures, we'd need to improve 9 the following by the following percentage points." 10 Do you see that? 11 A. Yes. 12 Q. And, in fact, this is a response from you -- 13 this is a response to your email at the bottom of this 14 page from May 1st where you say, "Thank you for the 15 info on Leapfrog. How many percentage points would we 16 need to move to get to national mean?" 17 Do you see that? 18 A. I do. 19 Q. Does this refresh your recollection as to 20 whether or not you as the CEO of Good Samaritan in or 21 around May of 2024 were -- did care about your Leapfrog 22 Hospital Survey grades? 23 A. I would say if the quality director sends 24 me, Hey, this is what it would take to be a B, I would 25 naturally ask, Hey, what percentage points is that to	Page 244 1 refers to Jim Zisson on the last page. 2 A. Right. He must have sent "America's Best 3 Hospitals Ranked" to me, some article. 4 Q. And who is Jim Zisson, Z-i-s-s-o-n? 5 A. He's just, you know, he's been a patient at 6 the hospital, been in the community a long time. 7 Q. He doesn't sit on the board? 8 A. No, he doesn't, huh-uh. 9 Q. And who is Dr. Ray Sekula, S-e-k-u-l-a? 10 A. I'm not sure who that is. 11 Q. What about Dr. Simovitch, S-i-m-o-v-i-t-c-h? 12 A. He is an orthopedic surgeon. 13 Q. Is he at Good Samaritan? 14 A. Yes, and Jupiter. And he is employed by 15 HSS. 16 Q. What's HSS? 17 A. Hospital for Special Surgeries. 18 Q. Okay. And he's got, that's .edu. Is that 19 an educational foundation or something? 20 A. HSS is -- address is that, I think that they 21 have like GME or orthopedic surgeons training at their 22 hospital in New York. That's probably why it's a 23 .edu, I'm guessing. 24 Q. Okay. And then there is Raul Rosenthal. Do 25 you know who he is?
Page 243 1 be a B, because at this point we weren't responding, 2 so... 3 Q. Right. 4 MS. BLAIR: Can you mark this one as 5 Exhibit 14? 6 (Defendant's Exhibit Number 14 for i.d.) 7 BY MS. BLAIR: 8 Q. Mrs. Montgomery, I've now handed you what 9 we've marked as Exhibit 14. My question about this one 10 is, the -- 11 Well, for the record, it's PBHN 11398 12 through 40 -- 11401, correct? Is that what you have in 13 front of you? 14 A. 98. 15 Q. To 401. 16 A. Yes. 17 Q. Okay. And do you see how it says, 18 "Subject - America's Best Hospitals Ranked"? 19 A. Yes. 20 Q. Do you know what that refers to? 21 A. I'm not really sure, but... 22 Q. Yeah, and if we look at 11400, PBHN 11400, 23 it looks like you initiated this email string by 24 forwarding something. And I don't have the what you 25 forwarded, and I'm just curious if you have this. It	Page 245 1 A. I do not. 2 Q. Do you have any understanding of why 3 Mr. Zisson would be sending this to all of you? 4 A. I mean, he was -- Jimmy has always been 5 engaged with Good Sam, and, you know, his parents many, 6 many years ago donated money to Good Samaritan, so he's 7 just tied in the community and would come in the 8 hospital a lot to visit kind of deal. 9 Q. Got it. And if you look at PBHN 11399, 10 looks like Taylor Pool is putting together some sort 11 of, quote, really quick breakdown of the different 12 publicly reported scores for hospital in Palm Beach 13 County. 14 Do you see that chart? 15 A. I do. 16 Q. Did you ask her to put that together? 17 A. I don't recall doing that. I probably just 18 sent her this article and... 19 Q. And the top message on the first page of 20 this Exhibit, Colleen Thielk says, "Thank you for 21 putting this together. We are going to be moving 22 up!!!!!" 23 Do you see that? 24 A. I do. 25 Q. Do you know what she's referring to? Moving

Page 246 1 up how? 2 A. I don't want to speculate. 3 Actually, she's not on the email, is she, 4 originally, Taylor? 5 "Moving up" to me would be continuing to 6 improve on our scores is what the CNO, I'm sure, is 7 referring to. 8 Q. Okay. But you don't know as you sit here 9 today whether that specifically refers to Leapfrog? 10 A. I do not. 11 MS. BLAIR: Can we mark this one as 15? 12 (Defendant's Exhibit Number 15 for i.d.) 13 BY MS. BLAIR: 14 Q. Mrs. Montgomery, I've now handed you what 15 we've marked Exhibit 15. Can I just see yours real 16 quick, the first page of that? 17 Okay. Good. This is the first page is 18 PBHN 11018, correct? 19 A. Yes. 20 Q. Excellent. 21 And you see the subject is "CI scope of work 22 and associated transition"? 23 A. Yes. 24 Q. And do you have any understanding, what does 25 "CI" refer to?	Page 248 1 MS. BLAIR: Right. 2 MR. MARCUS: -- I assume that these were 3 provided to you in native form -- 4 MS. BLAIR: In native. 5 MR. MARCUS: -- as an Excel, right? 6 MS. BLAIR: Correct. And I can tell you 7 that the native, it is PBHN 000011020. And so 8 these are just zoomed-in versions of the same 9 document so somebody could read it. 10 MR. MARCUS: For the record, are you 11 representing, so the last page is a zoomed 12 version of which, because there's two pages in 13 front of it? 14 MS. BLAIR: They're all the same. So the 15 first page is how it was produced, like the 16 microscopic. The second page, I blew it up a 17 little more. And the third page goes to -- and 18 you can see it -- one, two, three, four, five, 19 six, seven rows. It's just the first seven rows 20 of this giant spreadsheet. 21 MR. MARCUS: Right. But not the rest. 22 Okay. 23 MS. BLAIR: But not the rest. Yeah, so I 24 was just kind of making sure everybody could 25 read it.
Page 247 1 A. I'm thinking -- CI. CI could be clinical 2 informatics. Let me see. 3 (A discussion was held off the record.) 4 BY MS. BLAIR: 5 Q. And I'll just explain to you, 6 Ms. Montgomery, as you look through this document, the 7 first page of this, which is like literally impossible 8 for me to read, what I did was blow it up two times, so 9 this is how it was produced to me, this first page. 10 A. Okay. 11 Q. The second page I'm blowing it up a little 12 more. 13 A. Um-hum. 14 Q. And then this is a cut of this top part, and 15 I really want to specifically -- I have two questions 16 for you about this document. One, what does "CI" refer 17 to, if you know? 18 MR. MARCUS: Before you ask her a 19 question -- 20 MS. BLAIR: Yes. 21 MR. MARCUS: -- just to clarify the 22 record -- 23 MS. BLAIR: Yes. 24 MR. MARCUS: -- because there's no Bates 25 number --	Page 249 1 BY MS. BLAIR: 2 Q. So my first question, Ms. Montgomery, is, do 3 you know what "CI" refers to? 4 A. Clinical informatics. 5 Q. Okay. And clinical informatics is what? 6 A. It's really a position that we have at the 7 hospital that they're responsible for, you know, all 8 the Cerner training and Cerner training for physicians 9 and staff, that type of stuff. 10 Q. Okay. And if we turn to the very last page 11 of this document, which, for the record, is 12 PBHN 000011020. It's not on your document, but it's 13 the native that was produced. And I've blown up the 14 last several rows on that spreadsheet so you could read 15 it. 16 And I really just want to focus on this last 17 line here. 18 Do you see where it says "Audit Quality 19 Metrics Leapfrog testing"? 20 A. Yes. 21 Q. Do you know what that's referring to? 22 A. I don't. 23 Q. And if we go to the third column, it says 24 "Deployment Assignment Quality Pharmacy Administration 25 Sponsor." Do you know what that refers to?

Page 250 1 A. No. 2 Q. And the last, "approximate time, two hours," 3 do you see that? 4 A. Yeah. 5 Q. Do you have any idea what that refers to? 6 A. No. 7 Q. And then the last column says, "Approved 8 yes/no," and it says "yes," correct? 9 A. Correct. 10 Q. Do you know what that refers to? 11 A. Based on this email from Ram, attached is 12 approved list of work that will be transitioned back to 13 the hospital staff who currently report through CEO, 14 CFO and CNOs. 15 Q. And so at some point do you understand, 16 then, that Tenet home office was monitoring Leapfrog? 17 MR. MARCUS: Object to form. 18 A. My understanding of this email is they, the 19 CIs were, "Thank you for your patience as we've worked 20 through the CI scope of responsibility with our Tenet 21 executives and identified work that is considered 22 hospital operations." 23 This email is just stating, Hey, we're not 24 going to have the CIs do this any longer. We're going 25 to transition it to hospital operators.	Page 252 1 BY MS. BLAIR: 2 Q. And I think we talked a little bit earlier 3 that the genesis of that statement is based on 4 conversations you had with other people related to 5 payments that you believe Leapfrog takes in order to 6 influence grades, correct? 7 MR. MARCUS: Object to form. 8 A. No, I mean, my -- the statement for pay to 9 play is really, in my words, having to participate. 10 And the participation really is your payment, and as a 11 result, you won't be penalized because essentially we 12 were penalized for not playing -- 13 BY MS. BLAIR: 14 Q. Got it. 15 A. -- with the imputed scores. 16 Q. So you weren't referring to -- you were not 17 referring to this consulting situation where hospitals 18 could pay or you believe hospitals could pay Leapfrog 19 consulting fees to get better grades? 20 A. I mean, the payment I was referring to was 21 participating. 22 Q. Oh, okay. 23 And so would you agree with me that there is 24 no fee to participate in the survey? 25 A. Correct.
Page 251 1 BY MS. BLAIR: 2 Q. Okay. But in terms -- 3 A. That's what I understand it to mean. 4 Q. In terms of that last sheet, you really 5 don't understand what that relates to as it relates to 6 Leapfrog, correct? 7 A. I do not. 8 Q. And who would be the best person to ask what 9 that means? 10 A. You go to Gina or you could go to there's a 11 group clinical informatics. I can't recall his name. 12 Q. Okay. 13 A. We could provide that name. 14 Q. I don't -- 15 A. That's who I would -- or Ram. 16 Q. Yeah, he's on there. 17 A. Ram probably knew it very well it sounds 18 like. 19 Q. I want to transition a bit to these 20 pay-to-play allegations that we discussed earlier. 21 Would you agree with me that you've been pretty 22 outspoken in the media that, in fact, Leapfrog is a 23 pay-to-play organization? 24 MR. MARCUS: Object to form. 25 A. Yes, I have made a statement.	Page 253 1 Q. And did you tell me that you currently 2 utilize Press Ganey in connection with the review of 3 your HCAHPS scores? 4 A. Yes. 5 Q. And do you know who at Press Ganey 6 specifically you deal with? 7 A. No. It's normally the CNO would be 8 communicating with the Press Ganey individuals. 9 MS. BLAIR: And I'll mark this as 16. 10 (Defendant's Exhibit Number 16 for i.d.) 11 BY MS. BLAIR: 12 Q. Ms. Montgomery, I'm handing you a document. 13 The Bates labels on these are PBHN 5827 through 5829. 14 Is that the document you have in front of you? 15 A. Yes. 16 Q. Oh, wait. It looks like you have two 17 documents. 18 A. Do I have 5829? Oh, I have two copies. 19 MS. BLAIR: I have an extra copy if you want 20 it. 21 BY MS. BLAIR: 22 Q. Sorry. 23 And this is an email, the top email in this 24 chain is Naomi Seymour to Kathleen McDonald. Do you 25 see that?

Page 254 1 A. Yes. 2 Q. Who are these people? 3 A. Naomi is the CNO of Palm Beach Gardens 4 Medical Center. 5 Q. Okay. And if we look at two emails below 6 that, you've got Ricky Ramirez on this email chain as 7 well, correct? 8 A. Yes. 9 Q. And the subject line of that Ricky Ramirez 10 and of all these emails is "Recommendation: Tenet Palm 11 Beach Group Improvement Strategy." Do you see that? 12 A. I do. 13 Q. What is your understanding in or around 14 January 7th of 2025 as to the "Tenet Palm Beach Group 15 Improvement Strategy"? 16 A. My understanding from reviewing this is that 17 Press Ganey individual maybe called it the Tenet Palm 18 Beach Group Improvement Strategy." 19 Q. Okay. And do you know whether or not 20 Palm Beach Health Network reached out to Press Ganey 21 for an improvement strategy? 22 A. Well, Colleen, my CNO, reached out to 23 Press Ganey to have them come and do a visit. 24 Q. Okay. And if we look at the last page of 25 this Exhibit, 5829, and the second full paragraph,	Page 256 1 Q. That Leapfrog was free. 2 A. Oh. Doing the survey, yes. 3 Q. Correct. 4 Did you have any understanding around 5 January of 2025 that Press Ganey was, in fact, going to 6 be giving Palm Beach group an improvement strategy? 7 MR. MARCUS: Object to form. 8 A. No. 9 BY MS. BLAIR: 10 Q. Have you had any conversations with 11 Press Ganey as we sit here today about Leapfrog? 12 A. No. 13 Q. Do you have any reason to believe that 14 Press Ganey's statements that the Leapfrog survey is 15 transparent and free to the public? 16 MR. MARCUS: Object to form. 17 A. Do I have what? Say that again. What's the 18 question? 19 BY MS. BLAIR: 20 Q. Do you have any reason to believe that 21 Press Ganey's statements in this -- in this document 22 that say the Leapfrog hospital safety grade -- I said 23 survey before -- but safety grade is the only hospital 24 ratings program focused exclusively on preventing 25 medical errors and patient harm? It is fully
Page 255 1 Maika, M-a-i-k-a, Joiner of Press Ganey says, 2 "Good Sam's outreach is very timely. The Leapfrog 3 Group released its fall 2024 hospital safety grade 4 which evaluates hospitals' ability to prevent medical 5 errors and accidents and infections. The Leapfrog 6 hospital safety grade is the only hospital ratings 7 program focused exclusively on preventing medical 8 errors and patient harm. It is fully transparent, free 9 to the public." 10 Do you see that? 11 A. I do. 12 MR. MARCUS: Object to form. 13 BY MS. BLAIR: 14 Q. Did you have any reservations about engaging 15 with Press Ganey with respect to an improvement 16 strategy in light of the fact that they were taking the 17 position that the Leapfrog group's safety grade is 18 fully transparent and free? 19 MR. MARCUS: Object to form. 20 A. I mean, I wasn't on this email, to my 21 knowledge. 22 BY MS. BLAIR: 23 Q. But Taylor Pool had told you before this 24 that it was free, correct? 25 A. That, what, that Press Ganey?	Page 257 1 transparent, free to the public and updated by annually 2 in the fall and spring." 3 Do you have any reason to believe that 4 Press Ganey's statement in that regard is in error? 5 MR. MARCUS: Same objection. 6 A. I do. 7 BY MS. BLAIR: 8 Q. And what is that? 9 A. It is not fully transparent. 10 Q. What is not transparent about it? 11 A. There -- the survey is voluntary, and a 12 grade was given to my hospital, Good Sam, without 13 completing a survey, and there are seven measures that 14 equate to 35 percent of the score that we did not 15 provide, and then we were given really low scores for 16 those seven measures because we probably didn't have 17 access to the measures, and that's not transparent to 18 me. 19 Q. Well, do you understand that for three of 20 those seven measures you didn't -- it was just not 21 applicable, and they didn't score you on those 22 measures? 23 A. Which also changes the weighting of 24 everything else. 25 Q. Do you understand that in all of the years

Page 258 1 you weren't participating from 2021 to 2024 you were 2 receiving a grade? 3 MR. MARCUS: Object to form. 4 A. I'm aware. 5 BY MS. BLAIR: 6 Q. And, in fact, we -- and you weren't 7 participating in the survey during that time, correct? 8 A. We were not. 9 Q. And we just saw several Exhibits where 10 Good Sam was monitoring its hospital safety grade, 11 correct? 12 MR. MARCUS: Object to form. 13 A. I would say that we know when the grades are 14 coming out and communication about the grades is 15 obviously in those emails. 16 BY MS. BLAIR: 17 Q. Okay. And you were looking for ways to 18 improve your Leapfrog score, correct? 19 MR. MARCUS: Object to form. 20 BY MS. BLAIR: 21 Q. You saw those emails earlier? 22 A. Right. 23 Q. And at no time did anybody from 24 Good Samaritan reach out to Leapfrog and say, "We 25 should not be graded because we're not participating in	Page 260 1 A. Yes. 2 Q. And would the medical staff be the medical 3 staff of Good Samaritan? 4 A. Yeah, I believe it went to the medical 5 staff. 6 Q. And attached to this email is a document 7 that says, "Palm Beach Health Network filed legal 8 Complaint against Leapfrog," correct? 9 A. Correct. 10 Q. And that message, if we turn to 8190... 11 THE VIDEOGRAPHER: Can I change the tape 12 while you do that? 13 MS. BLAIR: Yeah, sure. 14 THE VIDEOGRAPHER: This ends the media unit 15 three. We're going off the record 4:31 p.m. 16 (A recess was taken from 4:31 p.m. to 4:31 p.m.) 17 THE VIDEOGRAPHER: We are back on the 18 record. The time is 4:31 p.m. 19 BY MS. BLAIR: 20 Q. Okay. Ms. Montgomery, I was just asking you 21 about this attachment to your email, which is -- 22 appears to be authored by Maggie Gill, group president. 23 Do you see that? 24 A. Yes. 25 Q. Did you have any hand in drafting this
Page 259 1 your hospital survey," correct? 2 A. Not to my awareness. 3 Q. And I want to provide you with what we're 4 now going to mark as Exhibit 18. 5 THE STENOGRAPHER: 17. 6 MS. BLAIR: 17, yes, you're correct. 7 (Defendant's Exhibit Number 17 for i.d.) 8 BY MS. BLAIR: 9 Q. There is an email from you, Ms. Montgomery, 10 to Colleen Thielk dated May 1st, 2025. Do you see 11 that? 12 A. Yes. 13 Q. It is Bates labeled PBHN 1188 through 1191, 14 correct? 15 A. Yes. 16 Q. Your email says, "This went to GB and 17 medical staff," dot, dot. 18 Do you see that? 19 A. I do. 20 Q. And "GB" would be the governing board, 21 correct? 22 A. Correct. 23 Q. And as we discussed earlier today, the 24 governing board is Good Sam's board of directors, 25 correct?	Page 261 1 before you sent it to the governing board and the 2 medical staff? 3 A. I don't recall doing that, no. 4 Q. But you did, in fact, send it to the 5 governing board and medical staff per your cover email, 6 correct? 7 A. Yes. 8 Q. And if we look at the third full paragraph, 9 this document says, "Beginning last year, Leapfrog" -- 10 "Leapfrog began actively punishing hospitals that did 11 not pay to participate in its flawed survey." 12 Do you see that? 13 A. I do. 14 Q. That's not true, is it? 15 MR. MARCUS: Object to form. 16 A. Well, depends on how you want to look at it. 17 You're thinking money to directly to Leapfrog. Our 18 payment is the participation, and there's payment to 19 all of our staff that have to complete the survey. So 20 there is a form of payment. It's just not to Leapfrog. 21 BY MS. BLAIR: 22 Q. Okay. But you say here, "Punishing 23 hospitals that did not" -- you don't say "that did not 24 participate." You say "that did not pay to 25 participate," correct?

Page 262 1 MR. MARCUS: Object to form. 2 A. Correct. 3 BY MS. BLAIR: 4 Q. And you expect the reader to understand that 5 that means you didn't pay in terms of resources to 6 complete the survey, and they should not take that to 7 mean monetary payment? 8 MR. MARCUS: Same objection. 9 A. I didn't expect the readers to -- I wasn't 10 trying to do anything here. 11 BY MS. BLAIR: 12 Q. What do you think your governing board 13 thought when they read that you did not pay to 14 participate in the flawed survey? 15 A. My governing board knows exactly what it's 16 about, and they now how it works, and they know it's a 17 voluntary survey. 18 Q. So the word "pay," the rider is supposed to 19 believe that that is referring to the resources and 20 time to fill out the survey, correct? 21 MR. MARCUS: Object to form. 22 BY MS. BLAIR: 23 Q. That's your testimony? 24 A. That is the payment that I consider a 25 payment.	Page 264 1 Q. Would you agree with me, though, as we sit 2 here today that there is no money exchanged between 3 hospitals that participate in the survey and Leapfrog 4 for the hospitals' participation in the survey? 5 MR. MARCUS: Object to form. 6 A. A payment to Leapfrog -- 7 BY MS. BLAIR: 8 Q. Correct. 9 A. -- just to complete the survey? 10 Q. Correct. 11 A. I would agree with that statement. 12 Q. And we went over this earlier, but have you 13 ever seen a single document in this litigation that 14 Leapfrog pressures hospitals to pay for consulting 15 services in exchange for better grades? 16 A. I think the pressure really is to complete 17 the survey. 18 MS. BLAIR: I'm going to mark this one as 19 18. 20 (Defendant's Exhibit Number 18 for i.d.) 21 BY MS. BLAIR: 22 Q. Ms. Montgomery, I'm handing you now what 23 we've marked Exhibit 18, which is PBHN 8116. It's an 24 email from Shelly Weiss to several people, including 25 yourself, and the subject line is "CBS 12 Leapfrog
Page 263 1 Q. And if we start the sentence that starts on 2 the -- at the end of 8189, "In essence, Leapfrog, 3 issues a zero score." 4 Do you see that, where it says "zero score" 5 on the top of 8109? 6 A. Yes. 7 Q. "...for any survey fields left blank." 8 Is that true? 9 A. Actually, if you look at it, I guess three 10 of the areas are zero, which are -- well, they're N/A, 11 and the other four are, I would not say they were zero. 12 Q. Okay. And you understand that the Complaint 13 that was filed in this action also claims that there 14 are -- there was payment by hospitals to participate in 15 this survey. Do you understand that allegation is made 16 in this Complaint? 17 MR. MARCUS: Object to form. 18 A. I'd have to re-review the document. 19 BY MS. BLAIR: 20 Q. As you sit here right now, do you know 21 whether or not that allegation is made in the 22 Complaint? 23 MR. MARCUS: Same objection. 24 A. I don't recall. I'd have to see the form. 25 BY MS. BLAIR:	Page 265 1 Story." 2 And if we go down to the second to last full 3 paragraph at the end of the page, it starts, "The 4 hospital has accused Leapfrog," do you see that? 5 A. Okay. Yes. 6 Q. And the second sentence in that paragraph 7 says, "They allege Leapfrog pressures hospitals to pay 8 for consulting services in exchange for better grades." 9 It says, "...consulting services and 10 promotional licenses in exchange for better grades," 11 but I want to focus on consulting services. 12 Have you seen any documents in this 13 litigation to substantiate the allegation by these 14 hospitals, these plaintiff hospitals that Leapfrog 15 pressures hospitals to pay for consulting services? 16 MR. MARCUS: Object to form. 17 A. I have not. 18 BY MS. BLAIR: 19 Q. And have you ever seen any evidence that 20 payment for consulting services would be in exchange 21 for better grades? 22 MR. MARCUS: Same objection. 23 A. Say that again. 24 BY MS. BLAIR: 25 Q. Have you ever seen any evidence in this --

Page 266 1 produced in this litigation or anywhere else that 2 Leapfrog pressures hospitals to pay for consulting 3 services in exchange for better grades? 4 MR. MARCUS: Same objection. 5 A. Like I said before, I'd say the pressure is 6 completing the survey. 7 BY MS. BLAIR: 8 Q. That's not what this says. This says, 9 "pressures hospitals to pay for consulting services." 10 This isn't even related to the survey, is it? 11 MR. MARCUS: Object to form. 12 A. From what I'm reading. 13 BY MS. BLAIR: 14 Q. Okay. But have you ever seen any evidence 15 that hospitals pay Leapfrog for consulting services in 16 exchange for better grades? 17 A. I have not. 18 Q. And we talked a little bit about the 19 methodology prior to fall of 2024, and you would agree 20 with me that the seven measures that you keep 21 discussing consists of three measures for which a 22 nonparticipating hospital gets an N/A and four measures 23 for which there is an imputed score, correct? 24 A. Correct. 25 Q. And I asked you this before, but do you have	Page 268 1 fall of 2024 was based on how participating hospitals 2 were doing in those four measures on the Leapfrog 3 Hospital Survey? 4 MR. MARCUS: Object to form. 5 A. No. 6 BY MS. BLAIR: 7 Q. You don't understand that's how your scores 8 were being -- 9 A. No, I did not. 10 Q. Okay. Do you think that's a fair way of 11 doing the methodology to give nonparticipating 12 hospitals a score based on how participating hospitals 13 were performing on those four measures? 14 A. No. 15 Q. And we saw several emails -- or, sorry, 16 several Exhibits which were emails, which I believe 17 were probably Exhibits 11, 12, 13, 14, about how 18 Taylor Pool was advising you regarding Leapfrog 19 measures in which Good Samaritan was lagging behind its 20 competitors. 21 Do you recall seeing those Exhibits? 22 MR. MARCUS: Object to form. 23 A. I recall seeing where she was saying where 24 the opportunities were, yes. 25 BY MS. BLAIR:
Page 267 1 an understanding as to how the imputed score for those 2 four measures was decided prior to fall of 2024? 3 A. No. 4 Q. Okay. Do you believe that under the prefall 5 of 2024 grading system it was deceptive of Leapfrog not 6 to tell consumers that Good Samaritan was actually 7 earning 100 points for those four measures without 8 providing any data? 9 MR. MARCUS: Object to form. 10 A. Do I think it was deceptive of Leapfrog? 11 BY MS. BLAIR: 12 Q. Correct. 13 A. My thoughts is we should -- as long as we 14 weren't participating, we shouldn't have had a grading 15 period. 16 Q. Right. And so my question is, you did have 17 a grade, correct? 18 A. We did have a grade. 19 Q. And for those four measures that we call the 20 imputed measures, Good Samaritan was getting a perfect 21 score for those four measures prior to the fall of 22 2024, correct? 23 A. Correct. 24 Q. And do you have an understanding that the 25 grade that Good Samaritan was receiving prior to the	Page 269 1 Q. And none of those measures were the four 2 imputed measures, correct? 3 MR. MARCUS: Same objection. 4 A. I don't recall. I don't think so. 5 BY MS. BLAIR: 6 Q. Okay. Do you believe that Good Samaritan 7 was gaming the system by riding the coattails of other 8 hospitals in their cohort to get 100 percent on the 9 four imputed measures prior to the fall of 2024? 10 A. We didn't give ourselves those grades so we 11 weren't gaming anything. 12 Q. But, in fact, you were getting the same 13 grades as other hospitals in your geographic area that 14 were participating in the survey, were you not? 15 A. That's what you're telling me. 16 Q. Do you believe the scores that 17 Good Samaritan was receiving on the four imputed 18 measures, BCNA, CPOE, hand hygiene and ICU physician 19 staffing, prior to the fall of 2024 accurately 20 reflected Good Samaritan's performance on those 21 measures? 22 MR. MARCUS: Object to form. 23 A. Well, from what you showed me on that report 24 card, if it's 100 percent on every measure, I don't 25 know. I'd have to look and see what everything is now.

Page 270 1 I mean, I would think most hospitals aren't perfect, 2 but depends on everything that the survey asks. I'd 3 have to go through it. 4 BY MS. BLAIR: 5 Q. Do you have any understanding as to why 6 Leapfrog implemented the scoring change in fall of 2024 7 with respect to those four measures? 8 A. No. 9 Q. Have you ever looked at the members of the 10 Leapfrog safety grade expert panel? 11 A. I don't believe so. 12 Q. So as you sit here today, you have no 13 understanding of whether or not the members of the 14 Leapfrog safety grade expert panel are qualified to 15 provide expert opinions about imputation modeling for 16 those four measures? 17 MR. MARCUS: Object to form. 18 A. I don't recall. I mean, I only remember 19 talking about their advisory board once, but I don't 20 think that, obviously, is the same people. 21 BY MS. BLAIR: 22 Q. Okay. Do you have an understanding that 23 there is an expert panel that volunteers for Leapfrog 24 that puts together the 22 measures, the weights, the 25 Z scores and the imputation model for its hospital	Page 272 1 improvement plans in place for Good Samaritan? 2 MR. MARCUS: Object to form. 3 A. Like in general? 4 BY MS. BLAIR: 5 Q. Yeah, in general. 6 A. I mean, we have quality improvement plans 7 all the time, on patient falls, you know, on HCAHPS, 8 pressure ulcers, all of those things. 9 Q. Did you understand that the improvement 10 plan -- I think it's Exhibit 16, but I could be wrong, 11 the improvement plan that was being discussed, yes, in 12 Exhibit 16, with Press Ganey was specific to CMS 13 measures? 14 MR. MARCUS: Object to form. 15 A. Would I say that that's what they were 16 referring to? 17 BY MS. BLAIR: 18 Q. Well, yes, I'm just trying to understand. I 19 understand you're a hospital so you have improvement 20 plans all the time. So why did you need a specific 21 Tenet Palm Beach group improvement strategy with 22 Press Ganey as opposed to the quality improvement plans 23 you already had in place? 24 MR. MARCUS: Same objection. 25 A. Colleen, from my understanding on this,
Page 271 1 safety grade methodology? 2 MR. MARCUS: Object to form. 3 A. I mean, I do now. 4 BY MS. BLAIR: 5 Q. Did you before? 6 A. I don't know who they employ. 7 Q. Well, they don't employ anybody. 8 A. Who they volunteer, who they have helping 9 them with their survey. 10 Q. So you don't know today who those people 11 are, correct? 12 A. I don't. 13 Q. And so you don't have an opinion one way or 14 the other whether they're qualified to provide opinions 15 about grading hospitals on patient safety, correct? 16 A. I cannot comment on that. 17 Q. Have there ever been any discussions at the 18 Med Exec level about the fact that Good Samaritan has a 19 one-star CMS rating? 20 A. Not that I recall. 21 Q. Prior to January 2025, and we saw that email 22 where the hospitals in the Palm Beach Health Network 23 engaged Press Ganey to do an improvement plan. And 24 that was January 2025. 25 Prior to that were there any quality	Page 273 1 Colleen reached out to Press Ganey to have them come 2 and visit because we were looking at patient 3 satisfaction and wanting to improve it. 4 This headline that this person from 5 Press Ganey is saying, she's like, you know that we can 6 go visit your other hospitals. 7 BY MS. BLAIR: 8 Q. Um-hum. 9 A. I recommend conducting similar baseline 10 observations at Palm Beach Gardens, Delray Medical 11 Center, et cetera, et cetera. 12 So to me, this Tenet Palm Beach group 13 improvement strategy is something that Press Ganey, in 14 my thoughts, are, you know, saying, Well, we should go 15 out to all the other hospitals as well. 16 Q. Well, if I read last page of this Exhibit, 17 5829, Maika Joiner said to Kate Bergez "Good morning, 18 Kate. Colleen Thielk and Mellissa Heath, clinical ops 19 director from Good Sam, reached out last month to 20 improve HCAHPS performance." 21 Do you see that? 22 A. Correct. 23 Q. And HCAHPS, as I understand it, is a CMS 24 measures, correct? 25 A. Correct.

Page 274 1 Q. And those are, in fact, patient experience 2 measures, correct? 3 A. That's correct. 4 Q. So my question is, do you know whether or 5 not this improvement strategy was specifically related 6 to HCAHPS? 7 MR. MARCUS: Object to form. 8 A. This was, yes. 9 BY MS. BLAIR: 10 Q. Okay. Prior to this discussion in January 11 of 2025, had Good Samaritan had any specific quality 12 improvement strategies with respect to patient 13 experience/HCAHPS? 14 A. Yes. We talked about them earlier. 15 Q. Okay. 16 A. Leadership rounding. 17 Q. Yes, we did. Thank you. It's been a long 18 day. I forgot. 19 Prior to June of 2024 as the CEO of 20 Good Samaritan, what did you consider to be the areas 21 in most need of improvement for patient safety for 22 Good Samaritan? 23 A. Prior to June? 24 Q. Of 2024. 25 A. June 2024. It was back to the balanced	Page 276 1 A. I don't. 2 (Defendant's Exhibit Number 19 for i.d.) 3 BY MS. BLAIR: 4 Q. If we look at, we'll mark this as 5 Exhibit 19. If you look at Exhibit 19, this is an 6 email string PBHN 5132 through PBHN 5137. 7 And if we go all the way to the back of this 8 document, you'll see there's an email on page 5136 from 9 Anna Gunod to DLDCQI only. 10 "Good morning quality leaders. I'm doing an 11 annual check-in on Leapfrog participation." 12 Do you see that? 13 A. Um-hum. 14 Q. Did you have any understanding that there 15 was an annual check-in on the Leapfrog participation? 16 MR. MARCUS: Object to form. 17 A. No. 18 BY MS. BLAIR: 19 Q. And Regina West responds, "PBHN are not 20 participating," correct? 21 A. Correct. 22 Q. And then if we go to PBHN 5134, and it 23 starts, Regina West email to Ann Gunod starts at the 24 bottom of that page and goes on to 5135, she says, "We 25 would like to participate in the next survey. Are we
Page 275 1 scorecard that really encompasses so much about patient 2 safety would be, you know, we would always try and 3 improve on our HCAHPS, anything related to patient 4 safety that we track, you know, fall, HAIs. To me if 5 you have more than one infection, that's one too many. 6 We want to have zero. So to me, it's a continuous, you 7 know, monitoring of all of those indicators in trying 8 to get to zero ultimately. So we're always going to 9 continue to make all of those things priorities and 10 continue to improve. 11 Q. Was there any measure that you thought was 12 way lower than the others that really needed some? 13 A. Well, if you look where you're not meeting 14 national averages, you obviously would focus on those 15 areas, too, but all mortalities are important to me; 16 all HCAHPS are important to me, whether we're meeting 17 the national average or not. 18 Q. Okay. Were you aware that in June of 2024, 19 Leapfrog put out a statement or a request for public 20 comment about the methodology change that was going to 21 occur in fall of 2024? 22 A. I don't recall. 23 Q. Do you know when the first time it was 24 brought to your attention that this methodology change 25 was going to occur?	Page 277 1 able? We have done this in the past so it would not be 2 new participation. Because we aren't participating, we 3 default to imputing" -- "imputed scoring. This takes 4 SMMC from 100 points in each of the categories below to 5 limited achievement scores." 6 Do you see that? 7 A. I do. 8 Q. Does this comport with your understanding 9 that the first time this was brought to your attention 10 would have been in or around September of 2024? 11 A. I don't remember the date, but I'm sure at 12 some point it leveled up. 13 Q. And, to your knowledge, no one at 14 Good Samaritan or any of the PBHN hospitals provided 15 comment, public comment to Leapfrog's request for 16 public comment regarding the change in the scoring 17 methodology, correct? 18 A. I'm not aware of anything, no. 19 Q. And if you look at that same page, 5134, 20 Anna Gunod says to Regina West, and Taylor Pool is on 21 this email too. "Hi, Gina, Leapfrog participation is 22 not supported unless it was directly tied to a 23 payment/contract or a local regulatory requirement." 24 Do you see that? 25 A. Which one was that on?

Page 278 1 Q. Oh, I'm sorry. 5134. 2 A. I got it. 3 Q. Do you see that? 4 A. Yes. 5 Q. What is your understanding of what Anna 6 means by that comment? 7 A. I don't know. 8 Q. Did you have any understanding that your 9 hospital was not allowed to participate in this type of 10 event unless it was directly tied to payment contract 11 or local regulatory requirement? 12 A. No, that was not my understanding at all, 13 no. 14 Q. Okay. And then Regina says on 5133 to 15 Anna Gunod, and, again, Anna Gunod is at home office, 16 correct? 17 A. National director of infection prevention. 18 Looks that way, yes, I would say. 19 Q. And at the bottom of 5133 she responds, Gina 20 responds, "Although not supported, is it left up to the 21 local markets to decide or a strict no from HO?" 22 Do you see that? 23 A. Yes. 24 Q. Do you understand HO to mean home office? 25 A. Yes.	Page 280 1 Q. When do you recall it being? 2 A. I recall when a grade actually came out most 3 of the discussions, I mean, but I could be wrong. 4 Q. And do you know when the fall grade came out 5 for -- the fall of 2024 grades came out? 6 A. I think it was November. 7 Q. Right. And do you understand that Leapfrog 8 tells hospitals what their grades are going to be 9 before they come out? 10 A. Yes, I think there's like a short period of 11 time for some -- for what reason, I don't know, but... 12 Q. Do you understand that you can dispute your 13 grade with Leapfrog during that time period in which 14 the grades were under review? 15 MR. MARCUS: Object to form. 16 A. No. 17 BY MS. BLAIR: 18 Q. Okay. And for the fall 2024 grade, did 19 anyone at Good Samaritan reach out to Leapfrog to 20 object to the grade that they were going to receive? 21 MR. MARCUS: Object to form. 22 A. Not to my knowledge. 23 MS. BLAIR: Can you mark this as Exhibit 20? 24 (Defendant's Exhibit Number 20 for i.d.) 25 BY MS. BLAIR:
Page 279 1 Q. Okay. And then Anna writes at the top of 2 this page, "It is a no from home office. Facilities 3 who need an exception due to Leapfrog participation 4 being tied to a local requirement contract or 5 compliance or reimbursement needs to submit their case 6 for review by Dr. Franklin." 7 Do you see that? 8 A. I do. 9 Q. Do you know whether or not Good Samaritan or 10 any of the PBH hospitals submitted a request to 11 Dr. Franklin for participation? 12 A. I'm not aware. 13 Q. Okay. And at the bottom of 5132 Taylor Pool 14 writes to Colleen Thielk, "Sharing home office response 15 below about Leapfrog participation. The scoring system 16 now penalizes hospitals for not participating. We can 17 expect to be an F for the next reporting period due to 18 change." 19 And then Colleen sends that to you with an 20 FYI, correct? 21 A. Yes. 22 Q. What is your memory about any discussions 23 that were occurring in or around September of 2024 24 about the change in the Leapfrog methodology? 25 A. I don't recall it really being in September.	Page 281 1 Q. Ms. Montgomery, I'm sharing with you now an 2 email from Taylor Pool dated 11-4-24 to you CCing 3 Colleen Thielk. On the first page of this, PBHN 5120, 4 Taylor writes, "A hospital onset C. diff case was 5 identified. This brings us 15 infections year to date. 6 We cannot have another C. diff infection through the 7 end of November in order to remain green on BSC." 8 Do you see that? 9 A. I do. 10 Q. What does "remain green on BSC" mean? 11 A. Meet your target. 12 Q. Okay. And then if we look down at the 13 bottom paragraph of this page, it says, "Home office 14 has identified issues with the data collection and 15 pulled the DCQIs across the enterprise together last 16 week." 17 Do you see that? 18 A. Yes. 19 Q. Is that referring specifically to PROMs, or 20 is that referring generally to issues with data 21 collection? 22 MR. MARCUS: Object to the form. 23 A. I don't know. 24 BY MS. BLAIR: 25 Q. Okay. And if we look at the last page or

Page 282 1 the next page, I'm sorry, 5121, number three says, 2 "Leapfrog," correct? 3 A. Yes. 4 Q. And he says here, "Basically we were 5 used" -- "we used to receive 100 percent credit and we 6 now receive a negative score." I said "he." Her. 7 Do you see where it starts basically in the 8 middle of that paragraph? 9 A. Yes. 10 Q. Is it your understanding you received a 11 negative score for these four measures? 12 A. I think the negative means, you know, a 13 penalty. I'm not sure what the weighting of it says on 14 the right-hand side of the scorecard, but it's a 15 punitive negative. 16 Q. And Taylor goes on to say, "Additionally, we 17 received negative scores for all five patient 18 experience measures." 19 Do you see that? 20 A. Yes. 21 Q. And those patient experience measures would 22 have come from CMS data, correct? 23 A. Yes. 24 Q. And then Taylor goes on to say, "The top 25 five most negative scores are for PE discharge, PE	Page 284 1 December of 2024 around the Leapfrog safety grade that 2 had been published? 3 A. Yes. 4 Q. And, to the best of your memory, why was 5 there a lot of discussion about that? 6 A. The failing grades. That's why. 7 Q. Okay. How did it first come to your 8 attention that there were -- well, strike that. 9 Who complained to you about the failing 10 grades, if anyone? 11 A. Who complained to me? 12 Q. Um-hum. 13 A. I mean, many people complained to me. 14 Q. And who are the "many people"? 15 A. Do you have a couple hours? Probably mostly 16 governing board, physicians, you know, people in the 17 community, people that I know personally, just, I mean, 18 it was -- it was a big deal to have a failing grade. 19 Q. And you went from a C to a D, correct? 20 A. First we went from a C to an F and then from 21 an F to a D. 22 Q. Oh, okay. So your grade went up in spring 23 of 2025, correct? 24 A. Yes. 25 Q. Do you recall asking Andrew Lofholm in
Page 283 1 communications about medication, PE nurse 2 communication, PE staff response and CPOE." 3 Do you see that? 4 A. I do. 5 Q. And so while CPOE is one of the most 6 negative scores that Taylor puts out there, she 7 certainly is informing you that there are other very 8 negative scores on the Leapfrog survey that come from 9 CMS data, correct? 10 MR. MARCUS: Object to form. 11 A. Yes. 12 BY MS. BLAIR: 13 Q. Do you have any reason to believe that 14 Taylor Pool's discussion in that regard with respect to 15 the top five most negative scores was wrong in any way? 16 A. I don't. 17 Q. And, in fact, in the fall of 2024 18 Good Samaritan received a D, correct? 19 A. In the fall, yes. 20 Q. What do you recall about discussions, if 21 any, that occurred around the fact that Good Samaritan 22 received a D in the fall of 2024 on the Leapfrog 23 hospital safety grade? 24 A. I don't really recall any discussions. 25 Q. Do you recall there was a lot of activity in	Page 285 1 December of 2024 to do research on articles critical of 2 Leapfrog? 3 MR. MARCUS: Object to form. 4 A. I don't recall exactly what -- I'm sure we 5 talked about a lot of things regarding Leapfrog. 6 BY MS. BLAIR: 7 Q. Once you were told by home office that it 8 was a no and the Palm Beach Health Network hospitals 9 could not participate in the Leapfrog survey, did you 10 as the president of Good Samaritan come up with another 11 strategy to combat the Leapfrog hospital safety grade? 12 MR. MARCUS: Object to form. 13 A. No, other than doing what we do every day 14 and provide great care, we continue to provide great 15 care and have our processes in place to show that we 16 are a quality hospital. 17 BY MS. BLAIR: 18 Q. In December of 2024, were you as the CEO of 19 Good Samaritan contemplating a lawsuit against 20 Leapfrog? 21 A. In December? 22 Q. Yes, in December of 2024. 23 A. So it was even brought up at my Med Exec 24 committee talking about that we should sue Leapfrog 25 after they understood how things worked, so there was

Page 286 1 discussions around that time that, you know, that some 2 action should be taken. 3 Q. And when you say -- when you say the 4 Med Exec committee talking about what -- talking about 5 that we should sue Leapfrog after they understood "how 6 things worked," how did they understand things worked? 7 What are you referring to there? 8 A. When they realized that it was a voluntary 9 survey and that there are measures in there that 10 Leapfrog takes or imputes us and penalizes us for not 11 responding, so, in essence, the survey is not accurate. 12 Q. Was the Med Exec under the impression, as 13 we've seen in the press coverage and different emails 14 in this lawsuit, that other hospitals that participated 15 in the survey were paying Leapfrog for better grades? 16 MR. MARCUS: Object to form. 17 A. I don't know if that was their impression. 18 BY MS. BLAIR: 19 Q. Did you tell them that? 20 A. I did not. 21 Q. Do you know if anybody told the Med Exec 22 that the reason other hospitals were getting better 23 grades is because they were paying Leapfrog for those 24 grades? 25 A. I have no idea whether people said those	Page 288 1 hospitals on site. That's the only way you can verify 2 the information is accurate. 3 Q. But you don't -- but you don't participate 4 in the survey, correct? 5 A. Correct. 6 Q. So why would they come? 7 A. But we did. 8 Q. Why would they come to a hospital that 9 doesn't participate in a survey to verify something? 10 A. So hospitals that participate and when we 11 did participate, Leapfrog never came to the hospitals. 12 Q. Do you understand Leapfrog does, in fact, 13 remember verify survey data? 14 MR. MARCUS: Object to form. 15 A. I mean, there's data that's from Medicare 16 that's verified, but I don't -- no, no. 17 BY MS. BLAIR: 18 Q. I'm talking about survey data. 19 A. Right, but on the survey there is Medicare 20 data as well. 21 Q. Well, there's Medicare data on the safety 22 grade, correct? 23 A. Right, well, on the -- right. 24 Q. Right. So the survey is separate and 25 distinct from the grade, right?
Page 287 1 things. I have no idea. 2 Q. Do you know if anybody told the Med Exec 3 that hospitals were paying consulting fees to Leapfrog 4 in exchange for better grades? 5 A. No. No, not while I was present. 6 Q. So when you say "how things worked, when the 7 Med Exec figured how things work," you're referring 8 specifically to the imputation model? 9 A. Yes, the survey that, one, it's voluntary, 10 so there's measures that anybody could put whatever 11 they wanted; two, Leapfrog doesn't come and verify any 12 of those measures because they don't come into our 13 institution like Joint Commission does when you're 14 getting accredited; and, three, that we weren't 15 participating. Then they understood. 16 Q. You also understand that there's allegations 17 in this case that Leapfrog does nothing to verify the 18 survey responses of participating hospitals, correct? 19 MR. MARCUS: Object to form. 20 A. Correct. 21 BY MS. BLAIR: 22 Q. Do you believe that's true? 23 A. I've never seen Leapfrog in our hospitals. 24 I don't know how you would ever verify it unless you're 25 actually surveying hospitals and going live to their	Page 289 1 A. Yes. 2 Q. Have you done any research to inform 3 yourself about whether or not Leapfrog goes on site to 4 hospitals to verify data that hospitals report on their 5 survey? 6 A. Everyone that I have talked in the 7 organization and healthcare says no. 8 Q. Okay. 9 A. So I've not called the president of Leapfrog 10 and asked her, I guess. 11 Q. Are you aware that Leapfrog sends out 12 document requests for verification of survey results to 13 participating hospitals? 14 MR. MARCUS: Object to form. 15 A. Documents saying "send us documents," is 16 that what you're saying? 17 BY MS. BLAIR: 18 Q. Correct, correct. 19 A. I mean, that's part of the survey process? 20 Q. No, as part of the verification of the 21 survey process. 22 MR. MARCUS: Same objection. 23 A. I don't know. 24 BY MS. BLAIR: 25 Q. You've done nothing to figure out whether

Page 290 1 that's true or not? 2 MR. MARCUS: Same objection. 3 A. If Leapfrog sends a verification form to a 4 hospital? 5 BY MS. BLAIR: 6 Q. Oh, no, no, no, no. I'm sorry. My question 7 might have been bad. 8 Are you aware that as part of the 9 verification process -- well, strike that. 10 Are you aware that hospitals must submit 11 their survey by June 30th, and a verification process 12 takes place between June 30th and when the survey 13 closes on August 31st -- 14 MR. MARCUS: Object to form. 15 BY MS. BLAIR: 16 Q. -- every year? 17 A. I don't know the process no. 18 Q. Okay. And you're unaware of any of the 19 verification process that takes place in those 60 days, 20 correct? 21 MR. MARCUS: Same objection. 22 A. Yes. 23 BY MS. BLAIR: 24 Q. And, yet, you're confident that the 25 allegations in this lawsuit that Leapfrog does nothing	Page 292 1 record. The time is 5:10 p.m. 2 (A recess was taken from 5:10 p.m. to 5:21 p.m.) 3 THE VIDEOGRAPHER: We are back on the 4 record. The time is 5:21 p.m. 5 BY MS. BLAIR: 6 Q. Ms. Montgomery, I want to move on to 7 Good Samaritan's claim in this litigation that it has 8 been harmed by the Leapfrog hospital safety grades. 9 By way of just orienting you to timeline, 10 the Complaint in this case was filed April 30th of 11 2025. Does that comport with your memory? 12 A. Yes. 13 Q. And as of April 30th, 2025, Good Samaritan, 14 for which you are the CEO, had suffered harm at that 15 point in time, correct? 16 A. Correct. 17 Q. And would you agree with me that on 18 April 30th, did they -- the day -- the day the 19 complaint was filed, the five plaintiff hospitals 20 undertook a media campaign to publicize their safety 21 grades that Leapfrog had provided them both in the fall 22 of 2024 and the spring of 2025? 23 MR. MARCUS: Object to form. 24 A. In April, is that what you said? 25 BY MS. BLAIR:
Page 291 1 to verify survey results is true and accurate, correct? 2 MR. MARCUS: Same objection. 3 A. I would say they don't go into hospitals and 4 verify hand washing, for example. 5 BY MS. BLAIR: 6 Q. You don't know whether or not Leapfrog does 7 random audits of hospitals, onsite audits of hospitals, 8 do you? 9 A. I am not aware of that. 10 Q. And you've done nothing to inform yourself 11 as to whether or not that's true, do you, have you? 12 MR. MARCUS: Object to form. 13 A. Yeah, speaking to people in the industry 14 that say otherwise. 15 BY MS. BLAIR: 16 Q. Okay. 17 MR. MARCUS: Good time for a break? 18 MS. BLAIR: Sure. We've got to be almost 19 done. I'm almost done. 20 MR. MARCUS: You said that an hour and a 21 half ago. 22 MS. BLAIR: Again, if I didn't have to ask 23 about all the documents, we'd be done. 24 Off the record. 25 THE VIDEOGRAPHER: We're going off the	Page 293 1 Q. Correct. 2 A. I thought we had gathered really that type 3 of information prior to then, but... 4 Q. Oh, yeah. I guess my question was more 5 specific. The Complaint is filed on April 30th, 2025, 6 correct? 7 A. Um-hum. 8 Q. And there are that same day press releases 9 going out from the five plaintiffs to media outlets 10 discussing the D's and F's that the five plaintiffs 11 hospitals had received from Leapfrog, correct? 12 MR. MARCUS: Object to form. 13 A. Okay. 14 BY MS. BLAIR: 15 Q. Do you recall that? 16 A. I don't recall at all. 17 Q. Okay. Do you recall any interviews you gave 18 to the media in or around late -- or April 30th to, 19 let's just say, the first week in May regarding these 20 five hospitals filing suit against Leapfrog? 21 A. I do recall questions coming up and Andrew 22 asking me questions, things of that nature for media 23 outlets. 24 Q. Did you ever sit down with a media outlet 25 and give an interview?

Page 294 1 A. I did not. 2 Q. Did you ever watch the interviews that were 3 done by your attorney, Mary Beth -- Mary Beth Maloney, 4 related to the filing of the lawsuit? 5 A. I do believe I saw them, one of -- yes, it 6 was on the news, I believe. 7 Q. Did you as the CEO of Good Samaritan have to 8 sign off on the talking points that Mary Beth Maloney 9 gave to the press -- 10 MR. MARCUS: Object to form. 11 BY MS. BLAIR: 12 Q. -- and third parties? 13 MR. MARCUS: Same objection. 14 A. I signed off on -- I believe so. Normally 15 it comes through Andrew. Anything that goes out as a 16 press release, we review. 17 BY MS. BLAIR: 18 Q. And so all of statements that Mary Beth 19 Maloney gave regarding the brazen pay to play process 20 of the Leapfrog hospital safety grades, you would have 21 signed off on that? 22 MR. MARCUS: Object to form. 23 A. Not her. Not her specifically, no, but like 24 anything that is going to come through like 25 Good Samaritan.	Page 296 1 A. All the things that occurred from December 2 until then, most certainly. 3 Q. And I've seen documents that have been 4 produced in this litigation about doctors telling -- 5 telling Good Samaritan that patients didn't want to 6 come to Good Samaritan hospital because of the Leapfrog 7 safety grade, correct? 8 A. Correct. 9 Q. Did you ever have any conversations -- did 10 you, Sheri Montgomery, ever have any direct 11 conversations with patients who told you they would not 12 go to Good Samaritan because of the Leapfrog hospital 13 safety grade? 14 A. No, the physicians did. 15 Q. Did the physicians ever provide you with the 16 names of the patients that they spoke to who allegedly 17 would not come to Good Samaritan because of 18 Good Samaritan's Leapfrog hospital safety grade? 19 A. No. 20 Q. Do you know how many patients refused to 21 come to Good Samaritan as a result of the Leapfrog 22 hospital safety grade? 23 A. I don't know how many. 24 Q. Are you contending that the Leapfrog 25 hospital safety grade had any impact on physician
Page 295 1 BY MS. BLAIR: 2 Q. Okay. Talking about -- have you done any 3 studies, Palm Beach Health Network, has Palm Beach 4 Health Network done any studies to determine whether or 5 not the impact of the plaintiffs' PR campaign after the 6 filing of the lawsuit in any way increased patient 7 knowledge of those five hospitals' Leapfrog hospital 8 safety grades? 9 MR. MARCUS: Object to form. 10 A. Was there an analysis done of the impact of 11 the media campaign, is that what you mean? 12 BY MS. BLAIR: 13 Q. Sure. Did anybody say, Well, X number of 14 people knew about our Leapfrog hospital safety grades 15 before we went to the press and did this media blitz, 16 and we've just publicized these grades to a much 17 farther reach after you engaged in the PR campaign? 18 MR. MARCUS: Object to form. 19 A. No, I'm not aware of one. 20 BY MS. BLAIR: 21 Q. Is there any way that you know of to make 22 the determination as to what the impact was to 23 Good Samaritan's reputation before the April 30th media 24 campaign that the plaintiffs engaged in regarding the 25 lawsuit and before?	Page 297 1 retention at Good Samaritan? 2 A. I would say that it is in the fact that 3 other contracts we may have, like for hospital for 4 special surgery, for example, is, in my opinion, that 5 the Leapfrog rating has prompted those physicians to 6 get on staff at Jupiter Medical Center because their 7 patients are complaining to them that we are an F. 8 They are only on staff at Good Samaritan Medical 9 Center. The physicians have told me that they are 10 getting on staff at Jupiter and that their patients 11 have complained about us being an F hospital. 12 Q. How many doctors are getting on staff at 13 Jupiter Medical? 14 A. So our top surgeons, so there's three or 15 four of them, the orthopedic surgeons. 16 Q. Are they revoking their privileges at 17 Good Samaritan? 18 A. No. 19 Q. Okay. So they're just adding Jupiter as a 20 hospital, correct? 21 A. Correct. 22 Q. Have they said to you how many patients they 23 have to treat at Jupiter as a result of the Leapfrog 24 hospital safety grade as opposed to treating at 25 Good Samaritan?

Page 298 1 A. No. 2 Q. So you don't have any number? 3 A. I don't have a number. 4 Q. And how many of those doctors are -- I'm 5 sorry if I already asked you this. 6 How many doctors have told you that they 7 have to go seek privileges at Jupiter due to the 8 hospital safety grade? 9 A. So that's just HSS surgeons. We have other 10 surgeons that are called splitters, meaning they're 11 already on staff at Jupiter, like Dr. Goodman, who had 12 to reschedule a surgery and go to Jupiter Medical 13 because a patient refused to come to our hospital 14 because we were an F. 15 Q. One patient? 16 A. That I could know about and could provide 17 names. 18 Q. So one patient you know about and could 19 provide a name, correct? 20 A. Oh, I could provide more names for sure. 21 Q. Oh, you could? 22 A. For the HSS. 23 Q. Okay. So let's break that down. How many 24 patients of HSS -- they're surgeons, correct? 25 A. Yeah.	Page 300 1 safety grade and I will not work with Good Samaritan? 2 A. Not that I'm aware of for Good Sam. 3 Q. Okay. And then let's talk about doctors 4 that are already on staff with you, have any of them 5 left Good Samaritan as a result of the Leapfrog 6 hospital safety grade? 7 A. No. 8 Q. And then there are those doctors that we 9 just discussed that sought privileges at Jupiter in 10 addition to Good Samaritan based on the Good Samaritan 11 hospital safety grade, correct? 12 A. Correct. 13 Q. In those discussions with the doctors that 14 are seeking privileges at Jupiter Medical Center, did 15 any of them express in any way dissatisfaction with 16 Good Samaritan's CMS star rating? 17 A. No. 18 Q. Only the Leapfrog hospital safety grade? 19 A. Yes, and the discussion was that this 20 physician wants to stay at Good Sam, loves Good Sam, 21 knows the quality of Good Sam, but HSS, they're not 22 sure if they're going to force them to do -- mostly go 23 to Jupiter or Jupiter completely. 24 Q. If home office will only allow you to 25 participate in the Leapfrog Hospital Survey if it's
Page 299 1 Q. How many patients of HSS surgeons have 2 specifically refused to come to Good Samaritan for a 3 surgery because of the Leapfrog safety grade? 4 A. I do not have a number. I do not know. 5 Q. How many names can you think of? 6 A. No, I'm saying I can obtain the names. 7 Q. You can obtain the names? 8 A. Right. 9 Q. But you don't have them as you sit here 10 today? 11 A. No. I don't have any patient names. 12 Q. And you don't have any numbers of patients, 13 right? 14 A. No. 15 Q. And so my original question was, have any 16 doctors refused to become associated with 17 Good Samaritan as a result of the Leapfrog hospital 18 safety grades? 19 MR. MARCUS: Object to form. 20 A. The physicians that are already with us on 21 staff, is that what you're referring to? 22 BY MS. BLAIR: 23 Q. Well, I guess we could break it down. Let's 24 start with, are there any doctors that you were trying 25 to recruit that said, No, I looked at your Leapfrog	Page 301 1 connected to a contract or payment, and as we saw in an 2 Exhibit earlier today, you don't have to hire anybody 3 to comply, anybody additional to comply with the 4 hospital survey, why isn't the fact that HSS cares 5 about the Leapfrog Hospital Survey enough to get a 6 dispensation from home office to participate? 7 A. Because this all happened after our F, 8 right. So all of this horrible mass destruction 9 happened after the F. So asking to be part of Leapfrog 10 prior to that was before this occurred. 11 I'm confident that we're probably not going 12 to now that there is so much -- now that there's a 13 general understanding of how it works and what occurred 14 with the F, we're certainly not going to want to be a 15 part of it. 16 Q. Well, because you filed suit, correct? 17 MR. MARCUS: Object to form. 18 A. (No response). 19 BY MS. BLAIR: 20 Q. So you could participate in Leapfrog and 21 under your allegations of this Complaint increase your 22 Leapfrog safety grade and avoid the harm, but you're 23 choosing not to, correct? 24 MR. MARCUS: Object to form. 25 A. The harm is already done.

Page 302 1 BY MS. BLAIR: 2 Q. So there's no continuing harm? 3 A. Yeah, it's going to continue. So you think 4 if all of a sudden we're going to participate and, Oh, 5 we're now a B that that's going to like -- it's just 6 not going to -- a lot of harm has already been done. 7 It's going to take a while to recover, but I wouldn't 8 want to really participate in the survey in the first 9 place because I really don't believe it does add the 10 value that the Joint Commission does, that the 11 accrediting bodies do that come and share best practice 12 with us, that meet with our leaders and go over things, 13 just like the Joint Commission when they were just in 14 our building, and we had the best emergency management 15 plan, but then they'll give us something another 16 hospital has that they think, Oh, you should -- maybe 17 you should look at this policy or doing it this way. 18 That's where we want to do a more of a collaboration 19 with than filling out the survey. 20 Q. Am I correct you're voluntarily choosing not 21 to perform in the Leapfrog Hospital Survey? 22 A. Well, it's a voluntary survey so we didn't 23 fulfill out the survey. 24 Q. And you have no intention of doing that 25 going forward, correct?	Page 304 1 Q. Well, you read the Complaint, right? 2 A. Yeah. 3 Q. Do you have any understanding of how much 4 has been incurred in attorney's fees to date? 5 MR. MARCUS: Object to form. 6 A. Do I know? 7 BY MS. BLAIR: 8 Q. Um-hum. 9 A. I mean, I've seen some allocations, but I 10 don't know how much has been spent on attorney's fees. 11 Q. What are the allocations that you've seen? 12 A. There are allocations from the home office. 13 I think it's our financial statement. 14 Q. Okay. But I'm just asking about the 15 attorney's fees. What are the allocations of 16 attorney's fees for this action that you'll be seeking? 17 MR. MARCUS: Object to form. 18 A. The amount? 19 BY MS. BLAIR: 20 Q. Um-hum. 21 A. For Good Sam, a million, a million and a 22 half maybe. 23 Q. And is that then multiplied by five since 24 there are five plaintiffs? Are you splitting it 25 equally?
Page 303 1 A. At the end of the day, I wouldn't make that 2 decision. 3 Q. And we just discussed, even if it turns out 4 that your assumptions regarding the Leapfrog Hospital 5 Survey are wrong, you still don't want to participate 6 in that survey? 7 MR. MARCUS: Object to form. 8 A. Even if the assumptions of what? 9 BY MS. BLAIR: 10 Q. Even if the assumptions that you've made, 11 it's pay to play, you pay for consulting services to 12 get your grade, there's no science behind the 13 imputation methodology, even if all those things turn 14 out to be wrong, you still have no intention of 15 engaging in the hospital survey, correct? 16 MR. MARCUS: Object to form. 17 A. I don't make those decisions. 18 BY MS. BLAIR: 19 Q. Who does? 20 A. Tenet corporate. 21 Q. You're also requesting your attorney's fees 22 in this matter, correct? Do you understand that? 23 MR. MARCUS: Object to form. 24 A. Okay. 25 BY MS. BLAIR:	Page 305 1 A. I don't know. 2 Q. What about costs, do you have any 3 understanding of what the costs are? 4 A. What do you mean? 5 Q. Well, there's expert fees, for example. Do 6 you know what those are in addition to the attorney's 7 fees? 8 A. No. 9 MR. MARCUS: Object to form. 10 BY MS. BLAIR: 11 Q. Is Good Sam currently paying the attorney's 12 fees associated with this case? 13 A. I don't -- I don't think so. I mean, we 14 are. It's in our financial statement, but, honestly, I 15 don't know what happens in accounts payable and who's 16 handling all of that information. 17 Q. Okay. But you believe the projections are 18 that Good Sam's share of the attorney's fees in this 19 case will be 1.5 million, correct? 20 MR. MARCUS: Object to form. 21 A. That is my understanding. 22 BY MS. BLAIR: 23 Q. How much time have you and your staff 24 devoted to this lawsuit since it was filed on 25 April 30th, 2025?

Page 306 1 A. I have no idea. 2 Q. More than 100 hours? 3 A. I would not be able to tell you. 4 Q. Well, I know you've spent at least seven 5 hours because we've been here almost seven, correct? 6 A. Right. 7 Q. Have you ever been told by Tenet home office 8 that the goal of this lawsuit is to stop Leapfrog from 9 grading hospitals? 10 A. No. 11 Q. Do you have any understanding as to whether 12 the goal of this lawsuit is for Tenet to have none of 13 its hospitals across the country graded by Leapfrog? 14 MR. MARCUS: Object to form. 15 A. I don't know if that's the goal or it's a 16 just that we're, you know, we don't -- if we don't 17 participate, we're just not given a grade is my 18 understanding. 19 BY MS. BLAIR: 20 Q. Have you ever had discussions with other 21 nonparticipating hospitals outside of the Tenet Health 22 network about joining your lawsuit? 23 A. No. 24 Q. Have you had any internal discussions about 25 the consequence of this lawsuit being that your	Page 308 1 with all of the documents, whether I have them or not, 2 you've provided them to your attorneys for production 3 in this matter? 4 A. Anything that I was asked, I produced. 5 MS. BLAIR: Excellent. I have no further 6 questions. 7 MR. MARCUS: Okay. 8 MS. BLAIR: Thank you. 9 THE VIDEOGRAPHER: Before we go off the 10 record, does anyone want to order the transcript 11 or the video? 12 MS. BLAIR: I will take a rough of the 13 transcript and then regular delivery of the 14 final in an eTtran. I do not want the video at 15 this time. 16 MR. SIMMONS: We do want the video. 17 MR. MARCUS: And the witness will read. 18 THE VIDEOGRAPHER: This concludes today's 19 deposition. We're going off the record. The 20 time is 5:41 p.m. 21 THE STENOGRAPHER: And, Counsel, do you need 22 to order the transcript? 23 MR. SIMMONS: Yes, please. 24 THE STENOGRAPHER: Do you need a rough draft 25 also?
Page 307 1 competitors, like Jupiter, would look bad in the public 2 by promoting their safety grade previously? 3 A. No. 4 Q. Is the goal of this lawsuit to affect 5 competition for Good Samaritan in any way? 6 A. No. 7 Q. What is your understanding of the goal of 8 this lawsuit? 9 A. To if we don't participate that we're not 10 given a grade. 11 Q. My last question is, do you have any plans 12 of producing any additional documents -- well, strike 13 that. 14 To your knowledge, have you given your 15 attorneys all of the documents that you plan on 16 producing in this litigation? 17 MR. MARCUS: Are you asking her personally 18 or are you asking her as a corporate rep? 19 BY MS. BLAIR: 20 Q. As a corporate rep, are you done providing 21 document -- I don't have all the documents yet, and I 22 understand your attorneys are reviewing them, and I'm 23 not faulting them for that. But I'm asking you, as the 24 corporate representative of Good Samaritan, is it your 25 understanding that you now have provided your attorneys	Page 309 1 MR. SIMMONS: Yes, please. 2 THE STENOGRAPHER: Regular delivery? 3 MR. SIMMONS: Yes. 4 (A discussion was held off the record.) 5 MR. MARCUS: We're designating the 6 transcript as confidential per the 7 confidentiality order that's in place. 8 MS. BLAIR: And we reserve our rights to 9 object to the confidential nature of certain 10 portions of the transcript. 11 MR. SIMMONS: Could we get a rush delivery 12 for the transcript? 13 THE STENOGRAPHER: Of course. When do you 14 need it? 15 MR. SIMMONS: Could we get it end of day 16 Wednesday? 17 THE STENOGRAPHER: Of course. 18 (Thereupon, the proceedings concluded at 19 5:45 p.m.) 20 (The witness did not waive signature.) 21 22 23 24 25

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writing 134:14 227:16				
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EXHIBIT 26

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

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

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

Plaintiffs,

-VS-

THE LEAPFROG GROUP,

Defendant.

VIDEO-RECORDED DEPOSITION OF ERIK CAZARES
PURSUANT TO RULES 30 AND 30(b)(6)
Volume 1 (Pages 1 - 101)

DATE: Wednesday, September 24, 2025
TIME: 10:34 a.m. - 1:01 p.m.
LOCATION: ASC Advisors LLC
550 South Andrews Avenue
Suite 700
Fort Lauderdale, Florida 33394

Stenographically Reported By:
Theresa Rust, RPR

Job No.: 422124

Erik Cazares
September 24, 2025

Page 2 1 APPEARANCES: 2 On behalf of Plaintiffs: 3 GIBSON, DUNN & CRUTCHER LLP 4 1700 M Street Northwest 5 Washington, DC, 20036 6 (202) 955-8500 7 BY: DANIEL CHUNG, ESQUIRE 8 dchung@gibsondunn.com 9 BY: ALEXANDER FISCHER, ESQUIRE 10 afischer@gibsondunn.com 11 On behalf of Defendant: 12 WILSON ELSEER MOSKOWITZ EDELMAN & DICKER LLP 13 2063 Main Street 14 Suite 100 15 Sarasota, Florida 34237 16 (941) 866-8561 17 BY: JURA ZIBAS, ESQUIRE 18 jura.zibas@wilsonelser.com 19 20 ALSO PRESENT: 21 Alex Rampone, Videographer 22 23 24 25	Page 4 1 Thereupon, 2 the following proceedings began at 10:34 a.m.: 3 THE VIDEOGRAPHER: We are now on the 4 record. My name is Alex Rampone. I'm the 5 videographer with Lexitas. Today's date is 6 September 24, 2025, and the time is 10:34 a.m. 7 eastern time. 8 This deposition is being held at 550 South 9 Andrews Avenue, Suite 700, Fort Lauderdale, 10 Florida 33301 in the matter of Good Samaritan 11 Medical Center, Inc. versus Leapfrog Group. The 12 deponent is Erik Cazares. 13 Would counsel and all present please 14 introduce themselves, and after, the court 15 reporter, Theresa Rust, will swear in the 16 witness. 17 MS. ZIBAS: My name is Jura Zibas. I'm 18 with the law firm of Wilson Elser on behalf of 19 the defendant, The Leapfrog Group. 20 MR. CHUNG: Daniel Chung of Gibson Dunn & 21 Crutcher for plaintiffs. 22 MR. FISCHER: Alexander Fischer from Gibson 23 Dunn. 24 THE STENOGRAPHER: Raise your right hand, 25 please.
Page 3 1 INDEX OF PROCEEDINGS 2 WITNESS PAGE 3 ERIK CAZARES 4 DIRECT EXAMINATION BY MS. ZIBAS 5 5 CROSS-EXAMINATION BY MR. CHUNG 94 6 CERTIFICATE OF OATH 98 7 CERTIFICATE OF REPORTER 99 8 LETTER TO WITNESS 100 9 ERRATA SHEET 101 10 11 EXHIBITS 12 EXHIBIT DESCRIPTION PAGE 13 1 Notice of deposition 7 14 2 TLG safety grade Hospital of 20 15 Providence Sierra Campus 2025 16 3 TLG safety grade Hospital of 21 17 Providence Sierra Campus 2025 18 4 Cazares declaration 67 19 5 Leapfrog hospital safety grade for 69 20 Palm Beach Gardens Medical Center F 21 6 E-mail from Maggie Gill dated 79 22 December 11, 2024 23 7 E-mail from Naomi Seymour dated 81 24 December 11, 2024 25 8 Governing board minutes dated 87 December 17, 2024 9 Amended complaint 94 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25	Page 5 1 Do you swear that the testimony you are 2 about to give will be the truth, the whole 3 truth, and nothing but the truth? 4 THE WITNESS: Yes. 5 THE STENOGRAPHER: Thank you. 6 THEREUPON: 7 ERIK CAZARES 8 Was called as a witness and, having been first duly 9 sworn and responding "I do," was examined and 10 testified as follows: 11 DIRECT EXAMINATION 12 BY MS. ZIBAS: 13 Q. Good morning, Mr. Cazares. As I indicated, 14 my name is Jura Zibas. I represent the defendants, 15 and we're here today to take your deposition as it 16 relates to the lawsuit filed in the Southern District 17 of Florida, U.S. District Court. 18 Have you been deposed before in the past? 19 A. Yes. 20 Q. How many times? 21 A. Twice. 22 Q. And what were the cases, if you recall? 23 A. One was an employment and the other one a 24 union matter. 25 Q. And were the lawsuits related to your work,

Page 6 1 meaning under your former employer or your current 2 employer? 3 A. Yes. 4 Q. All right. And the reason I ask is just in 5 terms of having to explain to you the process. So 6 you understand that we're going to be videotaping you 7 answering questions. Please wait until I finish 8 asking the question. If your attorney has an 9 objection, let your attorney object. Unless he 10 directs you not to answer, you answer the question 11 after the objection is on the record. If there's a 12 question that you don't understand, just let me know. 13 And we will do every -- I'll make every effort to 14 then rephrase it or explain the question. 15 If you need to take a break, please let us know. 16 You can take a break. This isn't an endurance test. 17 Just have to do it in between questions. 18 Does that all make sense to you? 19 A. Yes. 20 Q. All right. When did you first learn about 21 -- let's set up the foundation. You are aware that 22 there is a lawsuit filed by Palm Beach Community 23 Hospital against the Leapfrog Group; is that correct? 24 A. Yes. 25 Q. When did you first learn that a lawsuit	Page 8 1 Hospital. Is that your understanding of the purpose 2 of today? 3 A. Yes. 4 Q. What is your current job title? 5 A. I'm the CEO of Palm Beach Gardens Medical 6 Center. 7 Q. And when did you start in that role? 8 A. July of 2024. 9 Q. And before we go into your education or 10 employment background, going back to the two times 11 you were previously deposed. Were those in state or 12 Federal Court cases, do you know? 13 A. I don't recall. No, I don't recall. Long 14 time ago. 15 Q. Okay. So we want to go through some of 16 your back -- your history and background first. So 17 why don't you tell me your -- where did you earn your 18 college degree or nursing degree? 19 A. Sure. I graduated from the University of 20 Texas El Paso with a Bachelor of Science in nursing 21 in 2000. That was the first degree that I earned. 22 And I started practicing as a registered nurse in 23 January of 2001. Received a Master's in science and 24 nursing administration from Texas Tech University and 25 that was in 2013.
Page 7 1 would be filed against the Leapfrog Group by Palm 2 Beach Gardens Community Hospital? 3 MR. CHUNG: I'm going to object based on 4 privilege. If your answer involves any 5 communications with lawyers, either in-house 6 lawyers or outside lawyers, avoid those 7 conversations. 8 MS. ZIBAS: Yes. I'm not interested in 9 your conversation. Just if you -- when you 10 learned about it. 11 A. It was earlier this year. I don't have the 12 exact date. 13 (Exhibit 1 was marked.) 14 BY MS. ZIBAS: 15 Q. Okay. I have marked what is Cazares Number 16 1. It's an exhibit I want you to take a look at that 17 we're just going to identify and flip the pages. 18 A. Okay. 19 Q. Have you seen this document that is Cazares 20 Number 1 before? 21 A. This specific document, I have not. 22 Q. This is a deposition notice, and on the 23 front, it indicates that we are here for your 24 deposition as an individual and also as a 25 representative of Palm Beach Gardens Community	Page 9 1 Q. So while you were earning your Master's in 2 nursing administration, were -- did -- were you 3 employed? 4 A. Yes. 5 Q. And where was your -- what was your first 6 job after you graduated from nursing school? 7 A. It was in a hospital called Sierra Medical 8 Center. 9 Q. And how long did you work at Sierra Medical 10 Center? 11 A. I worked there until 2008. 12 Q. And after Sierra Medical Center, did you 13 work somewhere else? 14 A. Yes. I went to Sierra Providence East 15 Medical Center. 16 Q. And what was your title there? 17 A. Well, I had different titles. My initial 18 title was director of the telemetry floor, and then I 19 took over several other departments and eventually 20 became the assistant chief nurse officer for that 21 particular hospital. 22 Q. That was Sierra Providence East? 23 A. Correct. 24 Q. How long did you work at Sierra Providence 25 East in your various roles?

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Page 10 1 A. Until 2015. 2 Q. And then where did you go in 2015? 3 A. Then I went back to Sierra Medical Center 4 as the chief nursing officer. 5 Q. And when you're a chief nursing officer, 6 what are your duties, in general? 7 A. Oversight of all of nursing operations, 8 staffing, safety, quality, patient experience. 9 Q. And how long were you the chief nursing 10 officer at Sierra Medical Center? 11 A. I was there for approximately three years. 12 Q. And that's around 2018; is that correct? 13 A. Correct. 14 Q. And then where did you go? 15 A. Then I went back to Sierra Providence East. 16 By that time, it was called the Hospitals of 17 Providence East Campus and as a role of a chief 18 operating officer. 19 Q. So you went back to Sierra Providence East, 20 but it was then the Hospitals of Providence East 21 Campus? 22 A. The Hospitals of Providence East Campus. 23 Q. And you were the COO? 24 A. Correct. 25 Q. And then how long were you the COO?	Page 12 1 A. They built that hospital in 2008. 2 Q. Okay. So when you were at Hospitals of 3 Providence Sierra, were you considered a Tenet 4 employee or a hospital employee? 5 A. I was under the Tenet payroll. 6 Q. Did you ever -- when you were at Hospitals 7 of Providence Sierra, did you ever interact with 8 people at Tenet headquarters office regarding 9 quality, safety, or any of those -- any of those 10 principles? 11 A. Yes. 12 Q. And who did you interact with at Tenet 13 headquarters about quality and safety? 14 A. Different individuals depending on what we 15 were addressing, but they have leads. They have a 16 safety lead. They have a quality lead and so forth. 17 Q. And do you still interact with the safety 18 and quality lead today at your current role? 19 A. Yes. 20 Q. Who is the safety lead? 21 A. Well, we interact with like the chief 22 medical officer for the company, Ernest Franklin. 23 Dr. Franklin. And the chief nursing officer. That's 24 who I now interact with the most. Judy Chabot. 25 Q. Did you eventually start working at Palm
Page 11 1 A. I was there until 2022 as the COO. 2 Q. Okay. And then what did you do in 2022? 3 A. And then I transitioned back to the -- what 4 used to be Sierra Medical Center. Now, it's called 5 the Hospitals of Providence Sierra Campus as the 6 chief executive officer. 7 Q. And when you were the chief executive 8 officer of Hospitals of Providence Sierra Campus, 9 what would you call -- how would you describe your 10 overall duties? 11 A. I was responsible for oversight of all 12 hospital operations, financial, quality, safety, 13 contracts, physician relations. 14 Q. Did you report to a board of directors or 15 governing board? 16 A. There was a -- yes. There was a local 17 hospital governing board. 18 Q. And who owns The Hospitals of Providence 19 Sierra? 20 A. Tenet. 21 Q. When did Tenet buy The Hospitals of 22 Providence Sierra Campus? 23 A. I don't know. 24 Q. Did Tenet buy The Hospital of Providence 25 East Campus at some point, as well?	Page 13 1 Beach Gardens Community Hospital? 2 A. I'm sorry. Repeat the question. 3 Q. I said at some point, did you begin your 4 role as a chief executive officer at Palm Beach 5 Gardens Community Hospital? 6 A. Yes. In July of 2024. 7 Q. So what made you go from -- decide to go 8 from Texas, the Hospitals of Providence Sierra 9 campus, to Palm Beach Gardens? 10 A. Sure. I was approached with the 11 opportunity for the position at Gardens, and I was 12 open to relocate, so then that brought me here to 13 Florida. Explored the opportunity and it was 14 something that grabbed my attention, and I thought it 15 would be a good fit. 16 Q. Who approached you? 17 A. This was Maggie. 18 Q. Is that Maggie Gill? 19 A. Maggie Gill. 20 Q. And do you know what Maggie Gill's role is? 21 A. She is the regional leader for our 22 hospitals. 23 Q. And is she a Tenet employee? 24 A. I believe so. 25 Q. And what region does she lead?

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Page 14 1 A. Well, she's got multiple regions, but she's 2 over the Florida region, and I believe she has a few 3 more areas. 4 Q. So when you came to the Palm Beach Gardens 5 Community Hospital, did you have a transition period 6 where the prior CEO worked with you or you just 7 started sort of on your own? 8 A. I was -- on day one, I was by myself. 9 Q. And how many people report to you directly? 10 A. Oh, I have about six direct reports. 11 Q. And what are their titles? And if you 12 don't remember, that's fine. 13 A. Sure. I've got my executive assistant, 14 chief nursing officer, chief operating officer, chief 15 financial officer, chief human resource officer, and 16 there's one more. Who else? That's it because the 17 other ones -- so it's five. 18 Q. Is there a chief strategy officer at Palm 19 Beach Gardens? 20 A. There is. 21 Q. And does that person -- who does that 22 person report to? 23 A. To the market chief strategy lead. 24 Q. And who does the market chief -- is the 25 market chief strategy lead at Palm Beach Gardens or	Page 16 1 lines. 2 Q. And where is Palm Beach Gardens Community 3 Hospital physically located? 4 A. In Palm Beach Gardens. 5 Q. And what's the address there? 6 A. I don't know the exact address. It's on 7 Birds Road. 8 Q. Is it in a part of Palm Beach with a 9 population that is a little -- that is older? 10 A. Yes. 11 Q. So what is the -- what -- and this is 12 sometimes hard to figure out. What's the median age 13 of your patient population? 14 A. Yeah. When we last looked at it, it was 62 15 and a half years old. 16 Q. And when did you last look at it? 17 A. Several months ago. 18 Q. And why did you look at the median age of 19 the population? Were you doing a market study or -- 20 A. We do that from time to time, look at the 21 age of the population that we're serving. 22 Q. And is there a certain time of year that 23 Palm Beach Gardens Community Hospital is busier than 24 others, such as snowbird season? 25 A. Yes.
Page 15 1 is that a Tenet person? 2 A. No. He's a sister facility. 3 Q. What facility is that? 4 A. I believe he's Hospital Delray. 5 Q. And when you talk about a sister property, 6 is this part of the Palm Beach Health Network? 7 A. Correct. 8 Q. And you refer to them at sister properties? 9 A. Yeah. 10 Q. Do you have any direct or specific role at 11 Palm Beach Network yourself? 12 A. No, just my hospital. 13 Q. And how many beds do you have at Palm Beach 14 Gardens? 15 A. 199 licensed beds. 16 Q. And what do you mean by licensed beds? 17 A. That those are the amount of beds that 18 we're licensed through the State of Florida. 19 Q. And do you have a trauma center? 20 A. No. 21 Q. What services are offered at Palm Beach 22 Gardens? 23 A. The main service line is cardiac. We also 24 do orthopedics, neurology, general surgery, emergency 25 services. I would consider those the main service	Page 17 1 Q. And what is the Palm Beach snowbird season, 2 what months? 3 A. Well, I'm just beginning to learn it 4 because I've only been here one year. So last year 5 we were, I'd say, it was December through April. 6 Q. And do you see a large drop-off in 7 admissions and visits to the hospital after April? 8 A. There's a drop. 9 Q. Historically, and based on the information 10 that you've reviewed to date, has there always been a 11 drop after April? 12 A. Yes. 13 Q. Now, as CEO of Palm Beach Gardens, how much 14 oversight is there by Tenet Healthcare of your 15 everyday daily role? How much do they oversee you? 16 MR. CHUNG: Objection to form. 17 A. I mean, it's hard to quantify the amount of 18 oversight, but we get direction on different 19 initiatives, projects. 20 BY MS. ZIBAS: 21 Q. When you get direction from Tenet, does it 22 come through Maggie? 23 A. Not always. Sometimes through Maggie, 24 sometimes directly from corporate leaders. 25 Q. And in comparison to when you were the CEO

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Page 18 1 at Hospitals of Providence Sierra Campus, is it about 2 the same direction from corporate Tenet there as what 3 you see now at Palm Beach Gardens? 4 MR. CHUNG: Objection to form. 5 A. Yes. Yes, it's fairly similar. 6 BY MS. ZIBAS: 7 Q. The Leapfrog Group is the defendant in this 8 case filed by Palm Beach Gardens. Can you just give 9 me both in your personal capacity, what do you know 10 about The Leapfrog Group, in terms of what they do, 11 who they are, et cetera? 12 MR. CHUNG: Objection to form. 13 A. Well, the Leapfrog Group assigns hospitals 14 a patient safety letter grading using a methodology 15 that they've used for some time. But that 16 methodology recently changed. So my most recent 17 experience is that that methodology is now negatively 18 affecting hospitals that do not participate in 19 leapfrog, that they don't submit data. 20 A perfect example is Palm Beach Gardens Medical 21 Center. Palm Beach Gardens Medical Center hadn't 22 submitted data or participated in Leapfrog since 2022 23 and recently received a letter F grade for patient 24 safety. And that was based on incomplete data since 25 we didn't participate, deceptive, what we consider	Page 20 1 Q. And when you were at Hospitals of 2 Providence Sierra, did Hospitals of Providence Sierra 3 participate in taking Leapfrog survey? 4 A. Not while I was the CEO. 5 Q. And what was their grade when they did not 6 participate? 7 A. I believe it was a C. 8 Q. And did it continue to be a C through 2023 9 and 2024? 10 A. I believe so. 11 Q. And do you know if in 2025 that it was a C? 12 A. I don't know. I don't know. 13 MS. ZIBAS: I'm handing you a document that 14 is labeled Cazares 2. 15 (Exhibit 2 was marked.) 16 BY MS. ZIBAS: 17 Q. And it says Leapfrog hospital safety grade. 18 And if you look at the URL, it was taken off the 19 hospitalsafetygrade.org site. For the Hospital of 20 Providence Sierra Campus and in spring 2025, do you 21 see the hospital grade says C? 22 A. Yes. 23 Q. And as far as you know, was -- are they 24 participating in taking a survey? 25 A. I don't know. I cannot speak to what
Page 19 1 deceptive grading methodology, and it has had a 2 significant impact on the reputation of the hospital, 3 the way that the hospital is viewed by physicians, 4 patients, community stakeholders, employees. 5 BY MS. ZIBAS: 6 Q. When you say we, when you refer to we, the 7 deceptive grading methodology, who is the we you're 8 referring to when you just testified? 9 A. Repeat that. What did I say? 10 Q. You referred to we. So when you say we, 11 are you referring to Palm Beach Gardens as a we or 12 Tenet and Palm Beach Gardens? 13 A. Correct. Palm Beach Gardens. 14 Q. Now, how did you find out about the 15 background of not submitting data from Palm Beach 16 Gardens since 2022? Who provided you that background 17 information? 18 A. That was my quality director. 19 Q. And who is your quality director? 20 A. Kathleen McDonald. 21 Q. And how long has Kathleen McDonald worked 22 at Palm Beach Gardens? 23 A. I don't know off the top of my head. 24 Q. Has she been there more than five years? 25 A. I don't know for a fact.	Page 21 1 Sierra is doing now. 2 MS. ZIBAS: I'll give you Cazares 3. 3 (Exhibit 3 was marked.) 4 BY MS. ZIBAS: 5 Q. And this is another page from that same 6 Leapfrog hospital safety grade, but as you can see at 7 the bottom, it has infections, problems with surgery, 8 different tabs that you would click on. 9 A. Uh-huh. 10 Q. And if you go to the second page, under 11 notes and definitions, it said declined to report. 12 The hospital was asked to provide this information to 13 the public but did not. Does this help you determine 14 if they are participating in the survey? 15 MR. CHUNG: Objection to form. 16 A. Yeah. I cannot tell if they're 17 participating, and I can't speak to what -- what data 18 they're submitting or not submitting. 19 BY MS. ZIBAS: 20 Q. And why -- so if Palm Beach Gardens is not 21 submitting data and the Hospital of Providence Sierra 22 Campus is not submitting data, why do you think one 23 receives an F and one receives a C? 24 MR. CHUNG: Objection to form, 25 mischaracterizes prior testimony.

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Page 22 1 A. As I mentioned earlier, I cannot speak to 2 whether Sierra is participating or not participating 3 at this moment. 4 BY MS. ZIBAS: 5 Q. Do you know if any Tenet Healthcare 6 hospitals participate in the Leapfrog survey? 7 MR. CHUNG: Objection to form. 8 A. I'm not aware of that information. 9 BY MS. ZIBAS: 10 Q. Who would know that? 11 MR. CHUNG: Objection to form. 12 MS. ZIBAS: At Tenet, based on your 13 experience of working under Tenet. 14 A. I don't know. 15 BY MS. ZIBAS: 16 Q. Would the chief medical officer know? 17 MR. CHUNG: Objection to form. 18 A. I don't know if he would know, has 19 participated or not. 20 BY MS. ZIBAS: 21 Q. Does Palm Beach Gardens have a safety plan? 22 A. Yes. 23 Q. And do they have a safety plan in 2023? 24 A. My understanding is they did. 25 Q. What about 2024?	Page 24 1 Q. And do you know when Tenet purchased them? 2 A. I don't. 3 Q. Did you read any expert reports in 4 preparation for your deposition today? 5 A. No. 6 Q. Do you have anybody at Palm Beach Gardens 7 who manages marketing? 8 A. We have a marketing manager. 9 Q. Just one person? 10 A. Yes. 11 Q. And who is that? 12 A. Her name is Amanda Blanchard. 13 Q. And does Amanda Blanchard have a staff? 14 A. No. 15 Q. And is there anybody that does social media 16 management? 17 A. She handles some of it. 18 Q. Does she have an outside vendor or does she 19 handle it all herself? 20 A. I'm not quite sure how she handles it. 21 Q. Do you have a marketing budget at Palm 22 Beach Gardens? 23 A. We do. 24 Q. And is it based on revenue share, or is it 25 just a certain sum of money that's allocated?
Page 23 1 A. Yes. 2 Q. What about 2025? 3 A. Yes. 4 Q. What did you do to prepare for your 5 deposition today, outside of speaking with your 6 lawyers? I'm not interested in the sum and substance 7 of the conversation. Just in general, what did you 8 do to prepare? 9 A. Reviewed my declaration, reviewed the 10 complaint. 11 Q. During the course of this litigation, have 12 you gathered documents to respond to discovery 13 requests? 14 A. Yes. 15 Q. And did you -- anybody else, as far as you 16 know, at Palm Beach Gardens gather documents? 17 A. Yes. 18 Q. And were all documents you gathered 19 provided to your counsel? 20 A. Yes. 21 Q. Do you know when Palm Beach Gardens 22 Hospital -- Community Hospital was formed? 23 A. 1968. 24 Q. And do you -- are they owned by Tenet now? 25 A. Yes.	Page 25 1 A. It's an allocation. 2 Q. And who determines the annual budget for 3 the hospital? 4 A. It's the hospital leadership, myself, with 5 my chief financial officer, with approval from our 6 corporate office. 7 Q. Does your corporate -- and when you say 8 corporate office, I assume you mean Tenet; correct? 9 A. Correct. 10 Q. Have you found that Tenet reduces the 11 budget after you submit it, or is it pretty much a 12 rubber stamp? 13 MR. CHUNG: Objection to form. 14 A. It's neither. 15 BY MS. ZIBAS: 16 Q. Describe to me what you mean by neither. 17 A. They don't rubber stamp it, and they don't 18 necessarily reduce it. 19 Q. Do they move funds from one allocation to 20 another? 21 MR. CHUNG: Objection to form. 22 A. No. 23 BY MS. ZIBAS: 24 Q. So how do they -- how do they change the 25 budget, if they don't accept the budget that you

Page 26 1 submit? 2 MR. CHUNG: Objection to form, 3 mischaracterizes testimony. 4 A. When we submit the budget, it's a 5 conversation regarding whether the dollars are needed 6 and what they're needed for, and then we come to an 7 agreement. 8 BY MS. ZIBAS: 9 Q. Has the budget for 2026 been completed? 10 A. For 2026? 11 Q. Yes. 12 A. No. 13 Q. What are the role -- what's the role or the 14 tasks that are accomplished by Amanda Blanchard as 15 the marketing manager? 16 A. What are the -- can you repeat the 17 question? 18 Q. Yes. What are the tasks or the job duties 19 of Amanda Blanchard? 20 A. Basically everything that involves 21 marketing, whether it's social media, coordinating 22 community events, coordinating statements out to the 23 media or the organization. She works with 24 communications to do that, as well. 25 Q. And is that the Palm Beach Gardens	Page 28 1 Q. Did you ever review any statements prepared 2 by the Palm Beach Health Network about The Leapfrog 3 Group? 4 A. No. I got copied on communications after 5 it went out. 6 Q. Do you know why the Palm Beach Gardens 7 Community Hospital stopped participating in The 8 Leapfrog Group survey? 9 A. I don't. I don't know why. 10 Q. Do you know what year that was? 11 A. I believe it was back in 2022 they stopped 12 participating. 13 Q. You referenced earlier that you described 14 the -- that The Leapfrog Group has a methodology, had 15 a methodology and then it changed. Can you describe 16 to me your understanding of The Leapfrog Group 17 methodology before the change? 18 A. Sure. So the way that I understand it is 19 that before the change, nonparticipating hospitals, 20 when they didn't submit data in certain metrics, they 21 were awarded a score or given a score based on the 22 average of similar hospitals' performance, and that 23 changed to where the fall of 2024, on four particular 24 metrics, Leapfrog automatically scores them at the 25 lowest level for those four particular metrics:
Page 27 1 communications? 2 A. Correct. 3 Q. And is that a separate department? 4 A. I don't know if they're completely separate 5 or if they're linked. 6 Q. And are they -- would the communications 7 potentially be linked to a marketing manager, as far 8 as -- is that who reports to? 9 MR. CHUNG: Objection to form. 10 A. No. 11 BY MS. ZIBAS: 12 Q. Who does the communications person report 13 to? 14 A. There is a -- there's a communications 15 director and marketing. 16 Q. And do you meet with the communications 17 director? 18 A. No. 19 Q. Have you ever discussed The Leapfrog Group 20 with the communications director? 21 A. No. 22 Q. Have you ever given any -- you personally 23 given any statements to the press about The Leapfrog 24 Group? 25 A. No.	Page 29 1 handwashing, computerized physician order entry, bar 2 code medication scanning, and ICU staffing. And by 3 doing that, the score -- they got the lowest score 4 possible in those metrics, and the letter grade is 5 then affected. Drops either to a D or F. In the 6 case of Gardens, it dropped to an F. Before that, it 7 had been a C, even when the hospital was not 8 participating. 9 Q. So when it -- when they received a C 10 because of the scoring that you described by the 11 nonparticipating hospitals, did you think that was, 12 in your personal opinion, was that fair for not 13 participating that they received a high score and 14 then now it's a lower score? 15 MR. CHUNG: Objection to form. 16 A. I don't -- I'm not ready to comment whether 17 it was fair or not. What I do know is the letter 18 grade F is detrimental to the organization. And when 19 the hospital had a letter score of C, we did not 20 experience the negative reputation that we're 21 experiencing now that we have in awarding an F, from 22 physicians, from patients, community members, 23 governing board members. As soon as that F came out, 24 we started getting complaints and concerns from all 25 these individuals, which didn't exist when the

Page 30 1 hospital was rated a C. 2 BY MS. ZIBAS: 3 Q. How did the information get out, you said, 4 about the F? Was a press release put out by Palm 5 Beach Health Network? Who put the press release out? 6 MR. CHUNG: Objection to form. 7 A. I don't recall where the initial release 8 came out. But the grades came out and then it was 9 brought to our attention that patients were 10 significantly concerned about going to Gardens 11 because of the F grade. We even know our competitor 12 was publishing their letter grade of an A and ours of 13 an F, so they also had input into getting some of 14 that in the community, as well. 15 BY MS. ZIBAS: 16 Q. Who is your competitor that was publishing? 17 A. Jupiter. 18 Q. So did Jupiter Medical Center publish their 19 grade versus your grade into the -- I guess the news 20 media? 21 A. I don't know if they published it into the 22 news media, but they definitely public -- made it 23 public to their physician group, which is also the 24 same physicians in our organization. 25 Q. Do you know if Jupiter Medical Center	Page 32 1 especially after a Tik Tok video was created and was 2 out there broadcasting Gardens as the worst hospital 3 in Florida, specifically referencing handwashing. 4 After that Tik Tok video, I started receiving more 5 and more complaints from physicians, that they were 6 talking to patients in their offices, and especially 7 patients that needed to have procedures done. They 8 didn't want to go to Gardens because of the F letter 9 grade that had been awarded by Leapfrog for patient 10 safety. 11 One particular patient is a cardiac patient that 12 needed to have a cardiac procedure and did not want 13 to go to Palm Beach Gardens. I received a phone call 14 from the surgeon. This particular patient, when I 15 talked to him, said that the main reason was because 16 of Leapfrog. So he was looking at other facilities 17 to have his cardiac procedure. 18 Our hospital is well known for our cardiac care 19 and infrastructure experience, so these patients are 20 making decisions to go to other facilities where the 21 care may not be to the quality or caliber and have 22 the outcomes that we have, specifically for cardiac 23 care in this instance. 24 Q. Do you have a CCU unit at Palm Beach 25 Gardens?
Page 31 1 received an A? 2 A. Yes. 3 Q. Have you talked to anyone at Jupiter 4 Medical Center about their A grade? 5 A. No. 6 Q. Do you know the CEO of Jupiter Medical 7 Center? 8 A. I know who he is, but I don't talk to him. 9 Q. So as you sit here today, you still do not 10 know who initially published the score, The Leapfrog 11 Group score about Palm Beach Gardens hospital; is 12 that correct? 13 MR. CHUNG: Objection to form. 14 A. That's correct. 15 BY MS. ZIBAS: 16 Q. Did you ever investigate further as to who 17 initially published the grades? 18 A. No. 19 Q. Did Tenet ever publish the grades? 20 A. I don't know. 21 Q. Now, you talked about physician -- it was 22 detrimental because physicians talked about it. How 23 many physicians talked to you about it? 24 A. I can't recall the amount of physicians. 25 It's -- they continue to talk to me about it,	Page 33 1 A. We have a CVICU. 2 Q. And how many beds? 3 A. 12 bids. 4 Q. Do you have ICU? 5 A. We do. 6 Q. And how many beds? 7 A. 16. 8 Q. How many operatories? 9 A. How many what? 10 Q. Operatories? 11 A. What is that? 12 Q. An operating room? 13 A. Operating rooms? 14 Q. Operating rooms for cardiac. 15 A. We have two. 16 Q. And how many -- is that total operating 17 rooms or just for cardiac? 18 A. No, that's just for cardiac. 19 Q. And how many total? 20 A. 12. 21 Q. So you can do maximum -- you can schedule 22 maximum of two a day in the cardiac or just one? 23 A. No, you can do multiple. 24 Q. What's the maximum number you can do in a 25 day?

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Page 34 1 A. Depends how long the physician is willing 2 to work. Sometimes they can do up to three, four, 3 surgeries a day. 4 Q. So when you say this patient needed cardiac 5 procedure and the surgeon called you, when was that? 6 A. This was approximately three to four weeks 7 ago. 8 Q. And who was the surgeon? 9 A. Dr. Patel. 10 Q. Did Dr. Patel tell you there was only one 11 patient concerned about the handwashing? 12 A. No. He's told me about multiple patients, 13 and I asked them that if those patients, whenever he 14 gets those patients, if he could give me their 15 information so I can talk to them and reassure them 16 of the care that we deliver at Palm Beach Gardens 17 Medical Center. So this is a particular patient that 18 I talked to, and he expressed his concerns about our 19 Leapfrog score and that being the driving decision 20 for not wanting to have surgery at Gardens. 21 But he's -- Dr. Patel said he's had multiple 22 patients, and I can give you a list of other 23 physicians who have also received similar concerns. 24 Q. Okay. Give me a list of those physicians. 25 A. Sure. There's Dr. Mostel; he's another	Page 36 1 citing the F grade. 2 Q. And who put up the -- who created the Tik 3 Tok video? 4 A. I don't know. 5 Q. And who posted it? 6 A. I don't know. 7 Q. Did you view it on Tik Tok? 8 A. I viewed it on -- I don't have Tik Tok, but 9 I viewed it online. 10 Q. On what? 11 A. Online. I mean, click on the link and it 12 pops up. 13 Q. And now you said the governing board also 14 complained to you. Who on the governing board? 15 A. There's a physician on the governing board 16 whose name is Dr. Suarez. We also have a community 17 member, Michael Mitrone. Those are two that come to 18 mind. 19 Q. And what did Dr. Suarez say to you? 20 A. He immediately complained about why Gardens 21 received an F on patient safety and Jupiter has an A, 22 when he considers -- he practices at both hospitals, 23 and he considers the quality at Gardens to be 24 superior in many aspects to Jupiter. So he was very 25 concerned, to which I responded to him that we did
Page 35 1 cardiologist. I believe there's a few more that I 2 had shared with my legal team, with the legal team. 3 Q. You provided that information to your legal 4 team? 5 A. Yes. 6 Q. Did you put it in your responses to your 7 interrogatories? 8 A. No. I don't think so. 9 Q. Is there a reason you didn't put it in the 10 interrogatories? 11 A. It was just too many to list. 12 Q. But based on your understanding of this 13 lawsuit, there's a claim of reputational harm; 14 correct? 15 A. Correct. That's correct. 16 Q. But yet you didn't want to list -- 17 A. Well, no, because -- 18 Q. -- harm? 19 A. -- up until this day, I continue to get 20 calls from physicians. And as a matter of fact, 21 after the video, the viral video, it's only been 22 escalating, and it's three to four times a week I'm 23 getting either calls from physicians or patients 24 voicing their concerns about patients not wanting to 25 go to Palm Beach Gardens Medical Center, specifically	Page 37 1 not participate in Leapfrog at that time, and that 2 had -- we had been granted a low rating because of 3 those four metrics that I mentioned earlier. We 4 received the lowest possible score for not submitting 5 the data. So that was my explanation to him. 6 Q. And what about Michael Mitrone? What did 7 he say? 8 A. Same thing. He wanted -- he didn't think 9 it was fair, and he wanted to know what we were going 10 to do about the bad reputation that the letter, that 11 the F grade had created for the organization. 12 Q. And what did you tell him that Palm Beach 13 Gardens is going to do about the reputation that you 14 believe it's created? 15 A. I told him we were looking into that and to 16 see what is it we could potentially do about it. I 17 didn't give him any specific details. 18 Q. Did you ever tell the board that one of the 19 solutions was filing this lawsuit? 20 A. No. What I did tell Mike Mitrone and the 21 rest of the governing board is that part of our goal 22 to minimize or mitigate the negative reputation is 23 for us to go out there and promote the quality of 24 Gardens, which is what I've been doing. I've been 25 out in the community. I've been talking to people.

Page 38 1 I've been highlighting our different awards and 2 accolades that highlight our outcomes for the 3 organization. 4 Q. Does Palm Beach Gardens participate in 5 Healthgrades? 6 A. We do. 7 Q. And how are Healthgrades determined? 8 A. Healthgrades is based on patient outcomes, 9 and where the hospital excels compared to the rest of 10 the nation, then Healthgrades will award in that 11 specific area a recognition for the hospital. 12 Q. How do they get their data at Healthgrades? 13 A. I believe they pull the data. 14 Q. And does Palm Beach Gardens -- 15 A. Publicly-reported data. 16 Q. Does Palm Beach Gardens purchase the 17 license for using the logo to promote the accolade? 18 A. I'm not sure exactly what Gardens pays. I 19 know that we do buy like the trophy or plaque from 20 them there's a -- when there's an area that we excel 21 in. 22 Q. In the advertising, do you use the 23 Healthgrades logo? 24 A. Yes. 25 Q. So do you pay a license for that?	Page 40 1 A. I don't know if it's considered consulting 2 services because that is a regulatory and mandatory 3 survey that we need to have in order to continue 4 receiving payment from Centers for Medicare and 5 Medicaid services, but there is a fee associated. 6 BY MS. ZIBAS: 7 Q. But do you pay -- there is an additional 8 option to pay for consulting services to provide 9 guidance -- 10 A. Oh, not that I'm aware of. Not that I'm 11 aware of. 12 Q. Do you know what CMS star ratings are? 13 A. We're a one star. 14 Q. And what does that mean? 15 A. It's a one star on a scale of five. That's 16 what I understand. 17 Q. And what does -- is one the worst? 18 A. Yes. 19 Q. And are you aware that the CMS data is 20 public? 21 A. Yes. 22 Q. And are you aware that the CMS data is used 23 as part of the Leapfrog hospital grade? 24 A. Some of it, yeah, is used. 25 Q. And what is -- what is Palm Beach Gardens
Page 39 1 A. I don't know. 2 Q. Is that something -- who handles the 3 advertising for Palm Beach Gardens? 4 A. Amanda. 5 Q. And what about Joint Commission? Does Palm 6 Beach Gardens go through The Joint Commission 7 process? 8 A. Absolutely. Joint Commission is our main 9 credentialing body. They're one of the approved CMS 10 vendors to go in into our facility and basically look 11 at everything. So we -- we are Joint Commission 12 accredited. They were in our hospital last year at a 13 group surveyors that went in and did an intense, 14 rigorous survey of our organizations. They spent 15 three days looking at our processes, talking to 16 patients, talking to family members, employees, 17 physicians, observing procedures in the operating 18 room, looking at our facility infrastructure, looking 19 at handwashing, infection control practices. They 20 followed a very rigorous process, and we had 21 successful accreditation. No conditional findings 22 for the organization. 23 Q. Does Palm Beach Gardens pay for consulting 24 services with Joint Commission? 25 MR. CHUNG: Objection to form.	Page 41 1 Community Hospital doing, if anything, to try to 2 improve its CMS star rating? 3 A. Yeah. Well, we're not specifically 4 addressing CMS star rating. In general, the very 5 nature of what we do in hospitals is to take care of 6 patients. We continuously are looking at our 7 practices to improve patient safety and improve 8 quality, improve the patient experience, and that's 9 whether -- we're not doing it with a specific effort 10 of improving CMS star ratings or any particular 11 agency's rating or -- that's just what we do. As a 12 clinician, as a nurse, that's my priority, as well, 13 regardless of the ratings. 14 Q. So when people -- when you -- you mentioned 15 briefly about the detrimental reputation because The 16 Leapfrog grade. How would the fact that there's a 17 CMS one-star rating not impact Palm Beach Gardens 18 Community Hospital? 19 MR. CHUNG: Objection to form. 20 A. The CMS star rating is not being publicly 21 promoted in the community. It is not something that 22 has been brought to my attention by any physicians, 23 family members, community members, and even when -- 24 even before this, it was never something that 25 negatively affected the reputation of the hospital

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Page 42 1 the way that the Leapfrog F score has affected the 2 reputation of the facility. 3 BY MS. ZIBAS: 4 Q. Are you aware if Palm Beach Health Network 5 has been out promoting the low grades as part of this 6 lawsuit? 7 MR. CHUNG: Objection to form. 8 A. I'm not aware of that. 9 BY MS. ZIBAS: 10 Q. Do you regularly read the media in the 11 local Palm Beach papers related to the hospital and 12 the Palm Beach Health Network? 13 MR. CHUNG: Objection to form. 14 A. I've not -- I don't regularly read 15 newspapers. I'm aware there's been articles. 16 BY MS. ZIBAS: 17 Q. Have you read any of the articles? 18 A. No. 19 Q. So do you -- at Palm Beach Gardens 20 Community Hospital, do you consider hand hygiene to 21 be important for patient care? 22 A. Absolutely. 23 Q. And is there a plan or a metric that is 24 used to track the hand hygiene of the employees? 25 A. Yes.	Page 44 1 A. Well, there are many. Hospital patient 2 safety involves many components. For example, 3 there's prevention of wounds, prevention of 4 infections with central lines, catheters, follies, 5 what we call follies, other infections, such as have 6 Clostridium difficile, MRSA, that's one thing. 7 There's fall prevention protocols, as well. That 8 goes into a patient safety, quality. Medication 9 errors. 10 Q. And when -- what is done with the patient 11 safety data that's gathered regarding all of these 12 points? Is it given to a committee or reviewed by 13 you? 14 MR. CHUNG: Objection to form. 15 A. Sure. The findings are discussed in the -- 16 in the quality and safety committee. Where there's 17 opportunities for improvement, the hospital follows a 18 climb to steady act cycle for improvement where we 19 target those specific areas that need improvement and 20 we reevaluate and assess. That information is -- 21 does go up to the medical executive committee and the 22 governing. 23 BY MS. ZIBAS: 24 Q. And does any of it go further up to Tenet 25 corporate?
Page 43 1 Q. And what is that metric or system? 2 A. It's a surveillance methodology that the 3 hospital uses where they have trained staff to go out 4 there and observe employees, physicians, interacting 5 with patients to make sure they're following proper 6 protocol for handwashing, and then they report that 7 back to the infection control committee. 8 Q. And who is on the infection control 9 committee? 10 A. There are -- it's our infection control 11 nurse. There's an infectious disease doctor. There 12 are nursing leaders, chief nursing officer. 13 Q. Is there also a medical executive 14 committee? 15 A. Yes. 16 Q. And does the medical exec -- is the medical 17 executive committee informed about the outcomes of 18 the hand hygiene surveillance method? 19 A. Yes. 20 Q. What about safety, safety plan, is that 21 important to patient care? 22 A. Absolutely. 23 Q. And what metric, if any, is used at Palm 24 Beach Gardens hospital to monitor the safety plan and 25 adherence to the safety plan?	Page 45 1 A. Tenet has the ability to assemble that 2 data, as well. 3 Q. And what about ICU staffing? Obviously, if 4 it's staffing, you probably monitor it. Is this 5 something that also is a metric that is shared with 6 the quality safety committee or is it shared with 7 medical executive committee or both? 8 MR. CHUNG: Objection to form. 9 A. Are you referring to ICU staffing from the 10 physician side -- 11 MS. ZIBAS: Physician side. 12 A. -- or the nursing side. 13 Okay. So from the physician side, we contract 14 with a group that staffs our ICU with intensivists, 15 physicians, and midlevel providers, and they staff 16 the ICU around the clock, 24/7, with providers. And 17 that plan is shared with the medical executive 18 committee and the governing board. 19 BY MS. ZIBAS: 20 Q. Do you also contract services for the 21 emergency room for staffing physicians? 22 A. Yes. 23 Q. And what about your generalist, your 24 internists, do you also staff those with contract 25 physicians?

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Page 46 1 A. No. We have independent hospitalists. 2 Q. What about the computerized physician order 3 entry system, do you regularly track that with a 4 metric and report? 5 A. We do. 6 Q. And where is that data reported? 7 A. Similar committees, through the quality and 8 safety committees. 9 Q. Are you on the quality and safety 10 committee? 11 A. I attend. I don't attend all of them, but 12 I do attend from time to time. 13 Q. How many people are on that committee? 14 A. I can't tell you off the top of my head, 15 but it's -- it's well attended by different 16 specialties in the organization, including 17 physicians. 18 Q. And what about bar code medication 19 administration, is that tracked, as well? 20 A. Yes. 21 Q. And does that go to the same committees, 22 the quality safety committee? 23 A. I believe it does. 24 Q. Do you have a pharmacy on site? 25 A. Yes.	Page 48 1 trying to make sure. 2 THE VIDEOGRAPHER: We're off the record at 3 11:33 a.m. 4 (Brief recess was taken at 11:33 a.m.) 5 (Back on the record at 11:46 a.m.) 6 THE VIDEOGRAPHER: Back on the record at 7 11:46 a.m. 8 BY MS. ZIBAS: 9 Q. All right. Mr. Cazares, in our last 10 question, you explained or you testified that there 11 are 22 measures that you're aware of that Leapfrog 12 evaluates as part of their safety grade. Is that 13 Leapfrog evaluates or CMS? As far as you know, is it 14 22 for CMS or Leapfrog? 15 A. Leapfrog as far as I'm aware. 16 Q. Now, do you believe that through patient -- 17 do you -- let me cross that off. 18 Do you, at Palm Beach Gardens, conduct patient 19 experience surveys? 20 A. Yes. 21 Q. And who oversees the patient experience 22 surveys? 23 A. The chief nursing officer. 24 Q. And does someone assemble the data? 25 A. Yes.
Page 47 1 Q. And are the pharmacists staffed through 2 contract or are they hospital employees? 3 A. They're hospital employees. 4 Q. So do you agree that the measures that we 5 just walked through, the safety, the CPOE, the 6 medication administration, the ICU staffing, and hand 7 hygiene are all important factors for patient care? 8 A. Repeat that again. 9 Q. I said just going through the factors that 10 we just went through, the ICU staffing, the hand 11 hygiene, the safety plan, the CPOE, and the BCMA, are 12 these all factors that you think are important for 13 patient care at Palm Beach Gardens? 14 MR. CHUNG: Objection. 15 A. They are part of a -- they are part of 16 factors that do affect quality and safety, I would 17 agree with that, but they're not the only ones. 18 BY MS. ZIBAS: 19 Q. When we were discussing the Leapfrog 20 methodology before, do you know how many total 21 measures are evaluated to come to the grade? 22 MR. CHUNG: Objection to form. 23 A. I believe it's 22. 24 MS. ZIBAS: Excuse me. Off the record. My 25 mom is in the hospital with a clot, so just	Page 49 1 Q. And is that shared with you or with anybody 2 else? 3 A. Yes. 4 Q. And did you produce that data as part of 5 the discovery in this case? 6 A. Not me personally. 7 Q. Do you know if somebody else did? 8 A. I don't know. 9 Q. And is the patient experience data 10 assembled monthly, quarterly, annually? 11 A. I believe it's reported quarterly, but we 12 have the ability to pull it at any time. 13 Q. And what do you do with that data once you 14 review it? Do you create a plan to address people, 15 their negative experiences? What do you do? 16 A. Sure. The information that we gather from 17 the surveys, we use it to align our operations to 18 better meet the needs of our patients. 19 Q. Do you believe that -- do you agree that 20 patients should have transparency regarding the 21 patient care at Palm Beach Gardens? 22 MR. CHUNG: Objection to form. 23 A. Could you repeat the question? 24 BY MS. ZIBAS: 25 Q. Yes. Do you believe that patients are

Page 50 1 entitled to transparency into their patient care at 2 Palm Beach Gardens? 3 MR. CHUNG: Objection to form. 4 A. I believe in transparency, yes. 5 BY MS. ZIBAS: 6 Q. And are there any systems in place at Palm 7 Beach Gardens to give a patient transparency into 8 their medical care? 9 MR. CHUNG: Objection to form. 10 A. Yes. I don't understand the question. 11 BY MS. ZIBAS: 12 Q. Well, for instance, do you have medical 13 records and information about the hospital ratings 14 available for patients to review when they become 15 inpatients or outpatients? 16 MR. CHUNG: Objection to form. 17 A. We don't have ratings. We don't share 18 ratings with our patients. 19 BY MS. ZIBAS: 20 Q. What about their medical records, are they 21 entitled to review their medical records? 22 A. They are. 23 Q. While a patient? 24 A. Well, while a patient, there's a process 25 that has to be followed for them to be able to access	Page 52 1 A. That is tracked, as well. 2 Q. And do you know what the compliance rate 3 was in 2025 for that? 4 A. The last time I looked at that compliance 5 rate was approximately 80 percent. 6 Q. Do you know if as part of the CMS star 7 ratings, that if CMS looks at hand hygiene or the 8 CPOE? 9 A. I can't think -- I can't recall exactly all 10 the things that CMS looks at. 11 Q. Do you recall anything that CMS looks at? 12 A. Yes. They look at patient safety 13 indicators, infection rates. 14 Q. And -- 15 A. Patient experience. 16 Q. And what did you find in the CMS star 17 ratings in terms of the outcomes of infection rates 18 at Palm Beach Gardens? 19 MR. CHUNG: Objection to form. 20 A. That's -- repeat the question, again. 21 BY MS. ZIBAS: 22 Q. What did you find in CMS star ratings in 23 terms of the outcomes and infection rates at Palm 24 Beach Gardens? 25 MR. CHUNG: Objection to form.
Page 51 1 the records. 2 Q. Did you ever calculate the BCMA error rate 3 in 2024 at Palm Beach Gardens? You or somebody else 4 on your behalf ever calculate the error rate? 5 A. I didn't. I don't know if someone else 6 did. 7 Q. And do you know what the error rate was? 8 A. No. What do you mean by error rate? 9 Q. Well, any -- if they found that people did 10 not follow the policies or procedures for bar code 11 medication administration? 12 A. You're talking about the compliance? 13 Q. Correct. 14 A. Compliance rate or error rate? 15 Q. Both. Separately error rate and compliance 16 rate. 17 A. Yeah. For what year? 18 Q. 2024. 19 A. Oh, I'm not familiar for 2024. I don't 20 remember what that was. 21 Q. What about for 2025? 22 A. For 2025, I know the last time I looked at 23 the compliance rate was 95, close to 95 percent. 24 Q. And do you also track the compliance rate 25 of the computerized physician ordering entry?	Page 53 1 A. Last time that I looked at the CMS ratings, 2 on most metrics, our hospital, when it comes to 3 infection and outcomes on most metrics, we are in par 4 with the national average. 5 BY MS. ZIBAS: 6 Q. And what does that mean, being on par with 7 the national average? 8 A. That means that we are in the same range as 9 similar hospitals across the nation. 10 Q. Have you ever asked Maggie Gill or anyone 11 at Tenet if Palm Beach Gardens could participate in 12 the Leapfrog survey? 13 A. I have not. 14 Q. Have you ever reviewed the Leapfrog survey? 15 A. In its entirety? 16 Q. Yes. 17 A. No. 18 Q. Have you -- since you've been a CEO or COO 19 of any hospital, have any of the hospitals where 20 you've worked participated in the Leapfrog survey? 21 A. Repeat, since when? 22 Q. Since you were a COO or CEO? 23 A. When I was a COO, I believe our hospital 24 did participate. 25 Q. And when you were C -- and was that a

Page 54 1 decision made by whom to participate when you were 2 COO? 3 A. I don't remember. 4 Q. Are you permitted as the CEO of Palm Beach 5 Gardens for your hospital to participate? 6 A. Right now, we've -- we have a directive, 7 and directed not to participate in Leapfrog. 8 Q. And what about in 2024, was there a 9 directive when you first started not to participate 10 in Leapfrog? 11 A. Wasn't questioned in 2024. I didn't 12 question it. It wasn't an issue. 13 Q. And who was the directive from that you not 14 participate in the Leapfrog survey? 15 A. My immediate boss, Maggie. 16 Q. As part of Amanda's duties as marketing 17 manager or another person at Palm Beach Gardens, does 18 anybody participate or hire anyone to do market share 19 studies against your competitor, Jupiter Medical 20 Center? 21 A. No, I'm not aware. 22 Q. Is that something that's been considered? 23 A. Not that I'm aware of. 24 Q. Now, of your patient population, would you 25 say that over 50 percent of them obtain information	Page 56 1 A. Amongst other things, yes. 2 Q. And has the revenue increased or decreased 3 since 2024? 4 A. It's increased slightly. 5 Q. And going back to the reputational harm you 6 described, why don't you explain to me outside of the 7 complaints from some of the physicians and patients, 8 can you tell me how many patients you or somebody 9 else at the hospital have talked to about the 10 Leapfrog grades that were complained about? 11 MR. CHUNG: Objection to form. 12 A. I can't quantify the amount of patients. 13 Like I mentioned earlier, the amount of complaints 14 has been increasing, especially after the Tik Tok 15 video. That seemed to have really gotten out there 16 in the community, and more and more patients have 17 been complaining to the physicians, who then complain 18 to me, and I've also received direct complaints from 19 patients. They've left Google reviews referencing 20 the Tik Tok video. There's been different complaints 21 voiced, and we're seeing more and more of them as 22 time goes by. 23 BY MS. ZIBAS: 24 Q. And when you say more and more, how many do 25 you receive in a week?
Page 55 1 about what hospital to go to on the Internet? 2 A. I don't know. 3 MR. CHUNG: Objection to form. 4 BY MS. ZIBAS: 5 Q. Has there ever been a study done or survey 6 done at Palm Beach Gardens as to what patients rely 7 on for their source of selecting the hospital to go 8 to? 9 A. None that I'm aware of. 10 Q. Is it something that's been discussed to 11 survey? 12 A. Not that I'm aware of. 13 Q. Do you think it would be helpful to know 14 what the sources of information are for your patient 15 population? 16 MR. CHUNG: Objection to form. 17 MS. ZIBAS: To select a hospital. 18 MR. CHUNG: Objection to form. 19 A. I don't know if it would be helpful or not. 20 BY MS. ZIBAS: 21 Q. Is your compensation tied to the revenue 22 outcomes at Palm Beach Gardens? 23 A. To the revenue? 24 Q. Yes. Is there any compensation tied to the 25 revenues of the hospital?	Page 57 1 A. Between patients and physicians, between 2 four and five. 3 Q. And do you track those in a log or do you 4 have a journal or somewhere in the computer? 5 A. I do not. 6 Q. Does anybody track these complaints? 7 A. Some complaints are tracked. We have a 8 general grievance log, but it's not specifically for 9 Leapfrog letter grades or complaints. 10 Q. So what is the general grievance log? 11 A. That's -- it's a log that is maintained by 12 our patient safety officer and it's -- that's one of 13 the regulatory mandates by CMS. And this is mostly 14 for patients that have received services in our 15 facility. 16 Q. Why is there no log of the complaints 17 related to Leapfrog being maintained? 18 MR. CHUNG: Objection to form. 19 A. Yeah. I'm -- the hospital has -- that 20 would require additional resources, more time, you 21 know, dedicated to keeping track of all these 22 patients and complaints, and that is not something 23 that we can afford to do right now. Our staff is 24 committed to improving patient safety in the 25 hospital, and that's where we're redirecting our

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Page 58 1 resources. 2 BY MS. ZIBAS: 3 Q. Has the complaints about this Tik Tok 4 video, did they come from patients or from 5 physicians? 6 A. Patients, physicians, staff, governing 7 board members. 8 Q. And have you had any physicians resign 9 because of the Leapfrog grades? 10 A. No. 11 Q. How is the nursing recruiting and 12 retention? Is it difficult? 13 MR. CHUNG: Objection to form. 14 A. What do you mean by difficult? 15 BY MS. ZIBAS: 16 Q. I mean, in general, is it difficult for 17 Palm Beach Gardens to attract nurses, and I'd say if 18 you compared 2025 to 2024? 19 MR. CHUNG: Objection to form. 20 A. I would not say that it's any different 21 than most hospitals. 22 BY MS. ZIBAS: 23 Q. Would you say that most hospitals have 24 difficulty attracting nurses or there's as nursing 25 shortage essentially?	Page 60 1 I mentioned earlier, the patient safety plan involves 2 many different things, but particularly, in patient 3 experience, which is an area that the hospital has 4 struggled for some time, we have directed our teams 5 to increase compliance with our patient experience 6 initiatives. 7 Q. Is patient experience one of the measures 8 that CMS looks at in their star rating? 9 A. Yes. 10 Q. Are there any other rating systems that you 11 haven't talked about yet today that Palm Beach 12 Gardens participates in? We talked about 13 Healthgrades, basically. Are there any others that 14 the hospital participates in? 15 A. That rate the hospital? 16 Q. Yes. Or grade the hospital. One of the 17 two. 18 A. Grade the hospital. Well, we said Joint 19 Commission, Healthgrades. There may be a couple 20 others that are listed on awards. American Heart 21 Association, we have a designation for stroke. And 22 then we have one for cardiac rehab, American 23 Association of Cardio and Pulmonary Rehab. We also 24 have a certification, and that's based on actual 25 audits of the facility in person.
Page 59 1 A. I think, in general, there's a nursing 2 shortage. 3 Q. Have there been any contracts signed with 4 any outside vendors to provide services related to 5 patient safety, to provide any services or consulting 6 related to patient safety? 7 A. Not that I'm aware of. 8 Q. Do you have any contract signed with 9 outside vendors that would provide advice or 10 consulting for quality improvement? 11 A. None that I'm aware of. 12 Q. Have -- since you've taken on your role as 13 CEO, have you made any changes, you yourself, to the 14 quality improvement plan? 15 A. The actual written plan, no. 16 Q. Okay. Have you provided guidance or 17 suggestions to make changes to the quality 18 improvement plan? 19 A. I have. I've directed my teams to enforce 20 the patient safety plan and to make sure that we 21 increase compliance with the patient safety plan 22 across the organization. 23 Q. What was the compliance prior to you 24 providing the guidance to increase the compliance? 25 A. Well, that's a broad question because like	Page 61 1 Q. And does Palm Beach Gardens pay for using 2 the -- pay a license fee or pay any fee to be able to 3 use the logos from like American Heart? 4 A. I'm not sure if we're paying. I really 5 don't know if we're actually paying to use their 6 logo. 7 Q. Do you know if Palm Beach Gardens and the 8 Palm Beach Health Network have been monitoring the 9 Leapfrog grades every grading period? 10 MR. CHUNG: Objection to form. 11 A. My understanding is that our quality 12 director keeps track of the Leapfrog grades. 13 BY MS. ZIBAS: 14 Q. And why does the quality director track the 15 Leapfrog grades? 16 A. I believe she's the one that has access to 17 the website. So that's how it's been set up. 18 Q. And is that a directive from the Tenet 19 Healthcare home office, or is this just something of 20 interest of the quality director? 21 A. I don't -- I don't know if it's -- there's 22 guidance from home office that it should be the 23 quality director or not. That's the way it's been, 24 and the quality director is the one that pulls those 25 scores or tracks them.

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Page 62 1 Q. Has the quality director ever discussed 2 with you that they -- that Palm Beach Gardens would 3 like to participate in the Leapfrog survey? 4 MR. CHUNG: Objection to form. 5 A. No. She has not. 6 BY MS. ZIBAS: 7 Q. Do you have any -- do you have any evidence 8 or do you have any documents that would prove that 9 Leapfrog takes any money from hospitals to give them 10 better grades? 11 A. It is my understanding that when a 12 hospitals participates in Leapfrog, they submit data, 13 valuable data from their organization, and that 14 Leapfrog owns the rights to that data, which they can 15 then use for commercial purposes. Commercial gains 16 is what they actually have on their application when 17 the data is submitted, so we're technically having to 18 sign this form saying that Leapfrog now owns this 19 data and they can do with it as they please for 20 commercial gains. So we consider that a form of 21 compensation. 22 Once the hospital participates in Leapfrog, they 23 also have to pay Leapfrog to be able to market the 24 letter grade that they receive, so that's another 25 form of compensation. The opposite of that is if a	Page 64 1 A. They require -- from what I know, is that 2 you have to buy the trophy from them or the award, if 3 you want the award. You don't have to buy it. But 4 the big difference is that Healthgrades is not 5 penalizing us for not participating. If we don't 6 participate in Healthgrades or if we don't get an 7 award in Healthgrades, there is no public damage. 8 They don't go out there and automatically fail a 9 hospital in a particular area, as Leapfrog is doing. 10 Q. So these documents you talk about that you 11 have to sign, have you seen the documents that you 12 have to sign that Leapfrog requires you to sign? 13 A. Yes. 14 Q. When did you see them? 15 A. It's -- there's a document included in our 16 complaint that shows an example. 17 Q. Okay. And is that the first time you saw 18 the document in the complaint? 19 A. Yes, because I've never -- I've never 20 signed one before. 21 Q. And where is the information coming from 22 that indicates that you turned in the data and you -- 23 and the rights belong to Leapfrog? Where is that 24 information coming from? 25 A. From that document.
Page 63 1 hospital does not participate, they are then 2 penalized with a lower score in those four metrics 3 that we talked about earlier, which results in a 4 lower letter grade, as was the case in Palm Beach 5 Gardens Medical Center, and it ultimately resulted 6 with the public perception and reputation being 7 damaged, as I mentioned earlier, with physicians and 8 patients and community members complaining about 9 patients not wanting to go to Gardens because of the 10 low safety rating. 11 Q. So is it free -- is there a fee for the 12 hospital to complete the Leapfrog survey? 13 A. Not that I'm aware of. What I consider the 14 payment is what I mentioned earlier, which is we're 15 turning in the data, and we're handing it off, the 16 rights to that data, for Leapfrog to use and 17 monetize. And the CEO actually has to sign a 18 document that allows them to do that before 19 participating on that, as well as once the hospital 20 participates and they receive a letter grade, then 21 they're expected -- then they're expected to pay if 22 they want to market their letter grade, which is 23 another form of compensation there. 24 Q. But doesn't Healthgrades require you to pay 25 to market with their letter grade?	Page 65 1 Q. Is that also from the complaint? 2 A. From -- yes. 3 Q. Okay. So the first time that you saw this 4 information is in the complaint that's filed in the 5 lawsuit; correct? 6 A. Yes. I had already heard of it from my 7 colleagues. 8 Q. And who told you about it? 9 A. Other colleagues. 10 Q. Who, which colleagues? 11 A. Other CEOs. 12 Q. And which CEOs talked about it? 13 A. This is years, years ago. 14 Q. How many years ago? 15 A. Four, five, six years ago. Throughout my 16 long tenure, I've known about that. 17 Q. And were they all Tenet hospital CEOs, 18 Tenet-owned hospital CEOs? 19 A. Not necessarily. 20 Q. How many CEOs talked about Leapfrog that 21 you recall that were not Tenet owned? 22 A. I don't -- I don't remember. 23 Q. Do you have any meetings with CEOs of 24 hospitals, say, quarterly or even annually that are 25 not Tenet-owned hospital CEOs?

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Page 66 1 A. No, I don't have any formal meetings. 2 Q. Do you ever participate in any conferences 3 or any educational sessions with other CEOs of 4 hospitals that aren't Tenet owned? 5 A. I used to. 6 Q. And when did you stop? 7 A. I don't recall exactly. 8 Q. And why did you stop participating in 9 conferences? 10 A. Mostly time. 11 Q. So going back to this public perception. 12 Why don't you describe to me, quantify to me, what is 13 this public perception you keep describing in a very 14 negative way? How many people are impacted, et 15 cetera? Why don't you give me an idea, quantify 16 it -- 17 A. I cannot -- 18 MR. CHUNG: Objection to form. Asked and 19 answered, argumentative. 20 A. I cannot give you a specific number. Like 21 I mentioned, I'm currently receiving anywhere from 22 four to five complaints a week, combination of 23 physicians, patients, community stakeholders, and 24 those complaints have been increasing ever since that 25 Tik Tok video was released.	Page 68 1 A. I have not. 2 Q. Have you discussed this lawsuit with any of 3 the other CEOs of the five plaintiff hospitals? 4 A. No. 5 Q. Would you know why some of the sentences in 6 the declarations of yours and Jared Hanlon are 7 exactly the same? 8 MR. CHUNG: Objection to form. 9 A. I don't know why. 10 BY MS. ZIBAS: 11 Q. All right. So in looking at -- starting 12 with page 2. 13 A. Okay. 14 Q. So starting -- actually, go to page 6. And 15 looking at paragraphs 13 and 14, where did you obtain 16 this background information if you were not CEO at 17 the time for -- to draft these two paragraphs? 18 A. Once again, we don't participate in 19 Leapfrog, is that what you're -- 20 Q. No. I asked you where did you get this 21 information in 13 and 14 because you weren't CEO? So 22 I'm trying to understand where you got this 23 information. 24 A. Let me read it. I mean, this information 25 mimics the same sentiment I had at our previous
Page 67 1 BY MS. ZIBAS: 2 Q. Do you plan on tracking some of the 3 complaints now going forward, or are you still going 4 to continue to just not track -- 5 A. I don't have any plans to track. Like I 6 mentioned, we have many things that we're doing in 7 the organization to run a hospital 24/7, to drive 8 quality. It's just another activity that it's not -- 9 it's not a priority for us to be tracking all the 10 complaints that are coming in. 11 MS. ZIBAS: I'll mark this next Exhibit 4. 12 (Exhibit 4 was marked.) 13 BY MS. ZIBAS: 14 Q. I've put in front of you what we marked as 15 Exhibit 4, and it's a declaration that appears that 16 you drafted; is that correct? 17 A. Correct. 18 Q. And did you independently draft this? 19 A. This was drafted with the assistance of 20 lawyers. 21 Q. Did you ever discuss your declaration in 22 Exhibit 4 with Jared Hanlon? 23 A. No. 24 Q. Have you ever seen the declarations of the 25 other CEOs who are plaintiffs in this lawsuit?	Page 69 1 facilities, as well, on why we don't participate in 2 Leapfrog. 3 Q. Okay. But the previous facility still gets 4 Cs; correct? 5 MR. CHUNG: Objection to form. 6 A. I don't know. I don't know what the 7 previous facility is doing right now. 8 BY MS. ZIBAS: 9 Q. Based on the exhibits I gave you, and I 10 guess you can always check the website, that they are 11 getting Cs now. 12 A. This is only two pages. I'm pretty sure 13 there's more to the assessment. So I can't tell by 14 this if they participated or not. 15 MS. ZIBAS: All right. There's a -- so if 16 you look at the -- and we'll mark this as 17 Exhibit 5, so you can compare. 18 (Exhibit 5 was marked.) 19 BY MS. ZIBAS: 20 Q. If you look at Exhibit 5 that's been put in 21 front of you, the Leapfrog hospital safety grade for 22 Palm Beach Gardens Medical Center, and it says F on 23 it; correct? And if you go to the second page in 24 red, it says declined to report. The hospital was 25 asked to provide this information to the public but

Page 70 1 did not, under notes and definitions. Is that an 2 accurate statement? 3 A. This is showing specifically -- I just 4 don't know what this is referring to specifically. 5 Q. Have you ever looked at the Leapfrog 6 hospital grade website? 7 A. I've gone in there. 8 Q. And was there anywhere on the website, did 9 you notice on the website that there is that language 10 that says the hospital did not participate or was 11 asked to provide information but did not? Have you 12 ever seen that on the website? 13 A. There are some metrics where it states 14 that, but then we're still graded on some of them and 15 on some we're not, which is part of the confusion 16 here, why we're not okay with that methodology. 17 Q. Who is we? 18 A. We, the hospital, myself. 19 Q. Now, looking at -- so paragraphs 13 and 14, 20 did you draft these, at all, these two paragraphs? 21 Did you draft any of this language yourself? 22 A. This was drafted with the assistance of 23 lawyers. 24 Q. And are you aware it's identical to their 25 language used by the other CEOs?	Page 72 1 Q. How did you learn about -- you have a 2 statement in paragraph 18, in fall of 2024, TLG 3 adjusted it's grading methodology as noted below and 4 continued to grade community hospital. How did you 5 learn about the adjusted grading methodology that you 6 reference in this sentence? 7 A. I learned about it after we received an F, 8 and I learned of it from our quality director. 9 Q. Now, in paragraph 19, you state in your 10 declaration, it shows that if you participate in its 11 pay-to-play, time consuming hospital survey, TLG 12 assigns you a better grade. What do you mean by 13 pay-to-play? 14 A. Well, as I mentioned earlier, if the 15 hospital participates, part of the participation is 16 that they have to submit the data, hand over the data 17 to Leapfrog. Leapfrog then can use that data as they 18 wish, including for commercial gains, and that's part 19 of the earlier comment that I made. And then once 20 the hospital receives a letter grade, they have to 21 pay Leapfrog to be able to promote that score or 22 publish that score or use their logo. So that's one. 23 The other one is the hospital is pressured to do 24 so, almost coercion, if you -- could be a word to 25 describe that because if you don't participate, if
Page 71 1 A. That I did not know. I have not seen their 2 declarations. 3 Q. In paragraph 17 on the next page, it 4 references spring 2022 hospital safety grades and we 5 were surprised. Since you were not the CEO and you 6 were still working in Texas, where did the 7 information come from to draft paragraph 17? 8 A. This was -- this is on behalf of the 9 organization. 10 Q. And who provided you the information at the 11 organization to draft that paragraph? 12 A. This was in consultation with our lawyers. 13 Q. And paragraph 18 says in fall of 2024, TLG 14 adjusting it's grading methodology as noted below and 15 continued to grade the community hospital. How were 16 you notified about the adjustment to the grading 17 methodology? 18 MR. CHUNG: Objection to form. 19 In this line, continuing objection based on 20 privilege and just asking you based on privilege 21 not to -- if your responses involves 22 communications with counsel, not to -- not to go 23 into those communications. 24 A. Okay. Repeat the question. 25 BY MS. ZIBAS:	Page 73 1 the hospital does not participate, the hospital gets 2 scored at the lowest possible score on those four 3 metrics that we discussed earlier, which the 4 hospital, Palm Beach Gardens Medical Center, is 5 performing well; yet, they scored at the very lowest 6 level. 7 So there is pressure for the hospital to 8 participate, pressure for the hospital to submit the 9 data, to hand it over to Leapfrog, and that's 10 basically where this pay for play comes from. 11 Q. What are the commercial gains that Leapfrog 12 gets that you described? Where are you getting your 13 information about the commercial gains? 14 A. That's not my information. 15 Q. Where is it? 16 A. That's what Leapfrog puts in their 17 statement. In their statement, Leapfrog says that 18 the data can be used for commercial gains. 19 Q. Okay. And again, that is -- you first read 20 that based on the complaint filed in this case; 21 correct? That's where you first read that 22 information? 23 A. That's where I first read it, but I've 24 already had -- like I mentioned earlier, I had 25 already known about it.

Page 74 1 Q. Why doesn't Palm Beach Gardens merely 2 participate in the survey, rather than spend the time 3 having to address all of the reputational damage? 4 MR. CHUNG: Objection to form. 5 A. Gardens does not participate because it is 6 a very time consuming activity that the hospital does 7 not feel participating in the survey is improving 8 patient safety or quality, and that time and 9 resources could be better spent addressing real 10 initiatives in the organization to improve safety and 11 quality. 12 BY MS. ZIBAS: 13 Q. How much time would be spent filling out 14 the Leapfrog survey based on your estimate that it's 15 time consuming? 16 A. I wouldn't be able to give you a time 17 estimate. But the individuals that put this work 18 together, they have many other things to do in the 19 hospital, and this is not an additional burden that 20 we would want to provide them with. 21 Q. And since the hospital is already 22 completing the CMS data, isn't most of the data 23 that's submitted to Leapfrog similar? 24 MR. CHUNG: Objection to form. 25 A. Some of the data is similar, but there's	Page 76 1 physicians and other patients. Why did you not list 2 them in this paragraph? 3 MR. CHUNG: Objection to form. 4 A. I think I answered that earlier. We 5 continue to get complaints. Like I said, every week, 6 we get more and more complaints in there, as well. 7 And here it's broadly stated that we've been 8 receiving complaints from physicians and patients in 9 the community, and we continue to do so to this day. 10 BY MS. ZIBAS: 11 Q. How many complaints has medical executive 12 committee told you that they received? 13 A. I can't quantify that. 14 Q. Why can't you quantify it? 15 A. Because I'm not keeping track of how many 16 complaints are being brought to my attention from 17 every individual. I can tell you, in general, four 18 to five complaints a week is what I can tell you at 19 this point. 20 Q. Do you consider any of the complaints from 21 patients or the governing board legitimate complaints 22 about the patient care at Palm Beach Gardens? 23 MR. CHUNG: Objection to form. 24 A. I don't understand your question. 25 BY MS. ZIBAS:
Page 75 1 still a lot of work and additional work that is 2 required to submit the Leapfrog survey, and that is 3 not time or resources that the hospital is going to 4 commit when those could be better spent elsewhere in 5 the organization. 6 BY MS. ZIBAS: 7 Q. And you referenced that the organization 8 would rather spend it on improvements. What 9 improvements is the Palm Beach Gardens working on in 10 lieu of spending time and resources on the survey? 11 MR. CHUNG: Objection to form. 12 Mischaracterizes prior testimony. 13 A. Going back to my earlier comments about the 14 hospital's overall goals, our goal is to continuously 15 improve patient safety, quality, patient experience 16 in the organization, and we have many initiatives 17 that are geared towards that. And that's where our 18 resources will continue to be funneled to. 19 BY MS. ZIBAS: 20 Q. So going to page 13 of your declaration, 21 you have as the top line, TLG safety grades harm the 22 community, hospital, its patients, and its community. 23 You drafted this paragraph or with the guidance of 24 counsel drafted the paragraph, and today you came in 25 here and you're testifying about a number of	Page 77 1 Q. So you said that everyone that you're 2 receiving complaints, is that correct, complaints 3 about the Leapfrog grades? 4 A. Complaints about patients not wanting to go 5 to Gardens because of the letter F grade. 6 Q. And do you think that some of the concerns 7 of the patients are legitimate -- 8 MR. CHUNG: Objection to form. 9 MS. ZIBAS: -- regarding the patient care 10 at Palm Beach Gardens? 11 MR. CHUNG: Objection to form. 12 Mischaracterizes witness' testimony. 13 A. The concerns that the patients have are 14 that the hospital has received an F grade for patient 15 safety, and therefore, choosing not to come to the 16 hospital. That's the reputational harm that we're 17 referring to. 18 BY MS. ZIBAS: 19 Q. But you haven't been able to quantify, at 20 this point, that reputational harm? 21 MR. CHUNG: Objection to form. 22 Mischaracterizes the witness's testimony. 23 BY MS. ZIBAS: 24 Q. Because you state in your declaration, 25 there's reputational harm.

Page 78 1 A. There's reputational harm. 2 Q. Have you not been able to quantify it? 3 A. There's reputational harm, patient 4 complaints, patients are leaving to our sister 5 facility -- to our competing facility, which is 6 Jupiter Medical Center. They've communicated that to 7 our physicians. And these are the complaints that I 8 receive on a weekly basis. 9 Q. How -- What's your percentage of decrease 10 in admissions between 2024 and 2025? 11 A. I don't have it in front of me. There's a 12 document that, I believe, we address that, but I 13 can't think of it right off the top of my head. 14 Q. Is there a decrease in inpatient 15 admissions? 16 A. There's a slight increase. 17 Q. And is there a decrease in ER visits? 18 A. There is. 19 Q. What's the percentage? 20 A. Roughly, 5, 6 percent. Somewhere around 21 that range. 22 Q. And is there a decrease in the outpatient 23 services? 24 A. Yes. 25 Q. What's the percentage decrease?	Page 80 1 of the recipients of this e-mail. Do you see that in 2 the top of this e-mail? 3 A. I do. 4 Q. And the body of the e-mail and the subject 5 says FYI, and at the bottom, it says, please send me 6 request reintroduce Leapfrog reporting, include 7 rationale, imputed score, and clippings of negative 8 press/community and MD feedback. I will request an 9 exception for PBHN and PMC to start next reporting 10 period. Thanks, Maggie. 11 Do you recall that e-mail, receiving that 12 e-mail? 13 A. I do. 14 Q. And was this topic discussed with Maggie or 15 among the CEOs, at all, about reintroducing Leapfrog 16 reporting? 17 A. I don't recall having a conversation with 18 them. I do recall this e-mail. 19 Q. And was a request made to reintroduce 20 Leapfrog reporting? 21 A. No, not that I'm aware of. 22 Q. Did you hear anything further about this 23 e-mail? 24 A. No. 25 Q. Do you know why Maggie made that request?
Page 79 1 A. I believe it's similar, maybe a little 2 over. 3 Q. And have any -- has the hospital taken on 4 any survey or research as to what is causing the 5 decrease in the ER visits and the outpatient 6 services? 7 A. No. 8 Q. So in paragraph 25 of your declaration, you 9 indicate in the last sentence that resources that 10 could have otherwise been spent continuing to improve 11 patient care. So why don't you describe to me what 12 the resources -- what the patient care improvements 13 have been where you're spending the resources? 14 A. I mentioned that earlier. There's 15 different activities that the hospital targets when 16 it comes to patient experience, decreasing patient 17 falls, making sure we have compliance with different 18 quality metrics across the organization. For 19 example, handwashing, fall prevention, that's where 20 the resources are going. 21 MS. ZIBAS: I'll give you Exhibit 6. 22 (Exhibit 6 was marked.) 23 BY MS. ZIBAS: 24 Q. This is an e-mail from Maggie Gill dated 25 December 11, 2024. It's Exhibit 6. And you were one	Page 81 1 A. I can't speak for Maggie so -- but I'm -- 2 no. I can't speak for why Maggie made that request. 3 As far as my hospital is concerned, I had voiced to 4 Maggie that we were starting to get complaints from 5 physicians about our F grading in Leapfrog. 6 Q. Do you agree with the -- with Maggie's 7 e-mail to re -- to request to reintroduce Leapfrog 8 reporting? 9 MR. CHUNG: Objection to form. 10 A. I don't agree or disagree. I mean, that's 11 her statement. 12 BY MS. ZIBAS: 13 Q. Do you want -- did -- did Palm Beach 14 Gardens want to start participating in Leapfrog, 15 again, in the survey? 16 A. You mean, did I want to? 17 Q. Yes. 18 A. No. 19 MS. ZIBAS: Here's Number 7. 20 (Exhibit 7 was marked.) 21 BY MS. ZIBAS: 22 Q. I'm handing you an e-mail from Naomi 23 Seymour to you dated December 11, 2024. Do you see 24 that? 25 A. Yes.

Page 82 1 Q. Do you recall receiving this e-mail? 2 A. Yes. 3 Q. It says, Ricky shared that we will probably 4 start submitting to Leapfrog, again. So their tactic 5 worked. What does that mean, in your opinion, when 6 you received that e-mail? Did you understand that to 7 mean? 8 A. Which specific part? 9 Q. The whole sentence or two sentences. 10 A. The one that Naomi sent? 11 Q. Yes. First, who is Naomi? 12 A. She is my chief nursing officer. 13 Q. Okay. 14 A. Basically, she's saying that Ricky, who is 15 the group chief nursing officer, alluded to that we 16 may start submitting to Leapfrog, again, is what it 17 says there. And then she makes a reference so that 18 their tactic worked. She's referring to Leapfrog's 19 pressure on the hospitals to participate by handing 20 out F grades is what -- that's the way I interpret 21 the e-mail. 22 Q. Are you aware there are nonparticipating 23 hospitals that earn As and Bs? 24 MR. CHUNG: Objection, form. 25 A. No. I'm not aware of what other hospitals.	Page 84 1 A. Because my hospital is being -- is the one 2 receiving reputational harm as a result of the F 3 grade. 4 BY MS. ZIBAS: 5 Q. And how has that impacted the hospital? 6 MR. CHUNG: Objection to form, asked and 7 answered. 8 BY MS. ZIBAS: 9 Q. You don't have to repeat what you already 10 answered. If there's anything you want to add about 11 the reputational harm or goodwill damage that you've 12 put in your declaration. 13 A. As I mentioned earlier, we've lost patients 14 to other hospitals as a direct result of the F grade 15 that was handed to Palm Beach Gardens Medical Center, 16 and it continues to be a problem as physicians 17 continue to voice concerns about patients not wanting 18 to go to Palm Beach Gardens Medical Center to receive 19 care, and we're getting four to five complaints a 20 week on this. 21 Q. How many actual patients have you lost to 22 Jupiter Medical Center? Because you've only 23 mentioned two, specifically, during this deposition. 24 MR. CHUNG: Objection to form. 25 Mischaracterizes prior testimony.
Page 83 1 BY MS. ZIBAS: 2 Q. Have you ever looked at that factor, that 3 there are hospitals who do not participate that 4 receive high letter grades? 5 MR. CHUNG: Objection, form. 6 A. I have not looked into that. 7 BY MS. ZIBAS: 8 Q. Would it surprise you to learn that because 9 they had these other nonparticipating Leapfrog 10 hospitals that had high CMS scores ended up with high 11 letter grades? 12 MR. CHUNG: Objection. 13 A. What was your question? 14 BY MS. ZIBAS: 15 Q. I said would it surprise you to learn the 16 nonparticipating Leapfrog hospitals had high CMS 17 scores and, thus, they had high letter grades? 18 MR. CHUNG: Objection to form. 19 A. Yeah. I'm not concerned about other 20 hospitals. I'm concerned about my hospital. 21 BY MS. ZIBAS: 22 Q. If you're not concerned about other 23 hospitals, why does the reputational harm, why is 24 that an issue? 25 MR. CHUNG: Objection to form.	Page 85 1 BY MS. ZIBAS: 2 Q. How many are there that you can name? 3 A. I've mentioned that we -- that I receive 4 four to five complaints a week. 5 BY MS. ZIBAS: 6 Q. But of those complaints, how many of those 7 patients actually did come to Palm Beach Gardens? 8 A. That is not a question that I can directly 9 answer for you. 10 Q. Now, was the fact that there was -- would 11 be a lawsuit filed on behalf of Palm Beach Gardens 12 ever discussed with the governing board? 13 MR. CHUNG: Objection. 14 Based on privilege, I'm instructing the 15 witness not to answer that question. 16 MS. ZIBAS: These are governing board 17 minutes. There's nothing to do with lawyers. 18 This has to do with the governing board minutes 19 of a board that's public under Sunshine. 20 MR. CHUNG: You're referencing minutes that 21 we have not seen and have not been put in front 22 of the witness. 23 MS. ZIBAS: Well, I'm asking if he 24 discussed it with the board, which I'm allowed 25 to do.

Page 86 1 BY MS. ZIBAS: 2 Q. Did you discuss with the board, unrelated 3 to lawyers, the filing of this lawsuit? 4 MR. CHUNG: I'm objecting based on 5 privilege, if any of those discussions with the 6 governing board involved consultation with 7 counsel, either inside counsel or outside 8 counsel -- 9 MS. ZIBAS: And I'm not asking about that. 10 Just any discussions -- 11 MR. CHUNG: Let me finish the objection. 12 I'm asking you not to get into those 13 discussions, those communications. 14 BY MS. ZIBAS: 15 Q. So did you have any discussions with the 16 board members outside of the presence of counsel 17 about filing this lawsuit? 18 A. I don't recall. 19 Q. And who is paying the legal fees? Because 20 there's a request for attorney's fees made in this 21 lawsuit. Who is paying the legal fees on behalf of 22 Palm Beach Gardens? 23 A. I'm not sure. 24 Q. So you're not aware if the hospital is 25 paying? If the hospital is not paying, who is	Page 88 1 is Exhibit 8, are the governing board minutes dated 2 December 17, 2024. Do you see those? 3 A. Uh-huh. 4 Q. And if you review these minutes, is there 5 any reference to Leapfrog in the minutes? 6 A. There's a reference on here. 7 Q. Is that Bates number 17883 on the bottom 8 right-hand corner. 9 A. Yes. 10 Q. Okay. In that reference, was that reported 11 by you during the meeting or somebody else? Was it 12 reported by Kathleen McDonald, it looks like, under 13 quality report? 14 A. Well, it's got my name on there. 15 Q. And do you recall making the statement, it 16 says, Mr. Cazares noted that the hospital will likely 17 begin participation with Leapfrog moving forward in 18 efforts to mitigate the potential for disparaging 19 publications. Do you see that? 20 A. I do see that. 21 Q. And do you recall why you made that 22 statement in December 17, 2024? 23 A. Well, that must have been around the time 24 that the market was alluding to potentially begin 25 participating again.
Page 87 1 paying? 2 MR. CHUNG: Objection to form. 3 A. I said I'm not sure. That would be a 4 question for my CFO. 5 BY MS. ZIBAS: 6 Q. Have you ever discussed with your CFO the 7 legal fees for this lawsuit? 8 A. No. 9 Q. Have -- do you ever review the financials 10 on a monthly basis of expenditures? 11 A. High level. 12 Q. Do you ever look at the legal spent for the 13 hospital? 14 A. It's a line item. 15 Q. Have you looked at it in the last three 16 months? 17 A. I'm pretty sure I've looked at it, but I 18 don't recall what it was. 19 Q. You don't recall any numbers in the last 20 three months? 21 A. No. 22 MS. ZIBAS: This is Number 8. 23 (Exhibit 8 was marked.) 24 BY MS. ZIBAS: 25 Q. And if you take a look, what I'm giving you	Page 89 1 Q. And did you agree with your statement in 2 moving forward in efforts to mitigate the potential 3 for disparaging publications? 4 MR. CHUNG: Objection to form. 5 A. Repeat the question. 6 BY MS. ZIBAS: 7 Q. I mean, did you agree with your statement 8 about participating with Leapfrog moving forward in 9 efforts to mitigate the potential for disparaging 10 publications? 11 A. Yeah. It was a notification that the 12 market might move forward with participating in 13 Leapfrog again. 14 Q. In litigation, there's a statement that the 15 goodwill of Palm Beach Gardens Community Hospital has 16 been harmed. How has the goodwill been harmed? 17 MR. CHUNG: Objection to form. 18 A. Well, this goes back to my earlier 19 statements about patients, community members, 20 governing board members voicing complaints about the 21 hospital's low safety score. 22 BY MS. ZIBAS: 23 Q. What's your understanding of the term 24 goodwill, as used in the complaint and your 25 declaration?

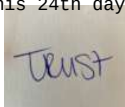
Page 90 1 A. Well, the hospital's ability to do right by 2 their patients, by the community. 3 MS. ZIBAS: I'm going to take, like, maybe 4 five or ten minutes and see what other things I 5 want to ask, if anything. 6 THE VIDEOGRAPHER: We're off the record at 7 12:43 p.m. 8 (Brief recess was taken at 12:43 p.m.) 9 (Back on the record at 12:51 p.m.) 10 THE VIDEOGRAPHER: We're back on the 11 record. Time is 12:51 p.m. 12 BY MS. ZIBAS: 13 Q. Are there any plans currently at Palm Beach 14 Gardens on how to improve the CMS star rating? 15 A. As I mentioned earlier, our goals are 16 ongoing to improving patient safety quality and 17 patient experience for the hospital, for our 18 patients, that's a part of our goal, not necessarily 19 to improve the specific grading of any organization. 20 Q. Do you have any documents that you 21 submitted in this case or that you know that your 22 staff may have submitted that directly links the 23 decrease in the ER visits and outpatient visits to 24 the Leapfrog grade? 25 MR. CHUNG: Objection to form.	Page 92 1 know. I don't know who made the final decision. 2 BY MS. ZIBAS: 3 Q. And is the governing board kept up-to-date 4 on the cost of the legal fees for the litigation? 5 A. No. The cost of the litigation are not 6 clear to us right now, so they haven't been updated 7 on what the cost of that. 8 Q. Will the governing board be updated? 9 A. I don't know. 10 Q. How -- when will you know if you need to 11 update them? 12 MR. CHUNG: Objection to form. 13 A. I think the decision will be made if -- 14 depending on where the funds come from, come from. 15 BY MS. ZIBAS: 16 Q. Where would the funds come from, if not 17 from the hospital? 18 A. I don't know. 19 Q. Does Palm Beach Gardens use a company 20 called Trulliant [sic.]? 21 A. Trulliant? 22 Q. Yes. 23 A. Or Trilliant? 24 Q. Trilliant. You may not. It's for data 25 gathering, not all hospitals use it.
Page 91 1 A. I don't. I'm not aware of any. 2 BY MS. ZIBAS: 3 Q. What about linking the admission, number of 4 admissions to the Leapfrog grading? Are there any 5 documentation to support such a statement? 6 MR. CHUNG: Objection to form. 7 A. I don't have any. I'm not aware of any 8 document that was submitted specific for that. 9 BY MS. ZIBAS: 10 Q. And was the governing board involved in 11 deciding whether to file this lawsuit creating more 12 publicity in litigating this case about the Leapfrog 13 grade? 14 MR. CHUNG: Objection to form. 15 A. The governing board was not involved in the 16 decision. 17 BY MS. ZIBAS: 18 Q. Who was involved in the decision? 19 MR. CHUNG: Objection to form. 20 MS. ZIBAS: To file the lawsuit and 21 increase the publicity about the Leapfrog grade. 22 MR. CHUNG: Objection to form. 23 A. The decision was made to file the lawsuit. 24 That's -- that was above my pay grade. From Maggie, 25 Maggie Gill. I don't know if above her, I don't	Page 93 1 A. Trilliant. 2 Q. Maybe I'm mispronouncing -- 3 A. I'm familiar with Trilliant. I do believe 4 some people in the market may use that for data 5 gathering. 6 Q. Does Palm Beach Gardens use it, as far as 7 you know? 8 A. Specifically, I don't -- I don't have 9 access to Trilliant, but I don't know if some of the 10 other employees have access to it. 11 Q. Does Palm Beach Gardens have a contract 12 with Vizient as a consulting firm? 13 A. I'm not aware of that? 14 MS. ZIBAS: I don't believe I have any 15 other questions at this time. Obviously, if new 16 documents are produced later on in this 17 litigation that involve this witness, we would 18 reserve the right to submit questions for that 19 purpose only. Not saying that's going to 20 happen, but if it does. 21 MR. CHUNG: I will have very brief 22 redirect. Let me ask you, Counsel, if you are 23 -- have a copy of the amended complaint? Do you 24 have a copy of the amended complaint that we can 25 use?

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Page 94 1 MS. ZIBAS: No. Mine is marked up. Can't 2 use mine. 3 MR. CHUNG: That's fine. I think what we 4 will do is just a couple of questions coming off 5 the amended complaint. We have it on laptop and 6 I think what we can do is get approved visually 7 and designate the complaint as I think 8 Exhibit 9, and we can deal with the logistics 9 later of getting it formally marked. 10 I'm going to ask Mr. Fischer to put an 11 electronic version of the amended complaint, 12 which we'll designate and later mark as 13 Exhibit 9. 14 (Exhibit 9 was marked.) 15 CROSS-EXAMINATION 16 BY MR. CHUNG: 17 Q. Mr. Cazares, do you recognize the document 18 that's in front of you as the amended complaint in 19 this action? 20 A. Yes. 21 Q. And are you familiar with the amended 22 complaint? 23 A. Yes. 24 Q. And I'm going to direct your attention to 25 page 17 and paragraph 42 of the amended complaint, if	Page 96 1 exactly? What is it an excerpt of? 2 A. It's part of the patient rights and ethics 3 section, basically an attestation by the CEO that is 4 being made here. 5 Q. All right. And what does that attestation 6 cover? 7 A. Basically that the information has been 8 reviewed. It's accurate. Reflects the most 9 up-to-date information. And then it talks about the 10 Leapfrog Group will retain exclusive ownership of the 11 data, intellectual property rights, and that the 12 hospital acknowledges that the group, that the 13 Leapfrog Group may use the information in a 14 commercial manner for profit. 15 Q. This is the document you were referring to 16 earlier? 17 A. Yes. 18 Q. When you were referencing -- 19 A. Commercial gains. 20 Q. -- the commercial gains that Leapfrog is 21 asking the hospital, the reporting hospital to sign 22 over as a condition of participating in the survey; 23 correct? 24 A. That's correct. That's the document that I 25 was referring to.
Page 95 1 you can just toggle down to it. And just let us know 2 when you're there. 3 A. 17? 4 Q. Yes. Page 17. It's paragraph 42. 5 A. Yes. 6 Q. Do you see that? 7 A. Yes. 8 Q. Earlier in the day, you were asked 9 questions by counsel about a document, a Leapfrog 10 document in the complaint that referenced commercial 11 purpose or commercial -- commercial gains in the 12 context of questions you were asked about the 13 pay-to-play allegation. 14 A. Correct. 15 Q. Do you remember those questions? 16 A. Yes, I do. 17 Q. Okay. Is the document that's kind of blown 18 up in paragraph 2, the document that you were 19 referencing? 20 A. Yes. 21 Q. And are you aware that that is -- or are 22 you familiar with the -- are you aware that document 23 is an excerpt from Leapfrog's hospital survey? 24 A. Correct. 25 Q. And can you just read the -- and what is it	Page 97 1 MR. CHUNG: Okay. No further questions. 2 Thank you. 3 MS. ZIBAS: Looks like we're done. 4 THE STENOGRAPHER: Would you like to read 5 of waive? 6 MR. CHUNG: I'm sorry? 7 THE STENOGRAPHER: Would you like to read 8 or waive? 9 MR. CHUNG: We can -- we'll read. 10 MS. ZIBAS: And you're going to gather all 11 of the exhibits, right, and take them with you 12 and attach them. Thank you. Appreciate it. 13 THE VIDEOGRAPHER: Off the record at 1:01 14 p.m. 15 (Thereupon, the proceedings concluded at 16 1:01 p.m.) 17 18 19 20 21 22 23 24 25

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	Page 98		Page 100
1	CERTIFICATE OF OATH	1	October 9, 2025
2		2	DANIEL CHUNG, ESQUIRE
3	THE STATE OF FLORIDA)		dchung@gibsondunn.com
4	COUNTY OF MIAMI-DADE)	3	
5		4	ERIK CAZARES
6		5	IN RE: GOOD SAMARITAN VS. THE LEAPFROG GROUP
7		6	CASE NO.: 9:25-CV-80526-DMM
8		7	TYPE OF PROCEEDING: DEPOSITION
9	I, THERESA RUST, the undersigned authority,	8	DATE: 9.24.25
10	certify that ERIK CAZARES, appeared before me and was	9	
11	duly sworn on the 24th day of September 2025.	10	The transcript of the above proceeding is now
12	Signed this 24th day of September 2025.	11	available and requires signature by the witness.
13		12	Please e-mail fl.production@lexitaslegal.com for
14		13	access to a read-only PDF transcript and PDF-fillable
15		14	errata sheet via computer or use the errata sheet
16		15	that is located at the back of the transcript.
17	THERESA RUST, RPR	16	Once completed, please print, sign, and return to the
18	Notary Public - State of Florida	17	e-mail address listed below for distribution to all
19	Commission No. #GG145788	18	parties.
20	Expires: October 25, 2025	19	
21		20	If you are in need of assistance, please contact
22		21	Lexitas at 888-811-3408.
23		22	If the witness does not read and sign the transcript
24		23	within a reasonable amount of time, the original
25		24	transcript may be filed with the Clerk of the court.
		25	If the witness wishes to waive his/her signature now,
			please have the witness sign in the blank at the
			bottom of this letter and return to the e-mail
			address listed below.
			Very truly yours,
			Theresa Rust, RPR
			Lexitas
			fl.production@lexitaslegal.com
			I do hereby waive my signature.
			ERIK CAZARES
			Job No. 422124

	Page 99		Page 101
1	CERTIFICATE OF REPORTER	1	ERRATA SHEET
2		2	DO NOT WRITE ON TRANSCRIPT - ENTER CHANGES HERE
3	THE STATE OF FLORIDA)	3	IN RE: GOOD SAMARITAN VS. THE LEAPFROG GROUP
4	COUNTY OF MIAMI-DADE)	4	CASE NO. 9:25-CV-80526-DMM
5		5	WITNESS: ERIK CAZARES TAKEN: 9/24/2025
6	I, Theresa Rust, Florida Professional	6	
7	Reporter, certify that I was authorized to and did	7	PAGE LINE CHANGE REASON FOR CHANGE
8	stenographically report the video-recorded deposition	8	
9	of ERIK CAZARES, pages 1 through 97, that a review of	9	
10	the transcript was requested, and that the transcript	10	
11	is a true and complete record of my stenographic	11	
12	notes.	12	
13	I further certify that I am not a relative,	13	
14	employee, attorney, or counsel of any of the parties,	14	
15	nor am I a relative or employee of any of the	15	
16	parties' attorney or counsel connected with the	16	
17	action, nor am I financially interested in the	17	
18	action.	18	
19		19	
20	DATED this 24th day of September 2025.	20	Under penalties of perjury, I declare that I
21		21	have read the foregoing document and that the facts
22		22	stated in it are true.
23		23	Date ERIK CAZARES
24	Theresa Rust, RPR, FCRR	24	
25		25	Job No. 422124
			fl.production@lexitaslegal.com

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EXHIBIT 27

What is the Hospital Safety Grade?

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

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

Delray Medical Center	LF-MPN:	10-0258
5352 Linton Boulevard		
Delray Beach	FL	33484-6580

Your Hospital Safety Grade	Spring 2025	F
	Fall 2024	F
	Spring 2024	D
	Fall 2023	C
	Spring 2023	C

Spring 2025, Fall 2024, Spring 2024, Fall 2023, Spring 2023

Process and Structural Measures

	Score Release Date	Your Hospital's Measure Score	Z-Score	National Mean for the Measure	Data Source(s)
Computerized Physician Order Entry (CPOE)	Spring 2025	15	-1.910	80.23	Imputation Model Applied
	Fall 2024	15	-1.850	74.04	Imputation Model Applied
	Spring 2024	100	0.571	91.81	Imputation Model Applied
	Fall 2023	100	0.609	90.58	Imputation Model Applied
	Spring 2023	100	0.540	91.77	Imputation Model Applied
Barcode Medication Administration (BCMA)	Spring 2025	25	-1.867	81.87	Imputation Model Applied
	Fall 2024	25	-1.789	80.51	Imputation Model Applied
	Spring 2024	100	0.628	93.42	Imputation Model Applied
	Fall 2023	100	0.660	92.67	Imputation Model Applied
	Spring 2023	100	0.704	91.22	Imputation Model Applied
ICU Physician Staffing (IPS)	Spring 2025	5	-1.375	65.15	Imputation Model Applied
	Fall 2024	5	-1.352	64.45	Imputation Model Applied
	Spring 2024	100	0.833	63.29	Imputation Model Applied
	Fall 2023	100	0.851	62.31	Imputation Model Applied
	Spring 2023	100	0.771	67.47	Imputation Model Applied

*This hospital does not have this measure available or included for this round of the Hospital Safety Grade.

#This hospital did not receive a Hospital Safety Grade for this round.

Spring 2025, Fall 2024, Spring 2024, Fall 2023, Spring 2023

Process and Structural Measures

	Score Release Date	Your Hospital's Measure Score	Z-Score	National Mean for the Measure	Data Source(s)
Safe Practice 1: Culture of Leadership Structures and Systems	Spring 2025	Declined to Report	*	117.49	*
	Fall 2024	Declined to Report	*	117.40	*
	Spring 2024	Declined to Report	*	117.59	*
	Fall 2023	Declined to Report	*	117.49	*
	Spring 2023	Declined to Report	*	116.86	*
Safe Practice 2: Culture Measurement, Feedback and Intervention	Spring 2025	Declined to Report	*	116.35	*
	Fall 2024	Declined to Report	*	116.60	*
	Spring 2024	Declined to Report	*	117.08	*
	Fall 2023	Declined to Report	*	116.99	*
	Spring 2023	Declined to Report	*	115.87	*
Safe Practice 9: Nursing Workforce	Spring 2025	Not Included	*	*	*
	Fall 2024	Not Included	*	*	*
	Spring 2024	Not Included	*	*	*
	Fall 2023	Not Included	*	*	*
	Spring 2023	Declined to Report	*	97.86	*
Total Nursing Care Hours per Patient Day	Spring 2025	Declined to Report	*	77.07	*
	Fall 2024	Declined to Report	*	76.10	*
	Spring 2024	Declined to Report	*	74.69	*
	Fall 2023	Declined to Report	*	71.00	*
	Spring 2023	Not Included	*	*	*
Hand Hygiene	Spring 2025	15	-1.643	74.40	Imputation Model Applied
	Fall 2024	15	-1.569	72.43	Imputation Model Applied
	Spring 2024	100	0.818	78.65	Imputation Model Applied
	Fall 2023	100	0.851	77.32	Imputation Model Applied
	Spring 2023	100	1.021	71.64	Imputation Model Applied

*This hospital does not have this measure available or included for this round of the Hospital Safety Grade.

#This hospital did not receive a Hospital Safety Grade for this round.

Spring 2025, Fall 2024, Spring 2024, Fall 2023, Spring 2023

Process and Structural Measures

	Score Release Date	Your Hospital's Measure Score	Z-Score	National Mean for the Measure	Data Source(s)
H-COMP-1: Nurse Communication	Spring 2025	79	-4.454	90.19	CMS
	Fall 2024	78	-4.709	90.04	CMS
	Spring 2024	78	-4.499	89.67	CMS
	Fall 2023	80	-3.710	89.55	CMS
	Spring 2023	81	-3.503	89.81	CMS
H-COMP-2: Doctor Communication	Spring 2025	81	-3.591	89.91	CMS
	Fall 2024	80	-3.944	89.80	CMS
	Spring 2024	79	-4.193	89.52	CMS
	Fall 2023	80	-3.732	89.45	CMS
	Spring 2023	81	-3.552	89.70	CMS
H-COMP-3: Staff Responsiveness	Spring 2025	64	-4.045	81.63	CMS
	Fall 2024	64	-3.961	81.48	CMS
	Spring 2024	64	-3.842	81.14	CMS
	Fall 2023	65	-3.661	80.97	CMS
	Spring 2023	66	-3.661	81.30	CMS
H-COMP-5: Communication about Medicines	Spring 2025	58	-3.979	74.42	CMS
	Fall 2024	57	-4.167	74.33	CMS
	Spring 2024	56	-4.356	74.09	CMS
	Fall 2023	58	-4.006	73.85	CMS
	Spring 2023	61	-3.374	74.21	CMS
H-COMP-6: Discharge Information	Spring 2025	71	-3.847	85.25	CMS
	Fall 2024	69	-4.274	85.14	CMS
	Spring 2024	68	-4.466	84.90	CMS
	Fall 2023	69	-4.154	84.80	CMS
	Spring 2023	71	-3.729	85.07	CMS

*This hospital does not have this measure available or included for this round of the Hospital Safety Grade.

#This hospital did not receive a Hospital Safety Grade for this round.

Spring 2025, Fall 2024, Spring 2024, Fall 2023, Spring 2023

Outcome Measures

	Score Release Date	Your Hospital's Measure Score	Z-Score	National Mean for the Measure	Data Source(s)
Foreign Object Retained After Surgery	Spring 2025	0.000	0.275	0.014	CMS
	Fall 2024	0.000	0.274	0.014	CMS
	Spring 2024	0.068	-1.048	0.014	CMS
	Fall 2023	0.068	-1.040	0.014	CMS
	Spring 2023	0.086	-1.257	0.015	CMS
Air Embolism	Spring 2025	0.000	0.035	0.002	CMS
	Fall 2024	0.000	0.035	0.002	CMS
	Spring 2024	0.000	0.073	0.001	CMS
	Fall 2023	0.000	0.073	0.001	CMS
	Spring 2023	0.000	0.062	0.001	CMS
Falls and Trauma	Spring 2025	0.479	-0.235	0.384	CMS
	Fall 2024	0.479	-0.233	0.385	CMS
	Spring 2024	0.473	-0.106	0.428	CMS
	Fall 2023	0.473	-0.102	0.429	CMS
	Spring 2023	0.345	0.198	0.437	CMS
CLABSI	Spring 2025	1.477	-1.496	0.651	CMS
	Fall 2024	1.335	-1.146	0.687	CMS
	Spring 2024	0.889	-0.269	0.730	CMS
	Fall 2023	0.225	0.939	0.888	CMS
	Spring 2023	0.107	1.107	1.077	CMS
CAUTI	Spring 2025	0.271	0.545	0.540	CMS
	Fall 2024	0.344	0.460	0.577	CMS
	Spring 2024	0.293	0.629	0.627	CMS
	Fall 2023	0.331	0.654	0.735	CMS
	Spring 2023	0.506	0.493	0.862	CMS

*This hospital does not have this measure available or included for this round of the Hospital Safety Grade.

#This hospital did not receive a Hospital Safety Grade for this round.

Hospital Safety Grade Report for Hospitals
Spring 2025, Fall 2024, Spring 2024, Fall 2023, Spring 2023

Outcome Measures

	Score Release Date	Your Hospital's Measure Score	Z-Score	National Mean for the Measure	Data Source(s)
SSI: Colon	Spring 2025	2.073	-1.803	0.831	CMS
	Fall 2024	1.965	-1.541	0.852	CMS
	Spring 2024	1.450	-0.889	0.845	CMS
	Fall 2023	0.726	0.162	0.832	CMS
	Spring 2023	0.244	0.855	0.822	CMS
MRSA	Spring 2025	0.922	-0.343	0.719	CMS
	Fall 2024	1.003	-0.438	0.746	CMS
	Spring 2024	1.044	-0.413	0.793	CMS
	Fall 2023	1.261	-0.459	0.927	CMS
	Spring 2023	1.300	-0.254	1.095	CMS
C. diff	Spring 2025	0.284	0.357	0.401	CMS
	Fall 2024	0.349	0.208	0.418	CMS
	Spring 2024	0.267	0.533	0.455	CMS
	Fall 2023	0.234	0.691	0.488	CMS
	Spring 2023	0.261	0.610	0.489	CMS
PSI 4: Death rate among surgical inpatients with serious treatable conditions	Spring 2025	108.94	2.852	177.45	CMS
	Fall 2024	91.65	3.510	168.34	CMS
	Spring 2024	91.65	3.501	168.38	CMS
	Fall 2023	73.88	3.976	143.25	CMS
	Spring 2023	73.88	3.970	143.23	CMS
CMS Medicare PSI-90: Patient safety and adverse events composite**	Spring 2025	1.03	-0.142	1.00	CMS
	Fall 2024	1.09	-0.437	1.01	CMS
	Spring 2024	1.09	-0.440	1.01	CMS
	Fall 2023	1.04	-0.352	0.98	CMS
	Spring 2023	1.04	-0.356	0.98	CMS

*This hospital does not have this measure available or included for this round of the Hospital Safety Grade.

#This hospital did not receive a Hospital Safety Grade for this round.

Spring 2025, Fall 2024, Spring 2024, Fall 2023, Spring 2023

Component PSIs (scores not used to calculate the Hospital Safety Grade)**

	Score Release Date	Your Hospital's Measure Score	Z-Score	National Mean for the Measure	Data Source(s)
PSI 3: Pressure ulcer rate	Spring 2025	0.56			CMS
	Fall 2024	0.70			CMS
	Spring 2024	0.70			CMS
	Fall 2023	0.62			CMS
	Spring 2023	0.62			CMS
PSI 6: Iatrogenic pneumothorax rate	Spring 2025	0.20			CMS
	Fall 2024	0.17			CMS
	Spring 2024	0.17			CMS
	Fall 2023	0.14			CMS
	Spring 2023	0.14			CMS
PSI 8: In-hospital fall with hip fracture rate	Spring 2025	0.31			CMS
	Fall 2024	0.09			CMS
	Spring 2024	0.09			CMS
	Fall 2023	0.07			CMS
	Spring 2023	0.07			CMS
PSI 9: Perioperative hemorrhage and hematoma rate	Spring 2025	2.22			CMS
	Fall 2024	2.86			CMS
	Spring 2024	2.86			CMS
	Fall 2023	2.18			CMS
	Spring 2023	2.18			CMS
PSI 10: Postoperative acute kidney injury rate	Spring 2025	1.61			CMS
	Fall 2024	1.49			CMS
	Spring 2024	1.49			CMS
	Fall 2023	0.90			CMS
	Spring 2023	0.90			CMS

**CMS calculates PSI 90 using the ten (10) component PSIs listed on pages 7-8. While scores for each of the 10 component PSIs are NOT used to calculate Hospital Safety Grades, they are publicly reported on the Hospital Safety Grade website (<https://www.hospitalsafetygrade.org>)

*This hospital does not have this measure available or included for this round of the Hospital Safety Grade.

#This hospital did not receive a Hospital Safety Grade for this round.

Spring 2025, Fall 2024, Spring 2024, Fall 2023, Spring 2023

Component PSIs (scores not used to calculate the Hospital Safety Grade)**

	Score Release Date	Your Hospital's Measure Score	Z-Score	National Mean for the Measure	Data Source(s)
PSI 11: Postoperative respiratory failure rate	Spring 2025	9.54			CMS
	Fall 2024	8.14			CMS
	Spring 2024	8.14			CMS
	Fall 2023	5.06			CMS
	Spring 2023	5.06			CMS
PSI 12: Perioperative pulmonary embolism or deep vein thrombosis rate	Spring 2025	5.06			CMS
	Fall 2024	5.03			CMS
	Spring 2024	5.03			CMS
	Fall 2023	5.25			CMS
	Spring 2023	5.25			CMS
PSI 13: Postoperative sepsis rate	Spring 2025	6.71			CMS
	Fall 2024	6.30			CMS
	Spring 2024	6.30			CMS
	Fall 2023	3.84			CMS
	Spring 2023	3.84			CMS
PSI 14: Postoperative wound dehiscence rate	Spring 2025	1.60			CMS
	Fall 2024	2.07			CMS
	Spring 2024	2.07			CMS
	Fall 2023	0.64			CMS
	Spring 2023	0.64			CMS
PSI 15: Unrecognized abdominopelvic accidental puncture/laceration rate	Spring 2025	1.03			CMS
	Fall 2024	0.73			CMS
	Spring 2024	0.73			CMS
	Fall 2023	1.06			CMS
	Spring 2023	1.06			CMS

**CMS calculates PSI 90 using the ten (10) component PSIs listed on pages 7-8. While scores for each of the 10 component PSIs are NOT used to calculate Hospital Safety Grades, they are publicly reported on the Hospital Safety Grade website (<https://www.hospitalsafetygrade.org>)

*This hospital does not have this measure available or included for this round of the Hospital Safety Grade.

#This hospital did not receive a Hospital Safety Grade for this round.

Hospital Safety Grade Report for Hospitals

Spring 2025, Fall 2024, Spring 2024, Fall 2023, Spring 2023

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*This hospital does not have this measure available or included for this round of the Hospital Safety Grade.

#This hospital did not receive a Hospital Safety Grade for this round.

Spring 2025, Fall 2024, Spring 2024, Fall 2023, Spring 2023

What is the Hospital Safety Grade?

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

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

Good Samaritan Medical Center		LF-MPN:	10-0287
1309 N. Flagler Drive			
West Palm Beach	FL	33401-3499	

Your Hospital Safety Grade	Spring 2025	D F C C C
	Fall 2024	
	Spring 2024	
	Fall 2023	
	Spring 2023	

Spring 2025, Fall 2024, Spring 2024, Fall 2023, Spring 2023

Process and Structural Measures

	Score Release Date	Your Hospital's Measure Score	Z-Score	National Mean for the Measure	Data Source(s)
Computerized Physician Order Entry (CPOE)	Spring 2025	15	-1.910	80.23	Imputation Model Applied
	Fall 2024	15	-1.850	74.04	Imputation Model Applied
	Spring 2024	100	0.571	91.81	Imputation Model Applied
	Fall 2023	100	0.609	90.58	Imputation Model Applied
	Spring 2023	100	0.540	91.77	Imputation Model Applied
Barcode Medication Administration (BCMA)	Spring 2025	25	-1.867	81.87	Imputation Model Applied
	Fall 2024	25	-1.789	80.51	Imputation Model Applied
	Spring 2024	100	0.628	93.42	Imputation Model Applied
	Fall 2023	100	0.660	92.67	Imputation Model Applied
	Spring 2023	100	0.704	91.22	Imputation Model Applied
ICU Physician Staffing (IPS)	Spring 2025	5	-1.375	65.15	Imputation Model Applied
	Fall 2024	5	-1.352	64.45	Imputation Model Applied
	Spring 2024	100	0.833	63.29	Imputation Model Applied
	Fall 2023	100	0.851	62.31	Imputation Model Applied
	Spring 2023	100	0.771	67.47	Imputation Model Applied

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#This hospital did not receive a Hospital Safety Grade for this round.

Spring 2025, Fall 2024, Spring 2024, Fall 2023, Spring 2023

Process and Structural Measures

	Score Release Date	Your Hospital's Measure Score	Z-Score	National Mean for the Measure	Data Source(s)
Safe Practice 1: Culture of Leadership Structures and Systems	Spring 2025	Declined to Report	*	117.49	*
	Fall 2024	Declined to Report	*	117.40	*
	Spring 2024	Declined to Report	*	117.59	*
	Fall 2023	Declined to Report	*	117.49	*
	Spring 2023	Declined to Report	*	116.86	*
Safe Practice 2: Culture Measurement, Feedback and Intervention	Spring 2025	Declined to Report	*	116.35	*
	Fall 2024	Declined to Report	*	116.60	*
	Spring 2024	Declined to Report	*	117.08	*
	Fall 2023	Declined to Report	*	116.99	*
	Spring 2023	Declined to Report	*	115.87	*
Safe Practice 9: Nursing Workforce	Spring 2025	Not Included	*	*	*
	Fall 2024	Not Included	*	*	*
	Spring 2024	Not Included	*	*	*
	Fall 2023	Not Included	*	*	*
	Spring 2023	Declined to Report	*	97.86	*
Total Nursing Care Hours per Patient Day	Spring 2025	Declined to Report	*	77.07	*
	Fall 2024	Declined to Report	*	76.10	*
	Spring 2024	Declined to Report	*	74.69	*
	Fall 2023	Declined to Report	*	71.00	*
	Spring 2023	Not Included	*	*	*
Hand Hygiene	Spring 2025	15	-1.643	74.40	Imputation Model Applied
	Fall 2024	15	-1.569	72.43	Imputation Model Applied
	Spring 2024	100	0.818	78.65	Imputation Model Applied
	Fall 2023	100	0.851	77.32	Imputation Model Applied
	Spring 2023	100	1.021	71.64	Imputation Model Applied

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#This hospital did not receive a Hospital Safety Grade for this round.

Spring 2025, Fall 2024, Spring 2024, Fall 2023, Spring 2023

Process and Structural Measures

	Score Release Date	Your Hospital's Measure Score	Z-Score	National Mean for the Measure	Data Source(s)
H-COMP-1: Nurse Communication	Spring 2025	84	-2.464	90.19	CMS
	Fall 2024	84	-2.362	90.04	CMS
	Spring 2024	84	-2.186	89.67	CMS
	Fall 2023	84	-2.156	89.55	CMS
	Spring 2023	84	-2.310	89.81	CMS
H-COMP-2: Doctor Communication	Spring 2025	86	-1.576	89.91	CMS
	Fall 2024	86	-1.529	89.80	CMS
	Spring 2024	86	-1.403	89.52	CMS
	Fall 2023	86	-1.362	89.45	CMS
	Spring 2023	87	-1.103	89.70	CMS
H-COMP-3: Staff Responsiveness	Spring 2025	72	-2.209	81.63	CMS
	Fall 2024	72	-2.148	81.48	CMS
	Spring 2024	73	-1.825	81.14	CMS
	Fall 2023	73	-1.827	80.97	CMS
	Spring 2023	73	-1.986	81.30	CMS
H-COMP-5: Communication about Medicines	Spring 2025	63	-2.768	74.42	CMS
	Fall 2024	63	-2.724	74.33	CMS
	Spring 2024	66	-1.949	74.09	CMS
	Fall 2023	65	-2.237	73.85	CMS
	Spring 2023	64	-2.608	74.21	CMS
H-COMP-6: Discharge Information	Spring 2025	76	-2.497	85.25	CMS
	Fall 2024	74	-2.950	85.14	CMS
	Spring 2024	75	-2.617	84.90	CMS
	Fall 2023	77	-2.051	84.80	CMS
	Spring 2023	76	-2.404	85.07	CMS

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#This hospital did not receive a Hospital Safety Grade for this round.

Spring 2025, Fall 2024, Spring 2024, Fall 2023, Spring 2023

Outcome Measures

	Score Release Date	Your Hospital's Measure Score	Z-Score	National Mean for the Measure	Data Source(s)
Foreign Object Retained After Surgery	Spring 2025	0.000	0.275	0.014	CMS
	Fall 2024	0.000	0.274	0.014	CMS
	Spring 2024	0.000	0.280	0.014	CMS
	Fall 2023	0.000	0.278	0.014	CMS
	Spring 2023	0.000	0.269	0.015	CMS
Air Embolism	Spring 2025	0.000	0.035	0.002	CMS
	Fall 2024	0.000	0.035	0.002	CMS
	Spring 2024	0.000	0.073	0.001	CMS
	Fall 2023	0.000	0.073	0.001	CMS
	Spring 2023	0.000	0.062	0.001	CMS
Falls and Trauma	Spring 2025	0.789	-1.005	0.384	CMS
	Fall 2024	0.789	-1.001	0.385	CMS
	Spring 2024	1.145	-1.683	0.428	CMS
	Fall 2023	1.145	-1.673	0.429	CMS
	Spring 2023	1.300	-1.862	0.437	CMS
CLABSI	Spring 2025	0.538	0.204	0.651	CMS
	Fall 2024	1.185	-0.881	0.687	CMS
	Spring 2024	1.495	-1.293	0.730	CMS
	Fall 2023	1.100	-0.300	0.888	CMS
	Spring 2023	1.110	-0.038	1.077	CMS
CAUTI	Spring 2025	1.567	-2.080	0.540	CMS
	Fall 2024	1.468	-1.764	0.577	CMS
	Spring 2024	1.105	-0.900	0.627	CMS
	Fall 2023	0.000	1.190	0.735	CMS
	Spring 2023	0.741	0.168	0.862	CMS

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#This hospital did not receive a Hospital Safety Grade for this round.

Spring 2025, Fall 2024, Spring 2024, Fall 2023, Spring 2023

Outcome Measures

	Score Release Date	Your Hospital's Measure Score	Z-Score	National Mean for the Measure	Data Source(s)
SSI: Colon	Spring 2025	1.679	-1.231	0.831	CMS
	Fall 2024	1.415	-0.779	0.852	CMS
	Spring 2024	0.323	0.768	0.845	CMS
	Fall 2023	0.000	1.265	0.832	CMS
	Spring 2023	0.000	1.216	0.822	CMS
MRSA	Spring 2025	0.000	1.216	0.719	CMS
	Fall 2024	0.306	0.748	0.746	CMS
	Spring 2024	1.103	-0.511	0.793	CMS
	Fall 2023	1.472	-0.749	0.927	CMS
	Spring 2023	1.203	-0.134	1.095	CMS
C. diff	Spring 2025	0.250	0.462	0.401	CMS
	Fall 2024	0.234	0.557	0.418	CMS
	Spring 2024	0.452	0.007	0.455	CMS
	Fall 2023	0.547	-0.162	0.488	CMS
	Spring 2023	0.401	0.235	0.489	CMS
PSI 4: Death rate among surgical inpatients with serious treatable conditions	Spring 2025	156.08	0.890	177.45	CMS
	Fall 2024	160.69	0.350	168.34	CMS
	Spring 2024	160.69	0.351	168.38	CMS
	Fall 2023	145.74	-0.143	143.25	CMS
	Spring 2023	145.74	-0.144	143.23	CMS
CMS Medicare PSI-90: Patient safety and adverse events composite**	Spring 2025	1.00	0.011	1.00	CMS
	Fall 2024	1.21	-1.076	1.01	CMS
	Spring 2024	1.21	-1.080	1.01	CMS
	Fall 2023	1.20	-1.286	0.98	CMS
	Spring 2023	1.20	-1.293	0.98	CMS

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#This hospital did not receive a Hospital Safety Grade for this round.

Spring 2025, Fall 2024, Spring 2024, Fall 2023, Spring 2023

Component PSIs (scores not used to calculate the Hospital Safety Grade)**

	Score Release Date	Your Hospital's Measure Score	Z-Score	National Mean for the Measure	Data Source(s)
PSI 3: Pressure ulcer rate	Spring 2025	0.42			CMS
	Fall 2024	0.91			CMS
	Spring 2024	0.91			CMS
	Fall 2023	1.04			CMS
	Spring 2023	1.04			CMS
PSI 6: Iatrogenic pneumothorax rate	Spring 2025	0.36			CMS
	Fall 2024	0.24			CMS
	Spring 2024	0.24			CMS
	Fall 2023	0.19			CMS
	Spring 2023	0.19			CMS
PSI 8: In-hospital fall with hip fracture rate	Spring 2025	0.35			CMS
	Fall 2024	0.09			CMS
	Spring 2024	0.09			CMS
	Fall 2023	0.13			CMS
	Spring 2023	0.13			CMS
PSI 9: Perioperative hemorrhage and hematoma rate	Spring 2025	3.03			CMS
	Fall 2024	2.90			CMS
	Spring 2024	2.90			CMS
	Fall 2023	2.80			CMS
	Spring 2023	2.80			CMS
PSI 10: Postoperative acute kidney injury rate	Spring 2025	1.69			CMS
	Fall 2024	1.56			CMS
	Spring 2024	1.56			CMS
	Fall 2023	0.91			CMS
	Spring 2023	0.91			CMS

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Spring 2025, Fall 2024, Spring 2024, Fall 2023, Spring 2023

Component PSIs (scores not used to calculate the Hospital Safety Grade)**

	Score Release Date	Your Hospital's Measure Score	Z-Score	National Mean for the Measure	Data Source(s)
PSI 11: Postoperative respiratory failure rate	Spring 2025	9.96			CMS
	Fall 2024	10.85			CMS
	Spring 2024	10.85			CMS
	Fall 2023	10.10			CMS
	Spring 2023	10.10			CMS
PSI 12: Perioperative pulmonary embolism or deep vein thrombosis rate	Spring 2025	4.95			CMS
	Fall 2024	5.03			CMS
	Spring 2024	5.03			CMS
	Fall 2023	4.32			CMS
	Spring 2023	4.32			CMS
PSI 13: Postoperative sepsis rate	Spring 2025	5.51			CMS
	Fall 2024	5.16			CMS
	Spring 2024	5.16			CMS
	Fall 2023	3.98			CMS
	Spring 2023	3.98			CMS
PSI 14: Postoperative wound dehiscence rate	Spring 2025	1.70			CMS
	Fall 2024	2.24			CMS
	Spring 2024	2.24			CMS
	Fall 2023	0.71			CMS
	Spring 2023	0.71			CMS
PSI 15: Unrecognized abdominopelvic accidental puncture/laceration rate	Spring 2025	0.64			CMS
	Fall 2024	0.98			CMS
	Spring 2024	0.98			CMS
	Fall 2023	1.36			CMS
	Spring 2023	1.36			CMS

**CMS calculates PSI 90 using the ten (10) component PSIs listed on pages 7-8. While scores for each of the 10 component PSIs are NOT used to calculate Hospital Safety Grades, they are publicly reported on the Hospital Safety Grade website (<https://www.hospitalsafetygrade.org>)

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Hospital Safety Grade Report for Hospitals

Spring 2025, Fall 2024, Spring 2024, Fall 2023, Spring 2023

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Spring 2025, Fall 2024, Spring 2024, Fall 2023, Spring 2023

What is the Hospital Safety Grade?

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

Palm Beach Gardens Medical Center**LF-MPN:****10-0176****3360 Burns Road****Palm Beach Gardens****FL****33410-4304**

Your Hospital Safety Grade	Spring 2025	F F C C C
	Fall 2024	
	Spring 2024	
	Fall 2023	
	Spring 2023	

Spring 2025, Fall 2024, Spring 2024, Fall 2023, Spring 2023

Process and Structural Measures

	Score Release Date	Your Hospital's Measure Score	Z-Score	National Mean for the Measure	Data Source(s)
Computerized Physician Order Entry (CPOE)	Spring 2025	15	-1.910	80.23	Imputation Model Applied
	Fall 2024	15	-1.850	74.04	Imputation Model Applied
	Spring 2024	100	0.571	91.81	Imputation Model Applied
	Fall 2023	100	0.609	90.58	Imputation Model Applied
	Spring 2023	100	0.540	91.77	Imputation Model Applied
Barcode Medication Administration (BCMA)	Spring 2025	25	-1.867	81.87	Imputation Model Applied
	Fall 2024	25	-1.789	80.51	Imputation Model Applied
	Spring 2024	100	0.628	93.42	Imputation Model Applied
	Fall 2023	100	0.660	92.67	Imputation Model Applied
	Spring 2023	100	0.704	91.22	Imputation Model Applied
ICU Physician Staffing (IPS)	Spring 2025	5	-1.375	65.15	Imputation Model Applied
	Fall 2024	5	-1.352	64.45	Imputation Model Applied
	Spring 2024	100	0.833	63.29	Imputation Model Applied
	Fall 2023	100	0.851	62.31	Imputation Model Applied
	Spring 2023	100	0.771	67.47	Imputation Model Applied

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#This hospital did not receive a Hospital Safety Grade for this round.

Spring 2025, Fall 2024, Spring 2024, Fall 2023, Spring 2023

Process and Structural Measures

	Score Release Date	Your Hospital's Measure Score	Z-Score	National Mean for the Measure	Data Source(s)
Safe Practice 1: Culture of Leadership Structures and Systems	Spring 2025	Declined to Report	*	117.49	*
	Fall 2024	Declined to Report	*	117.40	*
	Spring 2024	Declined to Report	*	117.59	*
	Fall 2023	Declined to Report	*	117.49	*
	Spring 2023	Declined to Report	*	116.86	*
Safe Practice 2: Culture Measurement, Feedback and Intervention	Spring 2025	Declined to Report	*	116.35	*
	Fall 2024	Declined to Report	*	116.60	*
	Spring 2024	Declined to Report	*	117.08	*
	Fall 2023	Declined to Report	*	116.99	*
	Spring 2023	Declined to Report	*	115.87	*
Safe Practice 9: Nursing Workforce	Spring 2025	Not Included	*	*	*
	Fall 2024	Not Included	*	*	*
	Spring 2024	Not Included	*	*	*
	Fall 2023	Not Included	*	*	*
	Spring 2023	Declined to Report	*	97.86	*
Total Nursing Care Hours per Patient Day	Spring 2025	Declined to Report	*	77.07	*
	Fall 2024	Declined to Report	*	76.10	*
	Spring 2024	Declined to Report	*	74.69	*
	Fall 2023	Declined to Report	*	71.00	*
	Spring 2023	Not Included	*	*	*
Hand Hygiene	Spring 2025	15	-1.643	74.40	Imputation Model Applied
	Fall 2024	15	-1.569	72.43	Imputation Model Applied
	Spring 2024	70	-0.331	78.65	Imputation Model Applied
	Fall 2023	70	-0.275	77.32	Imputation Model Applied
	Spring 2023	70	-0.059	71.64	Imputation Model Applied

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#This hospital did not receive a Hospital Safety Grade for this round.

Spring 2025, Fall 2024, Spring 2024, Fall 2023, Spring 2023

Process and Structural Measures

	Score Release Date	Your Hospital's Measure Score	Z-Score	National Mean for the Measure	Data Source(s)
H-COMP-1: Nurse Communication	Spring 2025	84	-2.464	90.19	CMS
	Fall 2024	84	-2.362	90.04	CMS
	Spring 2024	84	-2.186	89.67	CMS
	Fall 2023	85	-1.768	89.55	CMS
	Spring 2023	86	-1.515	89.81	CMS
H-COMP-2: Doctor Communication	Spring 2025	84	-2.382	89.91	CMS
	Fall 2024	85	-1.931	89.80	CMS
	Spring 2024	84	-2.200	89.52	CMS
	Fall 2023	86	-1.362	89.45	CMS
	Spring 2023	87	-1.103	89.70	CMS
H-COMP-3: Staff Responsiveness	Spring 2025	71	-2.439	81.63	CMS
	Fall 2024	70	-2.601	81.48	CMS
	Spring 2024	71	-2.273	81.14	CMS
	Fall 2023	73	-1.827	80.97	CMS
	Spring 2023	73	-1.986	81.30	CMS
H-COMP-5: Communication about Medicines	Spring 2025	62	-3.018	74.42	CMS
	Fall 2024	63	-2.724	74.33	CMS
	Spring 2024	65	-2.189	74.09	CMS
	Fall 2023	66	-1.984	73.85	CMS
	Spring 2023	67	-1.842	74.21	CMS
H-COMP-6: Discharge Information	Spring 2025	76	-2.497	85.25	CMS
	Fall 2024	76	-2.421	85.14	CMS
	Spring 2024	75	-2.617	84.90	CMS
	Fall 2023	75	-2.577	84.80	CMS
	Spring 2023	76	-2.404	85.07	CMS

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#This hospital did not receive a Hospital Safety Grade for this round.

Spring 2025, Fall 2024, Spring 2024, Fall 2023, Spring 2023

Outcome Measures

	Score Release Date	Your Hospital's Measure Score	Z-Score	National Mean for the Measure	Data Source(s)
Foreign Object Retained After Surgery	Spring 2025	0.000	0.275	0.014	CMS
	Fall 2024	0.000	0.274	0.014	CMS
	Spring 2024	0.000	0.280	0.014	CMS
	Fall 2023	0.000	0.278	0.014	CMS
	Spring 2023	0.000	0.269	0.015	CMS
Air Embolism	Spring 2025	0.000	0.035	0.002	CMS
	Fall 2024	0.000	0.035	0.002	CMS
	Spring 2024	0.000	0.073	0.001	CMS
	Fall 2023	0.000	0.073	0.001	CMS
	Spring 2023	0.000	0.062	0.001	CMS
Falls and Trauma	Spring 2025	0.439	-0.136	0.384	CMS
	Fall 2024	0.439	-0.134	0.385	CMS
	Spring 2024	0.144	0.666	0.428	CMS
	Fall 2023	0.144	0.667	0.429	CMS
	Spring 2023	0.181	0.552	0.437	CMS
CLABSI	Spring 2025	0.596	0.099	0.651	CMS
	Fall 2024	0.901	-0.379	0.687	CMS
	Spring 2024	0.714	0.026	0.730	CMS
	Fall 2023	0.621	0.378	0.888	CMS
	Spring 2023	1.200	-0.141	1.077	CMS
CAUTI	Spring 2025	0.758	-0.441	0.540	CMS
	Fall 2024	0.867	-0.575	0.577	CMS
	Spring 2024	0.275	0.663	0.627	CMS
	Fall 2023	0.752	-0.028	0.735	CMS
	Spring 2023	0.845	0.024	0.862	CMS

*This hospital does not have this measure available or included for this round of the Hospital Safety Grade.

#This hospital did not receive a Hospital Safety Grade for this round.

Spring 2025, Fall 2024, Spring 2024, Fall 2023, Spring 2023

Outcome Measures

	Score Release Date	Your Hospital's Measure Score	Z-Score	National Mean for the Measure	Data Source(s)
SSI: Colon	Spring 2025	0.511	0.465	0.831	CMS
	Fall 2024	1.075	-0.308	0.852	CMS
	Spring 2024	1.204	-0.527	0.845	CMS
	Fall 2023	0.000	1.265	0.832	CMS
	Spring 2023	0.000	1.216	0.822	CMS
MRSA	Spring 2025	0.278	0.746	0.719	CMS
	Fall 2024	0.315	0.733	0.746	CMS
	Spring 2024	1.085	-0.481	0.793	CMS
	Fall 2023	0.980	-0.073	0.927	CMS
	Spring 2023	1.164	-0.085	1.095	CMS
C. diff	Spring 2025	0.395	0.017	0.401	CMS
	Fall 2024	0.485	-0.203	0.418	CMS
	Spring 2024	0.502	-0.135	0.455	CMS
	Fall 2023	0.477	0.029	0.488	CMS
	Spring 2023	0.549	-0.161	0.489	CMS
PSI 4: Death rate among surgical inpatients with serious treatable conditions	Spring 2025	165.31	0.505	177.45	CMS
	Fall 2024	141.03	1.250	168.34	CMS
	Spring 2024	141.03	1.248	168.38	CMS
	Fall 2023	127.88	0.881	143.25	CMS
	Spring 2023	127.88	0.879	143.23	CMS
CMS Medicare PSI-90: Patient safety and adverse events composite**	Spring 2025	1.34	-1.725	1.00	CMS
	Fall 2024	1.33	-1.714	1.01	CMS
	Spring 2024	1.33	-1.721	1.01	CMS
	Fall 2023	1.17	-1.111	0.98	CMS
	Spring 2023	1.17	-1.118	0.98	CMS

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#This hospital did not receive a Hospital Safety Grade for this round.

Spring 2025, Fall 2024, Spring 2024, Fall 2023, Spring 2023

Component PSIs (scores not used to calculate the Hospital Safety Grade)**

	Score Release Date	Your Hospital's Measure Score	Z-Score	National Mean for the Measure	Data Source(s)
PSI 3: Pressure ulcer rate	Spring 2025	1.96			CMS
	Fall 2024	1.70			CMS
	Spring 2024	1.70			CMS
	Fall 2023	0.98			CMS
	Spring 2023	0.98			CMS
PSI 6: Iatrogenic pneumothorax rate	Spring 2025	0.26			CMS
	Fall 2024	0.24			CMS
	Spring 2024	0.24			CMS
	Fall 2023	0.16			CMS
	Spring 2023	0.16			CMS
PSI 8: In-hospital fall with hip fracture rate	Spring 2025	0.33			CMS
	Fall 2024	0.08			CMS
	Spring 2024	0.08			CMS
	Fall 2023	0.04			CMS
	Spring 2023	0.04			CMS
PSI 9: Perioperative hemorrhage and hematoma rate	Spring 2025	1.97			CMS
	Fall 2024	3.19			CMS
	Spring 2024	3.19			CMS
	Fall 2023	3.20			CMS
	Spring 2023	3.20			CMS
PSI 10: Postoperative acute kidney injury rate	Spring 2025	1.60			CMS
	Fall 2024	Not Available			*
	Spring 2024	Not Available			*
	Fall 2023	Not Available			*
	Spring 2023	Not Available			*

**CMS calculates PSI 90 using the ten (10) component PSIs listed on pages 7-8. While scores for each of the 10 component PSIs are NOT used to calculate Hospital Safety Grades, they are publicly reported on the Hospital Safety Grade website (<https://www.hospitalsafetygrade.org>)

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#This hospital did not receive a Hospital Safety Grade for this round.

Spring 2025, Fall 2024, Spring 2024, Fall 2023, Spring 2023

Component PSIs (scores not used to calculate the Hospital Safety Grade)**

	Score Release Date	Your Hospital's Measure Score	Z-Score	National Mean for the Measure	Data Source(s)
PSI 11: Postoperative respiratory failure rate	Spring 2025	10.91			CMS
	Fall 2024	Not Available			*
	Spring 2024	Not Available			*
	Fall 2023	Not Available			*
	Spring 2023	Not Available			*
PSI 12: Perioperative pulmonary embolism or deep vein thrombosis rate	Spring 2025	3.87			CMS
	Fall 2024	4.06			CMS
	Spring 2024	4.06			CMS
	Fall 2023	4.56			CMS
	Spring 2023	4.56			CMS
PSI 13: Postoperative sepsis rate	Spring 2025	5.35			CMS
	Fall 2024	Not Available			*
	Spring 2024	Not Available			*
	Fall 2023	Not Available			*
	Spring 2023	Not Available			*
PSI 14: Postoperative wound dehiscence rate	Spring 2025	1.74			CMS
	Fall 2024	1.85			CMS
	Spring 2024	1.85			CMS
	Fall 2023	0.74			CMS
	Spring 2023	0.74			CMS
PSI 15: Unrecognized abdominopelvic accidental puncture/laceration rate	Spring 2025	0.90			CMS
	Fall 2024	0.79			CMS
	Spring 2024	0.79			CMS
	Fall 2023	0.80			CMS
	Spring 2023	0.80			CMS

**CMS calculates PSI 90 using the ten (10) component PSIs listed on pages 7-8. While scores for each of the 10 component PSIs are NOT used to calculate Hospital Safety Grades, they are publicly reported on the Hospital Safety Grade website (<https://www.hospitalsafetygrade.org>)

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Hospital Safety Grade Report for Hospitals

Spring 2025, Fall 2024, Spring 2024, Fall 2023, Spring 2023

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Spring 2025, Fall 2024, Spring 2024, Fall 2023, Spring 2023

What is the Hospital Safety Grade?

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

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

West Boca Medical Center		LF-MPN:	10-0268
21644 State Road 7			
Boca Raton	FL	33428-1899	

Your Hospital Safety Grade	Spring 2025	F D D C C
	Fall 2024	
	Spring 2024	
	Fall 2023	
	Spring 2023	

Spring 2025, Fall 2024, Spring 2024, Fall 2023, Spring 2023

Process and Structural Measures

	Score Release Date	Your Hospital's Measure Score	Z-Score	National Mean for the Measure	Data Source(s)
Computerized Physician Order Entry (CPOE)	Spring 2025	15	-1.910	80.23	Imputation Model Applied
	Fall 2024	15	-1.850	74.04	Imputation Model Applied
	Spring 2024	100	0.571	91.81	Imputation Model Applied
	Fall 2023	100	0.609	90.58	Imputation Model Applied
	Spring 2023	100	0.540	91.77	Imputation Model Applied
Barcode Medication Administration (BCMA)	Spring 2025	25	-1.867	81.87	Imputation Model Applied
	Fall 2024	25	-1.789	80.51	Imputation Model Applied
	Spring 2024	75	-1.759	93.42	Imputation Model Applied
	Fall 2023	75	-1.592	92.67	Imputation Model Applied
	Spring 2023	75	-1.301	91.22	Imputation Model Applied
ICU Physician Staffing (IPS)	Spring 2025	5	-1.375	65.15	Imputation Model Applied
	Fall 2024	5	-1.352	64.45	Imputation Model Applied
	Spring 2024	5	-1.323	63.29	Imputation Model Applied
	Fall 2023	5	-1.294	62.31	Imputation Model Applied
	Spring 2023	5	-1.480	67.47	Imputation Model Applied

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#This hospital did not receive a Hospital Safety Grade for this round.

Spring 2025, Fall 2024, Spring 2024, Fall 2023, Spring 2023

Process and Structural Measures

	Score Release Date	Your Hospital's Measure Score	Z-Score	National Mean for the Measure	Data Source(s)
Safe Practice 1: Culture of Leadership Structures and Systems	Spring 2025	Declined to Report	*	117.49	*
	Fall 2024	Declined to Report	*	117.40	*
	Spring 2024	Declined to Report	*	117.59	*
	Fall 2023	Declined to Report	*	117.49	*
	Spring 2023	Declined to Report	*	116.86	*
Safe Practice 2: Culture Measurement, Feedback and Intervention	Spring 2025	Declined to Report	*	116.35	*
	Fall 2024	Declined to Report	*	116.60	*
	Spring 2024	Declined to Report	*	117.08	*
	Fall 2023	Declined to Report	*	116.99	*
	Spring 2023	Declined to Report	*	115.87	*
Safe Practice 9: Nursing Workforce	Spring 2025	Not Included	*	*	*
	Fall 2024	Not Included	*	*	*
	Spring 2024	Not Included	*	*	*
	Fall 2023	Not Included	*	*	*
	Spring 2023	Declined to Report	*	97.86	*
Total Nursing Care Hours per Patient Day	Spring 2025	Declined to Report	*	77.07	*
	Fall 2024	Declined to Report	*	76.10	*
	Spring 2024	Declined to Report	*	74.69	*
	Fall 2023	Declined to Report	*	71.00	*
	Spring 2023	Not Included	*	*	*
Hand Hygiene	Spring 2025	15	-1.643	74.40	Imputation Model Applied
	Fall 2024	15	-1.569	72.43	Imputation Model Applied
	Spring 2024	100	0.818	78.65	Imputation Model Applied
	Fall 2023	100	0.851	77.32	Imputation Model Applied
	Spring 2023	100	1.021	71.64	Imputation Model Applied

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Spring 2025, Fall 2024, Spring 2024, Fall 2023, Spring 2023

Process and Structural Measures

	Score Release Date	Your Hospital's Measure Score	Z-Score	National Mean for the Measure	Data Source(s)
H-COMP-1: Nurse Communication	Spring 2025	82	-3.260	90.19	CMS
	Fall 2024	81	-3.535	90.04	CMS
	Spring 2024	80	-3.728	89.67	CMS
	Fall 2023	84	-2.156	89.55	CMS
	Spring 2023	85	-1.912	89.81	CMS
H-COMP-2: Doctor Communication	Spring 2025	85	-1.979	89.91	CMS
	Fall 2024	84	-2.334	89.80	CMS
	Spring 2024	83	-2.599	89.52	CMS
	Fall 2023	84	-2.152	89.45	CMS
	Spring 2023	85	-1.920	89.70	CMS
H-COMP-3: Staff Responsiveness	Spring 2025	66	-3.586	81.63	CMS
	Fall 2024	65	-3.734	81.48	CMS
	Spring 2024	64	-3.842	81.14	CMS
	Fall 2023	66	-3.432	80.97	CMS
	Spring 2023	70	-2.704	81.30	CMS
H-COMP-5: Communication about Medicines	Spring 2025	64	-2.526	74.42	CMS
	Fall 2024	63	-2.724	74.33	CMS
	Spring 2024	62	-2.912	74.09	CMS
	Fall 2023	66	-1.984	73.85	CMS
	Spring 2023	67	-1.842	74.21	CMS
H-COMP-6: Discharge Information	Spring 2025	78	-1.957	85.25	CMS
	Fall 2024	75	-2.685	85.14	CMS
	Spring 2024	75	-2.617	84.90	CMS
	Fall 2023	76	-2.314	84.80	CMS
	Spring 2023	76	-2.404	85.07	CMS

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#This hospital did not receive a Hospital Safety Grade for this round.

Spring 2025, Fall 2024, Spring 2024, Fall 2023, Spring 2023

Outcome Measures

	Score Release Date	Your Hospital's Measure Score	Z-Score	National Mean for the Measure	Data Source(s)
Foreign Object Retained After Surgery	Spring 2025	0.000	0.275	0.014	CMS
	Fall 2024	0.000	0.274	0.014	CMS
	Spring 2024	0.000	0.280	0.014	CMS
	Fall 2023	0.000	0.278	0.014	CMS
	Spring 2023	0.000	0.269	0.015	CMS
Air Embolism	Spring 2025	0.000	0.035	0.002	CMS
	Fall 2024	0.000	0.035	0.002	CMS
	Spring 2024	0.000	0.073	0.001	CMS
	Fall 2023	0.000	0.073	0.001	CMS
	Spring 2023	0.000	0.062	0.001	CMS
Falls and Trauma	Spring 2025	0.652	-0.665	0.384	CMS
	Fall 2024	0.652	-0.662	0.385	CMS
	Spring 2024	0.321	0.251	0.428	CMS
	Fall 2023	0.321	0.253	0.429	CMS
	Spring 2023	0.000	0.943	0.437	CMS
CLABSI	Spring 2025	1.144	-0.893	0.651	CMS
	Fall 2024	1.027	-0.602	0.687	CMS
	Spring 2024	0.763	-0.056	0.730	CMS
	Fall 2023	0.355	0.755	0.888	CMS
	Spring 2023	1.030	0.053	1.077	CMS
CAUTI	Spring 2025	0.622	-0.166	0.540	CMS
	Fall 2024	0.624	-0.094	0.577	CMS
	Spring 2024	1.110	-0.910	0.627	CMS
	Fall 2023	1.442	-1.146	0.735	CMS
	Spring 2023	1.530	-0.924	0.862	CMS

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Spring 2025, Fall 2024, Spring 2024, Fall 2023, Spring 2023

Outcome Measures

	Score Release Date	Your Hospital's Measure Score	Z-Score	National Mean for the Measure	Data Source(s)
SSI: Colon	Spring 2025	2.922	-3.036	0.831	CMS
	Fall 2024	0.735	0.162	0.852	CMS
	Spring 2024	0.000	1.243	0.845	CMS
	Fall 2023	Not Available	*	0.832	*
	Spring 2023	Not Available	*	0.822	*
MRSA	Spring 2025	1.318	-1.013	0.719	CMS
	Fall 2024	0.630	0.197	0.746	CMS
	Spring 2024	0.558	0.386	0.793	CMS
	Fall 2023	0.000	1.272	0.927	CMS
	Spring 2023	1.212	-0.145	1.095	CMS
C. diff	Spring 2025	0.198	0.621	0.401	CMS
	Fall 2024	0.100	0.962	0.418	CMS
	Spring 2024	0.238	0.616	0.455	CMS
	Fall 2023	0.360	0.348	0.488	CMS
	Spring 2023	0.337	0.407	0.489	CMS
PSI 4: Death rate among surgical inpatients with serious treatable conditions	Spring 2025	Not Available	*	177.45	*
	Fall 2024	Not Available	*	168.34	*
	Spring 2024	Not Available	*	168.38	*
	Fall 2023	Not Available	*	143.25	*
	Spring 2023	Not Available	*	143.23	*
CMS Medicare PSI-90: Patient safety and adverse events composite**	Spring 2025	0.92	0.420	1.00	CMS
	Fall 2024	0.93	0.414	1.01	CMS
	Spring 2024	0.93	0.414	1.01	CMS
	Fall 2023	0.97	0.056	0.98	CMS
	Spring 2023	0.97	0.054	0.98	CMS

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Spring 2025, Fall 2024, Spring 2024, Fall 2023, Spring 2023

Component PSIs (scores not used to calculate the Hospital Safety Grade)**

	Score Release Date	Your Hospital's Measure Score	Z-Score	National Mean for the Measure	Data Source(s)
PSI 3: Pressure ulcer rate	Spring 2025	0.32			CMS
	Fall 2024	0.29			CMS
	Spring 2024	0.29			CMS
	Fall 2023	0.12			CMS
	Spring 2023	0.12			CMS
PSI 6: Iatrogenic pneumothorax rate	Spring 2025	0.23			CMS
	Fall 2024	0.23			CMS
	Spring 2024	0.23			CMS
	Fall 2023	0.17			CMS
	Spring 2023	0.17			CMS
PSI 8: In-hospital fall with hip fracture rate	Spring 2025	0.34			CMS
	Fall 2024	0.10			CMS
	Spring 2024	0.10			CMS
	Fall 2023	0.06			CMS
	Spring 2023	0.06			CMS
PSI 9: Perioperative hemorrhage and hematoma rate	Spring 2025	2.24			CMS
	Fall 2024	2.29			CMS
	Spring 2024	2.29			CMS
	Fall 2023	2.22			CMS
	Spring 2023	2.22			CMS
PSI 10: Postoperative acute kidney injury rate	Spring 2025	Not Available			*
	Fall 2024	Not Available			*
	Spring 2024	Not Available			*
	Fall 2023	Not Available			*
	Spring 2023	Not Available			*

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Spring 2025, Fall 2024, Spring 2024, Fall 2023, Spring 2023

Component PSIs (scores not used to calculate the Hospital Safety Grade)**

	Score Release Date	Your Hospital's Measure Score	Z-Score	National Mean for the Measure	Data Source(s)
PSI 11: Postoperative respiratory failure rate	Spring 2025	Not Available			*
	Fall 2024	Not Available			*
	Spring 2024	Not Available			*
	Fall 2023	Not Available			*
	Spring 2023	Not Available			*
PSI 12: Perioperative pulmonary embolism or deep vein thrombosis rate	Spring 2025	4.02			CMS
	Fall 2024	4.03			CMS
	Spring 2024	4.03			CMS
	Fall 2023	4.01			CMS
	Spring 2023	4.01			CMS
PSI 13: Postoperative sepsis rate	Spring 2025	Not Available			*
	Fall 2024	Not Available			*
	Spring 2024	Not Available			*
	Fall 2023	Not Available			*
	Spring 2023	Not Available			*
PSI 14: Postoperative wound dehiscence rate	Spring 2025	1.82			CMS
	Fall 2024	1.96			CMS
	Spring 2024	1.96			CMS
	Fall 2023	0.78			CMS
	Spring 2023	0.78			CMS
PSI 15: Unrecognized abdominopelvic accidental puncture/laceration rate	Spring 2025	0.81			CMS
	Fall 2024	0.99			CMS
	Spring 2024	0.99			CMS
	Fall 2023	0.95			CMS
	Spring 2023	0.95			CMS

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Hospital Safety Grade Report for Hospitals

Spring 2025, Fall 2024, Spring 2024, Fall 2023, Spring 2023

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St. Mary's Medical Center	LF-MPN:	10-0288
901 45th Street		
West Palm Beach	FL	33407-2495

Your Hospital Safety Grade	Spring 2025	D
	Fall 2024	D
	Spring 2024	C
	Fall 2023	C
	Spring 2023	C

Spring 2025, Fall 2024, Spring 2024, Fall 2023, Spring 2023

Process and Structural Measures

	Score Release Date	Your Hospital's Measure Score	Z-Score	National Mean for the Measure	Data Source(s)
Computerized Physician Order Entry (CPOE)	Spring 2025	15	-1.910	80.23	Imputation Model Applied
	Fall 2024	15	-1.850	74.04	Imputation Model Applied
	Spring 2024	100	0.571	91.81	Imputation Model Applied
	Fall 2023	100	0.609	90.58	Imputation Model Applied
	Spring 2023	100	0.540	91.77	Imputation Model Applied
Barcode Medication Administration (BCMA)	Spring 2025	25	-1.867	81.87	Imputation Model Applied
	Fall 2024	25	-1.789	80.51	Imputation Model Applied
	Spring 2024	100	0.628	93.42	Imputation Model Applied
	Fall 2023	100	0.660	92.67	Imputation Model Applied
	Spring 2023	100	0.704	91.22	Imputation Model Applied
ICU Physician Staffing (IPS)	Spring 2025	5	-1.375	65.15	Imputation Model Applied
	Fall 2024	5	-1.352	64.45	Imputation Model Applied
	Spring 2024	100	0.833	63.29	Imputation Model Applied
	Fall 2023	100	0.851	62.31	Imputation Model Applied
	Spring 2023	100	0.771	67.47	Imputation Model Applied

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Spring 2025, Fall 2024, Spring 2024, Fall 2023, Spring 2023

Process and Structural Measures

	Score Release Date	Your Hospital's Measure Score	Z-Score	National Mean for the Measure	Data Source(s)
Safe Practice 1: Culture of Leadership Structures and Systems	Spring 2025	Declined to Report	*	117.49	*
	Fall 2024	Declined to Report	*	117.40	*
	Spring 2024	Declined to Report	*	117.59	*
	Fall 2023	Declined to Report	*	117.49	*
	Spring 2023	Declined to Report	*	116.86	*
Safe Practice 2: Culture Measurement, Feedback and Intervention	Spring 2025	Declined to Report	*	116.35	*
	Fall 2024	Declined to Report	*	116.60	*
	Spring 2024	Declined to Report	*	117.08	*
	Fall 2023	Declined to Report	*	116.99	*
	Spring 2023	Declined to Report	*	115.87	*
Safe Practice 9: Nursing Workforce	Spring 2025	Not Included	*	*	*
	Fall 2024	Not Included	*	*	*
	Spring 2024	Not Included	*	*	*
	Fall 2023	Not Included	*	*	*
	Spring 2023	Declined to Report	*	97.86	*
Total Nursing Care Hours per Patient Day	Spring 2025	Declined to Report	*	77.07	*
	Fall 2024	Declined to Report	*	76.10	*
	Spring 2024	Declined to Report	*	74.69	*
	Fall 2023	Declined to Report	*	71.00	*
	Spring 2023	Not Included	*	*	*
Hand Hygiene	Spring 2025	15	-1.643	74.40	Imputation Model Applied
	Fall 2024	15	-1.569	72.43	Imputation Model Applied
	Spring 2024	100	0.818	78.65	Imputation Model Applied
	Fall 2023	100	0.851	77.32	Imputation Model Applied
	Spring 2023	100	1.021	71.64	Imputation Model Applied

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Spring 2025, Fall 2024, Spring 2024, Fall 2023, Spring 2023

Process and Structural Measures

	Score Release Date	Your Hospital's Measure Score	Z-Score	National Mean for the Measure	Data Source(s)
H-COMP-1: Nurse Communication	Spring 2025	86	-1.668	90.19	CMS
	Fall 2024	85	-1.971	90.04	CMS
	Spring 2024	83	-2.571	89.67	CMS
	Fall 2023	83	-2.545	89.55	CMS
	Spring 2023	85	-1.912	89.81	CMS
H-COMP-2: Doctor Communication	Spring 2025	86	-1.576	89.91	CMS
	Fall 2024	86	-1.529	89.80	CMS
	Spring 2024	84	-2.200	89.52	CMS
	Fall 2023	83	-2.547	89.45	CMS
	Spring 2023	85	-1.920	89.70	CMS
H-COMP-3: Staff Responsiveness	Spring 2025	75	-1.521	81.63	CMS
	Fall 2024	75	-1.468	81.48	CMS
	Spring 2024	73	-1.825	81.14	CMS
	Fall 2023	74	-1.597	80.97	CMS
	Spring 2023	76	-1.268	81.30	CMS
H-COMP-5: Communication about Medicines	Spring 2025	69	-1.314	74.42	CMS
	Fall 2024	67	-1.763	74.33	CMS
	Spring 2024	66	-1.949	74.09	CMS
	Fall 2023	64	-2.490	73.85	CMS
	Spring 2023	67	-1.842	74.21	CMS
H-COMP-6: Discharge Information	Spring 2025	80	-1.418	85.25	CMS
	Fall 2024	78	-1.891	85.14	CMS
	Spring 2024	77	-2.088	84.90	CMS
	Fall 2023	77	-2.051	84.80	CMS
	Spring 2023	80	-1.345	85.07	CMS

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Spring 2025, Fall 2024, Spring 2024, Fall 2023, Spring 2023

Outcome Measures

	Score Release Date	Your Hospital's Measure Score	Z-Score	National Mean for the Measure	Data Source(s)
Foreign Object Retained After Surgery	Spring 2025	0.000	0.275	0.014	CMS
	Fall 2024	0.000	0.274	0.014	CMS
	Spring 2024	0.000	0.280	0.014	CMS
	Fall 2023	0.000	0.278	0.014	CMS
	Spring 2023	0.000	0.269	0.015	CMS
Air Embolism	Spring 2025	0.000	0.035	0.002	CMS
	Fall 2024	0.000	0.035	0.002	CMS
	Spring 2024	0.000	0.073	0.001	CMS
	Fall 2023	0.000	0.073	0.001	CMS
	Spring 2023	0.000	0.062	0.001	CMS
Falls and Trauma	Spring 2025	0.665	-0.697	0.384	CMS
	Fall 2024	0.665	-0.694	0.385	CMS
	Spring 2024	0.940	-1.202	0.428	CMS
	Fall 2023	0.940	-1.194	0.429	CMS
	Spring 2023	0.783	-0.747	0.437	CMS
CLABSI	Spring 2025	0.229	0.764	0.651	CMS
	Fall 2024	0.426	0.461	0.687	CMS
	Spring 2024	0.874	-0.244	0.730	CMS
	Fall 2023	0.842	0.065	0.888	CMS
	Spring 2023	0.514	0.642	1.077	CMS
CAUTI	Spring 2025	1.217	-1.371	0.540	CMS
	Fall 2024	1.227	-1.287	0.577	CMS
	Spring 2024	0.657	-0.057	0.627	CMS
	Fall 2023	0.381	0.573	0.735	CMS
	Spring 2023	0.616	0.341	0.862	CMS

*This hospital does not have this measure available or included for this round of the Hospital Safety Grade.

#This hospital did not receive a Hospital Safety Grade for this round.

Spring 2025, Fall 2024, Spring 2024, Fall 2023, Spring 2023

Outcome Measures

	Score Release Date	Your Hospital's Measure Score	Z-Score	National Mean for the Measure	Data Source(s)
SSI: Colon	Spring 2025	0.354	0.693	0.831	CMS
	Fall 2024	0.597	0.354	0.852	CMS
	Spring 2024	0.382	0.681	0.845	CMS
	Fall 2023	1.626	-1.206	0.832	CMS
	Spring 2023	3.052	-3.299	0.822	CMS
MRSA	Spring 2025	0.829	-0.186	0.719	CMS
	Fall 2024	0.357	0.661	0.746	CMS
	Spring 2024	0.563	0.378	0.793	CMS
	Fall 2023	0.509	0.573	0.927	CMS
	Spring 2023	0.396	0.868	1.095	CMS
C. diff	Spring 2025	0.370	0.094	0.401	CMS
	Fall 2024	0.448	-0.091	0.418	CMS
	Spring 2024	0.666	-0.601	0.455	CMS
	Fall 2023	0.654	-0.453	0.488	CMS
	Spring 2023	0.433	0.150	0.489	CMS
PSI 4: Death rate among surgical inpatients with serious treatable conditions	Spring 2025	152.54	1.037	177.45	CMS
	Fall 2024	133.07	1.614	168.34	CMS
	Spring 2024	133.07	1.611	168.38	CMS
	Fall 2023	112.35	1.771	143.25	CMS
	Spring 2023	112.35	1.768	143.23	CMS
CMS Medicare PSI-90: Patient safety and adverse events composite**	Spring 2025	0.91	0.471	1.00	CMS
	Fall 2024	0.92	0.467	1.01	CMS
	Spring 2024	0.92	0.468	1.01	CMS
	Fall 2023	0.99	-0.060	0.98	CMS
	Spring 2023	0.99	-0.063	0.98	CMS

*This hospital does not have this measure available or included for this round of the Hospital Safety Grade.

#This hospital did not receive a Hospital Safety Grade for this round.

Spring 2025, Fall 2024, Spring 2024, Fall 2023, Spring 2023

Component PSIs (scores not used to calculate the Hospital Safety Grade)**

	Score Release Date	Your Hospital's Measure Score	Z-Score	National Mean for the Measure	Data Source(s)
PSI 3: Pressure ulcer rate	Spring 2025	0.20			CMS
	Fall 2024	0.43			CMS
	Spring 2024	0.43			CMS
	Fall 2023	0.73			CMS
	Spring 2023	0.73			CMS
PSI 6: Iatrogenic pneumothorax rate	Spring 2025	0.22			CMS
	Fall 2024	0.22			CMS
	Spring 2024	0.22			CMS
	Fall 2023	0.17			CMS
	Spring 2023	0.17			CMS
PSI 8: In-hospital fall with hip fracture rate	Spring 2025	0.26			CMS
	Fall 2024	0.09			CMS
	Spring 2024	0.09			CMS
	Fall 2023	0.06			CMS
	Spring 2023	0.06			CMS
PSI 9: Perioperative hemorrhage and hematoma rate	Spring 2025	2.44			CMS
	Fall 2024	2.68			CMS
	Spring 2024	2.68			CMS
	Fall 2023	2.37			CMS
	Spring 2023	2.37			CMS
PSI 10: Postoperative acute kidney injury rate	Spring 2025	1.69			CMS
	Fall 2024	1.57			CMS
	Spring 2024	1.57			CMS
	Fall 2023	0.91			CMS
	Spring 2023	0.91			CMS

**CMS calculates PSI 90 using the ten (10) component PSIs listed on pages 7-8. While scores for each of the 10 component PSIs are NOT used to calculate Hospital Safety Grades, they are publicly reported on the Hospital Safety Grade website (<https://www.hospitalsafetygrade.org>)

*This hospital does not have this measure available or included for this round of the Hospital Safety Grade.

#This hospital did not receive a Hospital Safety Grade for this round.

Spring 2025, Fall 2024, Spring 2024, Fall 2023, Spring 2023

Component PSIs (scores not used to calculate the Hospital Safety Grade)**

	Score Release Date	Your Hospital's Measure Score	Z-Score	National Mean for the Measure	Data Source(s)
PSI 11: Postoperative respiratory failure rate	Spring 2025	12.36			CMS
	Fall 2024	8.47			CMS
	Spring 2024	8.47			CMS
	Fall 2023	5.94			CMS
	Spring 2023	5.94			CMS
PSI 12: Perioperative pulmonary embolism or deep vein thrombosis rate	Spring 2025	3.66			CMS
	Fall 2024	2.39			CMS
	Spring 2024	2.39			CMS
	Fall 2023	2.53			CMS
	Spring 2023	2.53			CMS
PSI 13: Postoperative sepsis rate	Spring 2025	5.50			CMS
	Fall 2024	5.99			CMS
	Spring 2024	5.99			CMS
	Fall 2023	4.78			CMS
	Spring 2023	4.78			CMS
PSI 14: Postoperative wound dehiscence rate	Spring 2025	1.79			CMS
	Fall 2024	2.44			CMS
	Spring 2024	2.44			CMS
	Fall 2023	1.08			CMS
	Spring 2023	1.08			CMS
PSI 15: Unrecognized abdominopelvic accidental puncture/laceration rate	Spring 2025	0.84			CMS
	Fall 2024	1.00			CMS
	Spring 2024	1.00			CMS
	Fall 2023	0.96			CMS
	Spring 2023	0.96			CMS

**CMS calculates PSI 90 using the ten (10) component PSIs listed on pages 7-8. While scores for each of the 10 component PSIs are NOT used to calculate Hospital Safety Grades, they are publicly reported on the Hospital Safety Grade website (<https://www.hospitalafetygrade.org>)

*This hospital does not have this measure available or included for this round of the Hospital Safety Grade.

#This hospital did not receive a Hospital Safety Grade for this round.

Hospital Safety Grade Report for Hospitals

Spring 2025, Fall 2024, Spring 2024, Fall 2023, Spring 2023

The information contained in this report may be used for internal analysis and evaluation only. The owner of this document may not redistribute or sell the Data, in whole or in part, to any third party or use the Data on behalf of or for the benefit of any third party without the express written consent of The Leapfrog Group.

*This hospital does not have this measure available or included for this round of the Hospital Safety Grade.

#This hospital did not receive a Hospital Safety Grade for this round.

EXHIBIT 28



About the Grade

Leapfrog Hospital Safety Grades (formerly known as Hospital Safety Scores) are assigned to nearly 3,000 general acute-care hospitals across the nation twice annually. The Safety Grade is the gold standard measure of patient safety, cited in [MSNBC](#), [The New York Times](#), and [AARP The Magazine](#).



The Leapfrog Hospital Safety Grade uses up to 30 national performance measures from the Centers for Medicare & Medicaid Services (CMS), the Leapfrog Hospital Survey and information from other supplemental data sources. Taken together, those performance measures produce a single letter grade representing a hospital's overall performance in keeping patients safe from preventable harm and medical errors. The Leapfrog Hospital Safety Grade methodology has

been peer reviewed and published in the Journal of Patient Safety.

Leapfrog works under the guidance of an Expert Panel to select appropriate measures and develop a scoring methodology. The Expert Panel is made up of patient safety experts from across the country:

- David Bates, M.D., M.Sc.,
Harvard University
- Kathy McDonald, PhD, Johns
Hopkins University School of
Nursing
- Matthew D McHugh, Ph.D.,
J.D., M.P.H., R.N., C.R.N.P.,
F.A.A.N., University of
Pennsylvania School of
Nursing
- Arnold Milstein, M.D., M.P.H.,
Stanford University
- Doris Peter, PhD, Consultant
- Peter Pronovost, M.D., Ph.D.,
F.C.C.M., University
Hospitals
- Patrick Romano, M.D.,
M.P.H., University of
California, Davis
- Sara Singer, Ph.D., Stanford
University
- Arjun Srinivasan, M.D., CAPT
U.S. Public Health Service,

Centers for Disease Control
and Prevention

- Tim Vogus, Ph.D., Vanderbilt University

How the Leapfrog Hospital Safety Grade is produced

The Expert Panel selected 22 evidence-based measures of patient safety, including CMS Medicare PSI 90 Patient Safety and Adverse Events composite (which includes 10 component measures of patient safety), analyzed the data, and determined the weight of each measure based on **evidence**, **opportunity for improvement** and **impact**. In some cases where a hospital's information is not available for a certain measure, Leapfrog uses a supplemental data source. In cases where a hospital's information is not available from any data source, Leapfrog has outlined a methodology for dealing with the missing data.

The Leapfrog Hospital Safety Grade places each measure into one of two domains: (1)

Quick Links

- [Scoring Methodology Used in the Spring 2025 Release of the Hospital Safety Grades](#) [May 2025]
- [Explanation of Safety Grades](#) [May 2025]

Process/Structural Measures or
(2) **Outcome Measures**, each
accounting for 50 percent of the
overall score.

- **Process Measures** represent how often a hospital gives patients recommended treatment for a given medical condition or procedure. For example, “Responsiveness of hospital staff” looks at patients’ feedback on how long it takes for a staff member to respond when they request help. **Structural Measures** represent the environment in which patients receive care. For example, “Doctors order medications through a computer” represents whether a hospital uses a special computerized system to prevent errors when prescribing medications.
- **Outcome Measures** represent what happens to a patient while receiving care. For example, “Dangerous object left in patient’s body” measures how many times a patient undergoing surgery had a dangerous foreign

object, like a sponge or tool,
left in his or her body.

A hospital must have enough safety data available for our experts to issue them a letter grade. Hospitals missing more than **six** process measures, more than **five** outcome measures, or **PSI90** are not graded. All hospitals are encouraged to voluntarily report additional safety data through the [Leapfrog Hospital Survey](#), but they are not required to do so to receive a Safety Grade.

The Leapfrog Group's goal is to publicly report patient safety and quality information for the benefit of consumers, purchasers, and referring physicians as they make decisions about where to seek care and where to direct patients. Identifying differences among facilities is critical to inform patients and their family's decision-making. That's why Leapfrog reports results by facility for all programs.

However, some hospitals belong to health systems that report data to the Centers for Medicare & Medicaid Services (CMS) as a single entity with a shared "CMS Certification Number (CCN)." This

means that individual hospitals within these systems will be graded using some of the same aggregate data. Leapfrog encourages these types of hospitals to report additional safety data through the [Leapfrog Hospital Survey](#) so that patients can see how each hospital is doing individually for select measures included in the grade.

At this time, we are unable to assign a grade to VA hospitals, critical access hospitals, specialty hospitals, children's hospitals, outpatient surgery centers, etc. Our experts are studying ways to rate them in the future.



The Leapfrog Hospital Safety Grade

The Leapfrog Hospital Safety Grade is a public service provided by The Leapfrog Group, an

independent nonprofit organization committed to driving quality, safety, and transparency in the U.S. health system.

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EXHIBIT 29

LEAPFROG
HOSPITAL
SAFETY GRADE

Scoring Methodology

SPRING 2024 SAFETY GRADE

HOSPITAL

SAFETY GRADE

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HOSPITAL

SAFETY GRADE

WHAT IS THE HOSPITAL SAFETY GRADE?

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

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

ELIGIBLE HOSPITALS

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

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

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

HOSPITAL

SAFETY GRADE

MEASURES

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

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

PROCESS/STRUCTURAL MEASURES (12)				
Measure Name	Primary Data Source	Reporting Period	Secondary Data Source	Reporting Period
Computerized Physician Order Entry (CPOE)	2023 Leapfrog Hospital Survey	2023	Imputation Model Applied*	N/A
Bar Code Medication Administration (BCMA)	2023 Leapfrog Hospital Survey	2023	Imputation Model Applied*	N/A
ICU Physician Staffing (IPS)	2023 Leapfrog Hospital Survey	2023	Imputation Model Applied*	N/A
Safe Practice 1: Culture of Leadership Structures and Systems	2023 Leapfrog Hospital Survey	2023	N/A	N/A
Safe Practice 2: Culture Measurement, Feedback & Intervention	2023 Leapfrog Hospital Survey	2023	N/A	N/A

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PROCESS/STRUCTURAL MEASURES (12)

Measure Name	Primary Data Source	Reporting Period	Secondary Data Source	Reporting Period
Total Nursing Care Hours per Patient Day	2023 Leapfrog Hospital Survey	2023	N/A	N/A
Hand Hygiene	2023 Leapfrog Hospital Survey	2023	Imputation Model Applied*	N/A
H-COMP-1: Nurse Communication	CMS	04/01/2022 - 03/31/2023	N/A	N/A
H-COMP-2: Doctor Communication	CMS	04/01/2022 - 03/31/2023	N/A	N/A
H-COMP-3: Staff Responsiveness	CMS	04/01/2022 - 03/31/2023	N/A	N/A
H-COMP-5: Communication about Medicines	CMS	04/01/2022 - 03/31/2023	N/A	N/A
H-COMP-6: Discharge Information	CMS	04/01/2022 - 03/31/2023	N/A	N/A

*See Leapfrog's Imputation Method for CPOE, BCMA, IPS and Hand Hygiene for more information on the imputation methodology used for hospitals that did not submit a Leapfrog Hospital Survey by the Data Snapshot Date (January 31, 2024).

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 SAFETY GRADE

OUTCOME MEASURES (10)

Measure Name	Primary Data Source	Reporting Period	Secondary Data Source	Reporting Period
Foreign Object Retained	CMS	07/01/2020 - 06/30/2022	N/A	N/A
Air Embolism	CMS	07/01/2020 - 06/30/2022	N/A	N/A
Falls and Trauma	CMS	07/01/2020 - 06/30/2022	N/A	N/A
CLABSI	2023 Leapfrog Hospital Survey	07/01/2022 - 06/30/2023	CMS	04/01/2022 - 03/31/2023
CAUTI	2023 Leapfrog Hospital Survey	07/01/2022 - 06/30/2023	CMS	04/01/2022 - 03/31/2023
SSI: Colon	2023 Leapfrog Hospital Survey	07/01/2022 - 06/30/2023	CMS	04/01/2022 - 03/31/2023
MRSA	2023 Leapfrog Hospital Survey	07/01/2022 - 06/30/2023	CMS	04/01/2022 - 03/31/2023
C. Diff.	2023 Leapfrog Hospital Survey	07/01/2022 - 06/30/2023	CMS	04/01/2022 - 03/31/2023
PSI 4: Death rate among surgical inpatients with serious treatable complications	CMS	07/01/2020 - 06/30/2022	N/A	N/A
CMS Medicare PSI 90: Patient safety and adverse events composite*	CMS	07/01/2020 - 06/30/2022	N/A	N/A

* CMS calculates PSI 90 using the ten (10) component PSIs. While scores for each of the 10 component PSIs are not used to calculate spring 2024 Hospital Safety Grades, they will be publicly reported on the Hospital Safety Grade [website](#).

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

Component PSI	Primary Data Source	Reporting Period	Secondary Data Source	Reporting Period
PSI 3: Pressure ulcer rate	CMS	07/01/2020 - 06/30/2022	N/A	N/A
PSI 6: Iatrogenic pneumothorax rate	CMS	07/01/2020 - 06/30/2022	N/A	N/A
PSI 8: In-hospital fall with hip fracture rate	CMS	07/01/2020 - 06/30/2022	N/A	N/A
PSI 9: Perioperative hemorrhage or hematoma rate	CMS	07/01/2020 - 06/30/2022	N/A	N/A
PSI 10: Postoperative acute kidney injury requiring dialysis rate	CMS	07/01/2020 - 06/30/2022	N/A	N/A
PSI 11: Postoperative respiratory failure rate	CMS	07/01/2020 - 06/30/2022	N/A	N/A
PSI 12: Perioperative pulmonary embolism or deep vein thrombosis rate	CMS	07/01/2020 - 06/30/2022	N/A	N/A
PSI 13: Postoperative sepsis rate	CMS	07/01/2020 - 06/30/2022	N/A	N/A
PSI 14: Postoperative wound dehiscence rate	CMS	07/01/2020 - 06/30/2022	N/A	N/A
PSI 15: Abdominopelvic accidental puncture or laceration rate	CMS	07/01/2020 - 06/30/2022	N/A	N/A

Note: CMS calculates PSI 90 using the ten (10) component PSIs listed above. While scores for each of the 10 component PSIs are not used to calculate spring 2024 Hospital Safety Grades, they will be publicly reported on the Hospital Safety Grade [website](#).

MEASURE & SCORING DESCRIPTIONS**PROCESS/STRUCTURAL MEASURES**

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

COMPUTERIZED PHYSICIAN ORDER ENTRY (CPOE)

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

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

For hospitals that did not submit a 2023 Leapfrog Hospital Survey by November 30, see [Using Secondary Data Sources](#) for more information on Leapfrog's imputation methodology.

BAR CODE MEDICATION ADMINISTRATION (BCMA)

The BCMA measure is collected by The Leapfrog Group on the Leapfrog Hospital Survey. It measures a hospital's progress toward 1) implementation of BCMA throughout the hospital, 2) compliance with patient and medication scans during administration, 3) use of decision support, and 4) structures to monitor and reduce workarounds. Through participation in the Leapfrog Hospital Survey, hospitals are placed in one of several performance categories: "Achieved the Standard," "Considerable Achievement," "Some Achievement," "Limited Achievement," or "Does Not Apply." For the purposes of calculating the Safety Grade, a numerical score is assigned to each performance category:

Leapfrog Performance Category	Measure Score
Achieved the Standard	100
Considerable Achievement	75
Some Achievement	50
Limited Achievement	25
Does Not Apply	Not Available (See Scoring Terms)

For hospitals that did not submit a 2023 Leapfrog Hospital Survey by November 30, see [Using Secondary Data Sources](#) for more information on Leapfrog's imputation methodology.

ICU PHYSICIAN STAFFING (IPS)

The IPS measure is collected by The Leapfrog Group on the Leapfrog Hospital Survey. It measures a hospital's use of intensivists in ICUs. Through participation in the Leapfrog Hospital Survey, hospitals are placed in one of several performance categories: "Achieved the Standard," "Considerable Achievement," "Some Achievement," "Limited Achievement," or "Does Not Apply." For the purposes of calculating the Safety Grade, a numerical score is assigned to each performance category:

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

For hospitals that did not submit a 2023 Leapfrog Hospital Survey by November 30, see [Using Secondary Data Sources](#) for detailed information on Leapfrog's imputation methodology.

NATIONAL QUALITY FORUM (NQF) SAFE PRACTICES

Two (2) NQF Safe Practice measures are collected by The Leapfrog Group on the Leapfrog Hospital Survey. They measure a hospital's progress toward implementing endorsed processes and protocols to reduce and prevent adverse events. Through participation in the Leapfrog Hospital Survey, hospitals can earn up to 120 points for each NQF Safe Practice. For the purposes of calculating the Safety Grade, individual scores for each NQF Safe Practice are used:

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

There is no secondary data source for the NQF Safe Practices. Therefore, hospitals that did not submit a 2023 Leapfrog Hospital Survey by November 30 will not have these measures included in their Safety Grade and the measure will be reported as "Declined to Report." See [Dealing with Missing Data](#) for more information.

TOTAL NURSING CARE HOURS PER PATIENT DAY

The Total Nursing Care Hours per Patient Day measure is collected by The Leapfrog Group on the Leapfrog Hospital Survey. It measures the hospital's total number of productive hours worked by employee or contract nursing staff (i.e., RNs, LPNs, and UAPs) with direct patient care responsibilities per patient day across three unit types: medical, surgical, and med/surg. Through participation in the Leapfrog Hospital Survey, hospitals are placed in one of several performance categories: "Achieved the Standard," "Considerable Achievement," "Some Achievement," "Limited Achievement," or "Does Not Apply." For the purposes of calculating the Safety Grade, a numerical score is assigned to each performance category:

Leapfrog Performance Category	Measure Score
Achieved the Standard	100
Considerable Achievement	70
Some Achievement	40
Limited Achievement	15
Does Not Apply	Not Available (See Scoring Terms)

There is no secondary data source for the Total Nursing Care Hours per Patient Day measure. Therefore, hospitals that did not submit a 2023 Leapfrog Hospital Survey by November 30 will not have these measures included in their Safety Grade and the measure will be reported as "Declined to Report." See [Dealing with Missing Data](#) for more information.

HAND HYGIENE

The Hand Hygiene measure is collected by The Leapfrog Group on the Leapfrog Hospital Survey. It measures processes and protocols that hospitals have in place regarding monitoring hand hygiene practices, fostering a culture of good hand hygiene, offering training and education, and providing equipment. Through participation in the Leapfrog Hospital Survey, hospitals are placed in one of several performance categories: "Achieved the Standard," "Considerable Achievement," "Some Achievement," "Limited Achievement." For the purposes of calculating the Safety Grade, a numerical score is assigned to each performance category:

Leapfrog Performance Category	Measure Score
Achieved the Standard	100
Considerable Achievement	70
Some Achievement	40
Limited Achievement	15

For hospitals that did not submit a 2023 Leapfrog Hospital Survey by November 30, see [Using Secondary Data Sources](#) for detailed information on Leapfrog's imputation methodology.

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

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

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



OUTCOME MEASURES

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

HOSPITAL-ACQUIRED CONDITIONS

Three hospital-acquired condition measures are calculated by CMS through the [DRA HAC Reporting Program](#): Foreign Object Retained after Surgery, Air Embolism, and Falls and Trauma. Hospital-acquired condition rates are calculated by CMS based on Part A Medicare Fee-for-service (FFS) claims and publicly reported as a rate per 1,000 Part A Medicare FFS discharges. No age restrictions are applied. For the purposes of calculating the Safety Grade, the rate is used. More information is available in the [DRA HAC methodology](#).

HEALTHCARE-ASSOCIATED INFECTIONS

Five healthcare-associated infection measures are collected by The Leapfrog Group on the Leapfrog Hospital Survey: Central line-associated bloodstream infections (CLABSI) in ICUs and select wards, Catheter-associated urinary tract infections (CAUTI) in ICUs and select wards, Surgical site infections from colon surgery (SSI: Colon), Facility-wide inpatient MRSA Blood Laboratory-identified Events, and Facility-wide inpatient C.diff. Laboratory-identified Events. Through participation in the Leapfrog Hospital Survey, hospitals were required to 1) join Leapfrog's NHSN group, 2) provide an accurate NHSN ID in the Profile section of the Online Survey Tool, and 3) submit a Survey by November 30. For the purposes of calculating the Safety Grade, the [standardized infection ratio \(SIR\)](#) is used:

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

For hospitals that did not join Leapfrog's NHSN group, provide an accurate NHSN ID, or submit a 2023 Leapfrog Hospital Survey by November 30, see [Using Secondary Data Sources](#) for more information on Leapfrog's use of CMS data.

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AHRQ PATIENT SAFETY INDICATORS (PSI)

Two AHRQ Patient Safety Indicators are calculated by CMS through the Inpatient Quality Reporting Program and the [HAC Reduction Program](#): PSI 4 Death Rate among Surgical Inpatients with Serious Treatable Conditions and PSI 90 Patient Safety and Adverse Events Composite. PSI rates are calculated by CMS based on Medicare Fee-for-Service claims and publicly reported as a rate per 1,000 inpatient discharges. CMS only includes claims from patients 18 years or older. For the purpose of calculating the Safety Grade, the smoothed rate is used for both measures. More information on calculating PSIs is available on the [Patient Safety Indicators \(PSI\) 2024 Resources website](#).

Note: CMS calculates PSI 90 using the ten (10) component PSIs that are listed in the PSI 90 Components table [above](#). While scores for each of the 10 component PSIs are NOT used to calculate spring 2024 Hospital Safety Grades, they will be publicly reported on the Hospital Safety Grade [website](#). Additional information about the PSI 90 measure and how it is calculated by CMS can be found [here](#).

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USING SECONDARY DATA SOURCES

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

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

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

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

If the hospital had a score assigned by Leapfrog in the previous four rounds of grades (i.e., fall 2023, spring 2023, fall 2022, spring 2022), excluding imputed scores, the hospital is assigned the most recent score on that measure in the current Hospital Safety Grade (i.e., spring 2024).

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

The hospital is assigned to a cohort of other similar hospitals using three or four hospital characteristics obtained from the most recent CMS Impact File and the 2023 Leapfrog Hospital Survey: urban/rural status, safety net status, number of beds, and teaching status (urban cohorts only). The CMS Impact File is the data source for urban/rural status, safety net status, and number of beds. The [2023 Leapfrog Hospital Survey Results](#) are the primary data source for teaching status and the CMS impact file is the secondary data source.

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

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- **Mean of current and recent scores:** The mean score of the cohort is calculated based on the hospital scores in the current round (i.e., spring 2024) from either Leapfrog's publicly reported Survey Results or Step 1 of the imputation model.
- **Mean of scores obtained in each hospital's first year of reporting on Leapfrog's CPOE, BCMA, or Hand Hygiene standards via the Leapfrog Hospital Survey:** The mean score of the cohort is calculated based on the score (i.e., performance category from the Leapfrog Hospital Survey) each hospital in the cohort obtained the first year they reported on Leapfrog's CPOE, BCMA, or Hand Hygiene standards, starting with the 2018 Leapfrog Hospital Survey (the year the CPOE and BCMA standards were last significantly updated) or the 2020 Leapfrog Hospital Survey (the year the Hand Hygiene standard was first scored). CPOE Scores from the 2020 Leapfrog Hospital Survey are excluded as the CPOE Evaluation Tool was not included on the Leapfrog Hospital Survey due to COVID-19.

To determine a hospital's cohort and mean score:

1. Download the latest IMPACT Zip file [here](#).
 - a. Open the Microsoft Excel Worksheet in that Zip file named "FY 2024 IPPS Final Rule Impact File"
 - b. Select the "FY 2024 Final" tab
 - c. Filter for the hospital's CMS Certification Number (CCN) under the "Provider Number" column
 - d. Refer to criteria in Table 1: Cohort Criteria
2. View 2023 Leapfrog Hospital Survey Results [here](#).
 - a. Search for the hospital by name or location
 - b. If the hospital submitted a 2023 Leapfrog Hospital Survey, select "More Information" at the bottom of the webpage to view teaching status
 - c. Refer to the criteria in Table 1: Cohort Criteria
3. Find the cohort's scores for CPOE, BCMA, and Hand Hygiene in Table 2: Cohort Scores

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Table 1: Cohort Criteria

Characteristic	2023 Leapfrog Hospital Survey Results	Column in CMS Impact File	Criteria
Urban/rural status	N/A	URGEO (Column I)	CMS Impact File: Urban: LURBAN or OURBAN Rural: RURAL
Safety net status	N/A	DSHPCT (Column Y)	CMS Impact File: Safety net: DSHPCT is greater than or equal to 0.3993* * 0.3993 is the 80 th percentile of the IMPACT file
Number of Beds	N/A	Beds (Column U)	CMS Impact File Fewer than 100 beds 100 or more beds
Teaching status	Teaching Status	Resident to Bed Ratio (Column S)	2023 Leapfrog Hospital Survey Results (primary source): Non-teaching Teaching CMS Impact File (secondary source): Non-teaching: Resident to bed Ratio equals 0 Teaching: Resident to bed ratio is greater than 0

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Table 2: Cohort Scores

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

STEP 2: USE THE CMS COST REPORT (APPLIES TO IPS ONLY)

A hospital's ICU designation (i.e., operating a medical ICU, surgical ICU, or pediatric ICU) is based on the number of medical, surgical and/or pediatric ICU beds reported in Worksheet S-3 Part 1 of the hospital's most recent CMS Cost Report. Hospitals that reported one or more medical, surgical, and/or pediatric ICU beds are assigned 5 points, which is equivalent to those hospitals that earned Limited Achievement on Leapfrog's IPS Standard, meaning that they operate an adult or pediatric medical and/or surgical ICU or neuro ICU but do not meet other aspects of Leapfrog's national standard for ICU staffing.

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CMS DATA FOR HAIS

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

Hospitals That Did Not Join Leapfrog's NHSN Group and Submit Section 7: Managing Serious Errors of the 2023 Leapfrog Hospital Survey by November 30, 2023

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

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

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SCORING METHODOLOGY

WEIGHTING INDIVIDUAL MEASURES

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

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

EVIDENCE

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

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

OPPORTUNITY

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

IMPACT

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

1. Number of patients affected
2. Severity of harm

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

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

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

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

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

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

NUMBER OF COMPONENT MEASURES

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

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STANDARD MEASURE WEIGHTS

Measure	Evidence Score	Opportunity Score	Impact Score	Number of Component Measures	Standard Measure Weight
Process/Structural Measure Domain (50%)					
CPOE	2	1.16	3	1	5.6%
BCMA	2	1.11	3	1	5.4%
IPS	2	1.70	3	1	7.2%
SP 1	1	1.05	2	1	3.2%
SP 2	1	1.10	2	1	3.3%
Total Nursing Care Hours per Patient Day	2	1.41	2	1	4.9%
Hand Hygiene	2	1.33	2	1	4.7%
H-COMP-1	1	1.03	2	1	3.1%
H-COMP-2	1	1.03	2	1	3.1%
H-COMP-3	1	1.05	2	1	3.2%
H-COMP-5	1	1.06	2	1	3.2%
H-COMP-6	1	1.04	2	1	3.1%
Outcome Measure Domain (50%)					
Foreign Object Retained	1	3.00	2	1	4.3%
Air Embolism	1	3.00	1	1	2.4%
Falls and Trauma	2	2.00	3	1	4.9%
CLABSI	2	1.81	3	1	4.5%
CAUTI	2	1.85	3	1	4.6%
SSI: Colon	2	1.80	2	1	3.4%
MRSA	2	1.77	3	1	4.4%
C. Diff.	2	1.77	3	1	4.5%
PSI 4	1	1.13	2	1	2.0%
PSI 90	1	1.19	2	10	15.0%

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CALCULATING Z-SCORES

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

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

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

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

Process and Structural Measures	Mean	Standard Deviation
CPOE	91.81	14.36
BMCA	93.42	10.47
IPS	63.29	44.05
SP 1	117.59	6.43
SP 2	117.08	11.32
Total Nursing Care Hours per Patient Day	74.69	30.66
Hand Hygiene	78.65	26.10
H-COMP-1	89.67	2.59
H-COMP-2	89.52	2.51
H-COMP-3	81.14	4.46
H-COMP-5	74.09	4.15
H-COMP-6	84.90	3.78

Outcome Measures	Mean	Standard Deviation
Foreign Object Retained	0.014	0.05
Air Embolism	0.001	0.01
Falls and Trauma	0.428	0.43
CLABSI	0.730	0.59
CAUTI	0.627	0.53
SSI: Colon	0.845	0.68
MRSA	0.793	0.61
C. Diff.	0.455	0.35
PSI 4	168.38	21.92
PSI 90	1.01	0.19

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A NOTE ABOUT EXTREME VALUES

For hospitals that have an “extreme” value for a particular measure (i.e., a value that exceeds the 99th percentile) Leapfrog “trims” the reported value to the 99th percentile. For example, a rate of 0.500 per 1,000 patient discharges for Foreign Object Retained after Surgery is “trimmed” to 0.336 (e.g., the 99th percentile). Only “trimmed” rates are displayed on the Leapfrog Hospital Safety Grade [website](#). The table below includes the “trim” values for the spring 2024 Leapfrog Hospital Safety Grade. The PSI 90 measure score represents an observed to expected ratio that has already been risk adjusted at both the component PSI level and at the composite level; therefore, the measure is not “trimmed” by Leapfrog.

Measure	99 th Percentile
Foreign Object Retained	0.336
Air Embolism	0.308
Falls and Trauma	2.006
CLABSI	2.944
CAUTI	2.482
SSI: Colon	3.207
MRSA	2.908
C. Diff.	1.791
PSI 4	222.70

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

DEALING WITH MISSING DATA

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

For example, if a hospital is missing a measure score for ICU Physician Staffing because the hospital does not operate an adult or pediatric medical and/or surgical ICU, the standard weight of 7.2% will be re-apportioned to the remaining 11 measures within the process/structural measure domain.

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

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

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

CALCULATING WEIGHTED MEASURE SCORES

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

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

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

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ADDITIONAL SCORING INFORMATION

TERMS USED IN SCORING AND PUBLIC REPORTING

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

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

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

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

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

SHARED CMS CERTIFICATION NUMBERS

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

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UPDATES TO DATA USED IN THE LEAPFROG HOSPITAL SAFETY GRADE

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

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

DATA FROM THE LEAPFROG HOSPITAL SURVEY

During the Safety Grade Review Period (February 26 – March 15), Leapfrog will only make corrections to a hospital's data from the 2023 Leapfrog Hospital Survey if a recording error is identified (i.e., we have recorded a different measure score than what is posted on our Survey Results website) or a scoring error is identified (i.e., Leapfrog has calculated an incorrect measure score based on the submitted responses and Leapfrog's published scoring algorithms). Updates to Leapfrog Hospital Survey data that are submitted after the Data Snapshot Date will **not** be included in the current Leapfrog Hospital Safety Grade. Hospitals submitting a Leapfrog Hospital Survey are urged to take advantage of the opportunity to review their Survey Results for accuracy and completeness prior to each of the two published Data Snapshot Dates.

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

The Leapfrog Hospital Survey is open from April 1 to November 30 of each year. Following the Submission Deadline (June 30), Survey Results are published monthly on a secure 'Hospital Details' page and a public website (ratings.leapfroggroup.org). Hospitals are urged to review their Survey Results immediately. Hospitals that identify any reporting errors are instructed to log back into the Survey to submit a correction. Hospitals can correct and re-submit a previously submitted Survey until the Survey closes for the year. Note that corrections submitted after the Data Snapshot Date are not included in the current Leapfrog Hospital Safety Grade. Leapfrog has several automated processes in place to prevent hospitals from making data entry errors in the Online Survey Tool and to enhance the overall accuracy of the Survey Results. Learn more at <http://www.leapfroggroup.org/survey-materials/data-accuracy>.

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

During the Safety Grade Review Period (February 26 – March 15), Leapfrog will only make corrections to a hospital's data from CMS if the correction is issued by CMS and posted on either the Data.Medicare.Gov website or the Data.CMS.Gov website. If a hospital has identified an error with a measure score published by CMS, and CMS cannot post a correction within the review period, the measure score will not be used in calculating the hospital's Safety Grade, provided that the hospital can document that CMS has agreed to publicly issue a correction or remove the measure score from public reporting. Hospitals participating with CMS are urged to take advantage of the opportunity to participate in the CMS 30-day review periods.

CMS FOOTNOTE 23 POLICY

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

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

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

CMS administers several hospital-based reporting and payment programs including the Inpatient Quality Reporting Program, HAC Reduction Program, and Value-based Purchasing Program. Several measures collected and calculated by CMS via its various hospital-based programs are used in the Leapfrog Hospital Safety Grade. CMS provides hospitals with a 30-day preview period before publishing measure scores on the Data.Medicare.Gov website and the Data.CMS.Gov website. More information is available at <https://qualitynet.org>.

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HOW TO PARTICIPATE IN THE LEAPFROG HOSPITAL SURVEY

If a hospital did **not** complete a 2023 Leapfrog Hospital Survey by November 30, Survey Results were not used to calculate the spring 2024 Leapfrog Hospital Safety Grade. Hospitals that would like Survey Results included in the fall 2024 Hospital Safety Grade must submit a 2024 Leapfrog Hospital Survey (including the CPOE Evaluation) by June 30, 2024. Hospitals will be able to review their publicly reported Survey Results in July and respond to any issues identified by Leapfrog's Extensive Monthly Data Verification before the Data Snapshot Date for the fall 2024 Safety Grade of August 31. More information is available at <https://leapfroggroup.org/survey>.

LEAPFROG'S HELP DESK

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

EXHIBIT 30

*Exhibit 30 – Leapfrog Statement of Facts/K. Blair Declaration***Spring 2024 Imputation Process:****USING SECONDARY DATA SOURCES**

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

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

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

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

If the hospital had a score assigned by Leapfrog in the previous four rounds of grades (i.e., fall 2023, spring 2023, fall 2022, spring 2022), excluding imputed scores, the hospital is assigned the most recent score on that measure in the current Hospital Safety Grade (i.e., spring 2024).

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

The hospital is assigned to a cohort of other similar hospitals using three or four hospital characteristics obtained from the most recent CMS Impact File and the 2023 Leapfrog Hospital Survey: urban/rural status, safety net status, number of beds, and teaching status (urban cohorts only). The CMS Impact File is the data source for urban/rural status, safety net status, and number of beds. The [2023 Leapfrog Hospital Survey Results](#) are the primary data source for teaching status and the CMS impact file is the secondary data source.

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

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[Scoring Methodology](#)

Last updated 4/22/2024

LEAPFROG00039287

Exhibit 30 – Leapfrog Statement of Facts/K. Blair Declaration

Fall 2024 Imputation Process:



USING SECONDARY DATA SOURCES

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

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

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

STEP 1: USE A HOSPITAL'S MOST RECENT SCORE ON THE MEASURE (APPLIES TO CPOE, IPS, AND HAND HYGIENE ONLY)

If the hospital had a score assigned by Leapfrog in the previous two rounds of grades (i.e., spring 2024, fall 2023), excluding imputed scores, the hospital is assigned the most recent score on that measure in the current Hospital Safety Grade (i.e., fall 2024).

STEP 2: USE IMPUTATION POINT ASSIGNMENT (APPLIES TO CPOE, BCMA, IPS AND HAND HYGIENE)

If the hospital does not have historical data from the last two rounds (i.e., spring 2024, fall 2023) of the Safety Grade, the hospital is assigned a point value that is equivalent to receiving "Limited Achievement" for this measure on the Leapfrog Hospital Survey:

Measure	Leapfrog Hospital Survey Performance Category	Corresponding Safety Grade Measure Score
CPOE	Limited Achievement	15
BCMA	Limited Achievement	25
IPS	Limited Achievement	5
Hand Hygiene	Limited Achievement	15

Note about IPS: Only hospitals that operate an adult or pediatric medical and/or surgical ICU or neuro ICU are eligible for Step 2 Imputation of the IPS measure. A hospital's ICU designation (i.e., operating a medical ICU, surgical ICU, or pediatric ICU) is determined from the number of medical, surgical and/or pediatric ICU beds reported in Worksheet S-3 Part 1 of the hospital's most recent CMS Cost Report. If your hospital does not operate an ICU, but shares a CMS Certification Number with a hospital that does, please [contact the Help Desk](#) immediately if an IPS score was imputed.

EXHIBIT 31

Message

From: The Leapfrog Group [helpdesk@leapfrog-group.org]
Sent: 5/21/2024 4:49:18 PM
To: West, Regina [Regina.West@tenethealth.com]
Subject: Review Planned Updates to the Fall 2024 Hospital Safety Grade

Review Planned Updates to the Fall 2024 Hospital Safety Grade

Informational Updates for Hospitals

[View this email in your browser](#)



Fall 2024 Hospital Safety Grade

Review Planned Changes & Submit a Public Comment by June 7

Starting in fall 2024, Leapfrog will update the Imputation Methodology for CPOE, BCMA, IPS, and Hand Hygiene measures for hospitals that do not submit a 2024 Leapfrog Hospital Survey by August 31, 2024. The changes come under the guidance of Leapfrog's national expert panel, the research team at Johns Hopkins Medicine, and in response to stakeholder feedback.

Leapfrog is accepting public comments for these planned updates until **June 7, 2024**. Leapfrog will publish final methodology updates and responses to public comments by June 30, 2024.

[Review Planned Changes and Submit a Comment](#)

Educational Opportunities

MONTHLY SUPPORT AND GUIDANCE FOR HOSPITAL SURVEY PARTICIPATION

The [2024 Leapfrog Hospital Survey Webinar Series](#), which is held monthly from March to December, is designed for hospitals that would benefit from more regular support and an interactive presentation of Survey materials and information.

Hospitals that join the Webinar Series will have access to:

- **Monthly office hours with Leapfrog's subject matter experts:** 30-minute sessions to get real-time technical assistance, answers to your questions and help staying on top of upcoming deadlines. Staffed by Leapfrog's subject matter experts.
- **Monthly webinars:** Timely and focused presentations on Survey measures and specifications, scoring information, frequently asked questions and public reporting. Each webinar focuses on a specific topic (e.g., nurse staffing and workforce, barcode medication administration, preparing for data verification, etc.) and concludes with a 20-minute open Q&A session.
- **Archive library:** Slides and recordings from each webinar are archived in an online portal that participants can access from March to January.

[Review the 2024 Webinar Series schedule and register now.](#)

In addition to the Webinar Series, Leapfrog offers **free** technical and content-related support to all participating facilities via our electronic [Help Desk](#), which is staffed by dedicated subject matter experts.

Important Dates

JUNE 30 SUBMISSION DEADLINE

The 2024 Leapfrog Hospital Survey Submission Deadline is June 30. Hospitals submitting by June 30 will be able to preview their results on their Hospital Details Page starting July 12 and will have results [publicly reported](#) on July 25. Hospitals will also receive a free [Competitive Benchmarking Summary Report](#).

[Review key deadlines.](#)

HELP DESK HOLIDAY SCHEDULE

The Leapfrog Help Desk is staffed from 9:00 a.m. to 5:00 p.m. ET on all regular business days. The Help Desk is not staffed on federal holidays. Please take note of the following upcoming closures.

Staff Training

May 22 - closed

Memorial Day

May 24 - closing at 2 pm ET

May 27 - closed

Juneteenth

June 19 - closed

Independence Day

July 4 - closed

Other Announcements

SURVEY SUPPORT FOR HEALTH SYSTEMS

Are you responsible for coordinating the Leapfrog Hospital Survey submission for all the hospitals in your health system? Want to make it easier to track submission status, review responses and scored results, and track performance from year to year?

Subscribe to Health System Support and receive all your hospital's 16-digit security codes, Survey responses, and scored Survey Results in an Excel file three times a year: following the June 30 deadline, following August 31 (the deadline for Top Hospital and the Snapshot Date for the fall 2024 Hospital Safety Grade), and following the January 31 year-end deadline.

Subscribers also receive a free registration for Leapfrog's [monthly webinar series](#).

[Find more information here](#)

RECOGNIZED LEADER APPLICATION OPENS JULY 1

Look out for the next round of applications for the [Recognized Leader in Caring for People Living with Diabetes](#) program! The application to be a 2025 Recognized Leader opens July 1, 2024, to all hospitals who have submitted a 2024 Leapfrog Hospital Survey. Details on updates to the program will be available in late June. Applications will be open until November 30, 2024, with Recognized Leaders announced in Spring 2025.

A joint effort from The Leapfrog Group and the American Diabetes Association, this first-ever national inpatient diabetes recognition program honors hospitals providing safe and high-quality health care for people living with diabetes, taking steps such as:

- Making it a policy to work with patients to safely self-manage their diabetes medications
- Implementing blood glucose testing and hypoglycemia protocols as well as additional testing and monitoring before and during inpatient surgeries
- Supporting patients with education they need to manage their care, and connecting them with health care providers after they leave the hospital

[Find more information here](#)

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The Leapfrog Group
1775 K St NW
Suite 400
Washington, DC 20006

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EXHIBIT 32

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

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

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

Plaintiffs,

v.

THE LEAPFROG GROUP,

Defendant.

**PLAINTIFF WEST BOCA MEDICAL CENTER, INC.’S
AMENDED AND SUPPLEMENTED RESPONSES AND OBJECTIONS TO
DEFENDANT THE LEAPFROG GROUP’S FIRST SET OF
INTERROGATORIES TO WEST BOCA MEDICAL CENTER, INC.**

Pursuant to Federal Rules of Civil Procedure 26 and 33 and the *Pretrial Scheduling Order and Order Referring Case to Mediation* (ECF No. 36) (the “Pretrial Scheduling Order”), Plaintiff West Boca Medical Center, Inc. (“Plaintiff” or “West Boca Medical Center”), by and through its undersigned counsel, hereby submit its amended and supplemented responses and objections (“Responses”), to Defendant The Leapfrog Group’s (“TLG”) First Set of Interrogatories, dated July 11, 2025 (the “Interrogatories” and each numbered interrogatory, an “Interrogatory”) in the above-captioned action (the “Action”).

Plaintiff’s Responses to the Interrogatories are made solely for purposes of this Action and to the best of Plaintiff’s present knowledge, information, and belief regarding the matters about which inquiry have been made. Discovery is ongoing, and Plaintiff reserves the right to amend, supplement, clarify, or further explain its Responses at any time prior to the trial in

this Action. Plaintiff further reserves the right to raise any additional objections deemed necessary or appropriate in light of any further review.

OBJECTIONS TO INSTRUCTIONS AND DEFINITIONS

1. Plaintiff objects to the definition of terms “Plaintiffs” and “Plaintiff Hospitals” as overbroad, unduly burdensome, and not proportional to the needs of the case to the extent it seeks to require Plaintiffs to respond on behalf of entities or individuals other than themselves.

2. Plaintiff objects to the definition of the terms “West Boca,” “West Boca Medical Center,” “Plaintiff,” “You,” and “Your” to the extent each term seeks to require Plaintiff to respond on behalf of entities or individuals other than itself, including on behalf of agents, employees, directors, or other non-party entities that are not part of this litigation. Such information is overbroad and beyond the scope of permissible discovery. Accordingly, Plaintiff states that its Responses are on behalf of itself only.

3. Plaintiff objects to the definition of the terms “Tenet Healthcare” and “Tenet” to the extent it seeks to require Plaintiff to respond on behalf of entities or individuals other than itself, including on behalf of Tenet, Tenet’s agents, employees, directors, or other non-party entities that are not part of this litigation. Such information is overbroad and beyond the scope of permissible discovery. Accordingly, Plaintiff states that its Responses are on behalf of itself only.

4. Plaintiff objects to the definition of “identify, when referring to a person,” as overbroad and unduly burdensome to the extent it calls for the “address” and “present or last-known employer” of identified individuals. Such information is overbroad and beyond the scope of permissible discovery.

5. Plaintiff objects to the instruction that the relevant time period for the Interrogatories begins on January 1, 2020. Plaintiff will apply to each Interrogatory the time period

of November 1, 2023 to present (the “Relevant Time Period”). Any response to an Interrogatory that provides information that falls outside of the Relevant Time Period should not be construed as an admission that the Relevant Time Period begins prior to November 1, 2023.

SPECIFIC RESPONSES TO INTERROGATORIES

Interrogatory No. 1: State the full name, address, job title or position, and hospital or employer affiliation of all individuals that assisted with responding to these interrogatories.

Answer: The following individuals assisted with responding to these Interrogatories.

Full Name	Address	Job Title / Position	Hospital or Employer Affiliation
Jerad Hanlon	c/o Gibson, Dunn & Crutcher LLP 200 Park Avenue New York, NY 10166	Chief Executive Officer	West Boca Medical Center
Regina West	c/o Gibson, Dunn & Crutcher LLP 200 Park Avenue New York, NY 10166	Market Quality Director	Palm Beach Health Network and St. Mary’s Medical Center

Interrogatory No. 2: Identify every individual not identified in Your Rule 26(a) initial disclosures with knowledge of facts pertaining to the allegations in Your Complaint in this Lawsuit (and any subsequent amendments) and/or whom You believe may have discoverable knowledge, information or data regarding this matter, including those who You expect to call as a fact or opinion witness at any hearing in this proceeding or whose testimony (by affidavit, deposition or testimony) You intended to submit in connection with this proceeding, and the substance of his/her testimony or affidavit, and, with respect to each person identified, provide:

- A. full name,
- B. address,
- C. telephone number,
- D. job title or position,
- E. hospital or employer affiliation,
- F. and describe in detail the facts possessed by each such person.

Plaintiff objects to this Interrogatory as overly broad, unduly burdensome, and not proportional to the needs of this Action to the extent it seeks the identity of “every individual...with knowledge” or who “may have discoverable knowledge, information or data regarding this matter.” Plaintiff will not provide more than the identity of individuals most likely to have knowledge regarding this matter. Plaintiff further objects to this Interrogatory as premature because it requests disclosure of Plaintiff’s witnesses for hearings and the substance of witness testimony before such disclosure is required under applicable law or the Pretrial Scheduling Order. Plaintiff will submit its trial witness list on October 2, 2025, per the Pretrial Scheduling Order, and disclose any other witnesses and witness testimony as further ordered by the Court or otherwise required by applicable law. Plaintiff also objects to this Interrogatory’s request for the identity of “opinion witness[es]” as vague, since witnesses are either “fact” or “expert” witnesses. Plaintiff will interpret “opinion witness” to mean “expert witness.” Plaintiff submitted expert reports on August 7, 2025, per the Pretrial Scheduling Order.

Answer: Subject to the foregoing objection, Plaintiff will amend its Rule 26(a)(1) Initial Disclosures to identify additional individuals who may have knowledge of facts pertaining to the allegations in the Complaint.

Amended Answer: In addition to those disclosed in Plaintiff’s supplemental disclosures, the following individuals may have relevant factual knowledge:

Full Name	Address	Job Title / Position	Hospital or Employer Affiliation
Regina West	c/o Gibson, Dunn & Crutcher LLP 200 Park Avenue New York, NY 10166	Market Quality Director	Palm Beach Health Network and St. Mary’s Medical Center

Full Name	Address	Job Title / Position	Hospital or Employer Affiliation
Andrea Nunes	c/o Gibson, Dunn & Crutcher LLP 200 Park Avenue New York, NY 10166	Quality Director	West Boca Medical Center

In addition to the individuals identified above, persons identified in documents produced in this dispute have knowledge of facts pertaining to the allegations in the Amended Complaint. *See* Fed. R. Civ. P. 33(d). Discovery is ongoing, and Plaintiff reserves the right to supplement, amend, correct, clarify, or modify this Response as further information becomes available.

Interrogatory No. 3: Describe in detail all factual bases for Your contention that Leapfrog’s published Safety Grade for Your hospital was false, inaccurate, misleading, deceptive, or unfair. In so answering, identify with particularity each measure, data point, or metric that You contend was inaccurately reported, calculated, or misrepresented by Leapfrog in calculating the Safety Grade for Your hospital.

Answer: Plaintiff objects to this Interrogatory as overly broad, unduly burdensome, and not proportional to the needs of this Action to the extent it seeks “all factual bases” for Plaintiff’s contention. *See Megdal Assocs., LLC v. La-Z-Boy, Inc.*, 2016 WL 4503337, at *6 (S.D. Fla. Feb. 1, 2016) (finding interrogatories asking for “‘all’ facts or witnesses that support an opposing party’s case” to be “unduly broad”) (citing 8B Wright, Miller, & Kane, Federal Practice and Procedure: Civil 3d § 2167 (2015)). Plaintiff further objects to this Interrogatory as premature to the extent it requests that Plaintiff “[d]escribe in detail all factual bases” to support its contention. *In re Reliance Fin. & Inv. Grp., Inc.*, 2006 WL 8435541, at *4 (S.D. Fla. Feb. 14, 2006) (Contention interrogatories “are more appropriately used after a substantial amount of discovery has been conducted--typically, at the end of the discovery period.”). Plaintiff also objects to this Interrogatory to the extent it attempts to limit or mischaracterize Plaintiff’s claim as just

challenging the false, inaccurate, misleading, deceptive, or unfair nature of TLG's Safety Grade. As the Court explained in its order denying TLG's motion to dismiss, the core of the Complaint is "a challenge to Defendant's representations about its methodology, which they claim mislead consumers by failing to distinguish between absent data and damning data, and professing that grades are not influenced by a hospital's lack of survey participation." *Order on Motion to Dismiss* 6 (ECF No. 41). Plaintiff also challenges the provably false facts and deceptive scoring system underlying these grades, which TLG admits it relies on to arrive at its deceptive Safety Grades.

Subject to the foregoing objections and as more fully stated in the *Amended Complaint* (ECF No. 74) ("Complaint"), TLG has engaged in deceptive and unfair business practices and misrepresentations when issuing the Safety Grade for Plaintiff's hospital as part of TLG's annual "Hospital Survey." TLG posts these Safety Grades online at hospitalsafetygrade.org.

To arrive at these Safety Grades, TLG uses CMS data, survey responses from participating hospitals, and other supplemental data sources. For participating hospitals, TLG uses the hospitals' self-reported responses to the Hospital Survey for 12 of the 22 measures. For non-participating hospitals, TLG uses other sources for those 12 measures. For the remaining four measures—Computerized Physician Order Entry, Bar Code Medication Administration, ICU Physician Staffing, and Hand Hygiene Score (the "Deceptive Score Categories")—TLG devised and uses a so-called "imputation model." Prior to Fall 2024, TLG's imputation model assigned non-participating hospitals a score based on the average score applicable to a similarly situated hospital. Beginning in Fall 2024, TLG modified its imputation model. TLG now assigns the lowest possible score to non-participating hospitals, which has the effect of punishing non-participating hospitals and artificially deflating their Safety Grades. TLG has even admitted the changes in Fall 2024 were designed to penalize non-participating hospitals. TLG also misleads consumers about how

it grades hospitals, stating “[t]he Hospital Safety Grade reflects how well a hospital does on safety, not whether they complete the [TLG] Hospital Survey.” *Declaration of Lee Crain* (ECF No. 21) (“Crain Decl.”), Ex. 1 at 4 (“Frequently Asked Questions About the Leapfrog Hospital Safety Grade”).

As TLG explains, “not all hospitals have enough data publicly available to be eligible for a grade.” Crain Decl. Ex. 1 at 5. “As per the National Expert Panel guidance, [TLG] has requirements for the minimum amount of data [it] need[s] to issue an accurate grade.” Crain Decl. Ex. 1 at 5. According to TLG, “[h]ospitals missing more than six process measures” are “not graded.” Crain Decl. Ex. 2 at 6. Non-participating hospitals should fall easily into that “not graded” bucket, because their decision not to participate in TLG’s survey necessarily means TLG is missing seven process measures that rely on voluntary submission of hospital data.¹

TLG then deceptively conceals how it makes up grades for the four “imputation” measures and even suggests on its website that TLG *does* have data sufficient to score TLG on those four measures. By way of example, TLG acknowledges that Plaintiff “Declined to Report” information in response to questions about “Staff work[ing] together,” but then tells consumers—as if it were a fact—that Plaintiff is “Worse Than Average” on “Handwashing,” “Communication,” “medication administration,” and the like—even though TLG has no basis whatsoever to adopt those conclusions. Crain Decl. Ex. 32 at 2. TLG itself says handwashing is among the “most important” measures in its survey, Crain Decl. Ex. 15 at 4, yet it deceptively conceals that it has no data with which to grade the Plaintiff hospital on that measure. *Defendant The Leapfrog Group’s Responses to Plaintiffs’ Requests for Production* at 7 (“Leapfrog is not itself in possession

¹ Those seven include CPOE, BCMA, IPS, Safe Practice 1: Culture of Leadership Structures and Systems; Safe Practice 2: Culture Measurement, Feedback & Intervention; Total Nursing Care Hours per Patient Day; and Hand Hygiene.

of data showing Plaintiffs' performance on the 'imputed metrics' considered by the methodology."'). Of course, Plaintiff in fact has a comprehensive and thorough handwashing policy. And had Plaintiff merely filled out TLG's survey, it would have received a full two letter grades higher on TLG's score. *Expert Report of Professor Sean Nicholson* (Aug. 7, 2025), Ex. 6.

Based on the foregoing, and as more fully set forth in the Complaint, TLG engages in deceptive trade practices by, among other things, deceiving consumers about its grading methods by implying that Plaintiff has failed on certain measures that, in truth, TLG has no data or other basis to evaluate; deceiving consumers by telling them the Hospital Safety Grade reflects how well a hospital does on safety, not whether they complete the Hospital Survey; deceiving consumers when it represents that it does not grade hospitals if it lacks sufficient data, when, in truth, it does grade hospitals by "imputing" or making up a grade for the Deceptive Score Categories; hiding the truth about its "imputation model" from consumers by burying it in fine print on a separate website; punishing non-participating hospitals by "imputing" scores, which artificially deflate a hospital's Safety Grade; and favoring participating hospitals. Additional factual bases for the Plaintiff's claims are presented in the Complaint.

Interrogatory No. 4: Describe the scoring or grading methodology You believe Leapfrog should have used to assess Your hospital's patient safety performance and explain why that method would yield a different result.

Plaintiff objects to this Interrogatory because it seeks discovery of information that is irrelevant to the claims and defenses in this Action and is overly broad, unduly burdensome, and not proportional to the needs of this Action. Plaintiff's provision of an alternative scoring or grading methodology has nothing to do with the claims and defenses in this case related to TLG's

decision to use deceptive business practices. Plaintiff further objects to this Interrogatory to the extent it calls for speculation.

Answer: Plaintiff declines to respond to this Interrogatory.

Amended Answer: Subject to the foregoing objections, Plaintiff responds that TLG should use a scoring system that is not unfair or deceptive. By way of example only, TLG could decline to grade hospitals that do not participate in TLG's survey, because their decision not to participate means TLG is missing seven process measures that rely on voluntary submission of hospital data. This would yield a different result, because the hospitals would not receive a grade at all. TLG's methodology certainly should not affirmatively assign an arbitrary low score to a particular metric just because a hospital does not provide data for that metric.

Interrogatory No. 5: State whether You submitted any data, corrections, or appeals to Leapfrog regarding the Safety Grade Your hospital received, and for each such submission, identify the date of the submission, the medium of the submission (i.e. telephone, video conference, email, letter, etc.), who was involved in the submission, and the content of the submission.

Plaintiff objects to this Interrogatory because it seeks discovery of information that is irrelevant to the claims and defenses in this Action and is overly broad, unduly burdensome, and not proportional to the needs of this Action. Whether or not Plaintiff submitted "any data, corrections, or appeals to Leapfrog regarding the Safety Grade" Plaintiff hospital received has nothing to do with the claims and defenses in this case related to TLG's decision to use deceptive business practices. Plaintiff further objects to this Interrogatory to the extent it seeks information that is already in TLG's possession, custody and control, or equally available to TLG.

Answer: Subject to the foregoing objections, Plaintiff engaged in correspondence prior to the commencement of this case demanding that TLG reform its deceptive practices and cease and desist reporting deceptive and unfair Safety Grades, but at every turn TLG refused.

Amended Answer: Subject to the foregoing objections, Plaintiff did not submit any data, corrections or appeals to Leapfrog regarding the Safety Grades it has received.

Interrogatory No. 6: State whether You provided any comment or input in any form during Leapfrog's requests for public comments for planned updates to the Leapfrog Hospital Safety Grade methodology that was proposed for the calculation of Hospital Safety Grades (including but not limited to for the Fall 2024 methodology update). If yes, please identify the date of the comment, the medium of the submission (i.e. telephone, video conference, email, letter, etc.), who was involved in the comment and the content of the comment. If no, please state the reason why You chose not to comment.

Answer: Plaintiff objects to this Interrogatory because it seeks discovery of information that is irrelevant to the claims and defenses in this Action and is overly broad, unduly burdensome, and not proportional to the needs of this Action. Whether or not Plaintiff submitted "any comment or input" in response to TLG's request for public comments has nothing to do with claims and defenses in this case related to TLG's decision to use deceptive business practices. Plaintiff further objects to this Interrogatory to the extent it seeks information that is already in TLG's possession, custody and control, or equally available to TLG.

Subject to the foregoing objections, Plaintiff did not provide comments in response to Leapfrog's requests for public comments for planned updates to the Leapfrog Hospital Safety Grade scoring system because Plaintiff generally does not respond to requests for public comment from private entities like TLG.

Interrogatory No. 7: Describe all actions Your hospital took in response to (or in deciding not to respond to) its Safety Grade or the Hospital Survey, including internal meetings, media statements, or public relations efforts. In so answering, state the date of the action, the individuals involved in the action and the content of the action.

Plaintiff objects to this Interrogatory as overly broad, unduly burdensome, and not proportional to the needs of this Action to the extent it seeks “all actions” Plaintiffs may have taken in response to TLG’s Safety Grades. *See Megdal Assocs., LLC v. La-Z-Boy, Inc.*, No. 14-81476-CIV, 2016 WL 4503337, at *6 (S.D. Fla. Feb. 1, 2016) (finding interrogatories asking for “‘all’ facts or witnesses that support an opposing party’s case” to be “unduly broad”) (citing 8B Wright, Miller, & Kane, Federal Practice and Procedure: Civil 3d § 2167 (2015)). Plaintiff further objects to this Interrogatory to the extent it seeks information that is subject to a claim of privilege or otherwise protected from disclosure, including seeking information protected by the attorney-client privilege, work-product doctrine, or other immunity.

Answer: Subject to the foregoing objections, Plaintiff devoted substantial time and resources that could have otherwise been spent continuing to improve patient care to respond to the significant harm and disruption caused by TLG’s deceptive and unfair Safety Grade. Plaintiff’s response included meeting internally with Plaintiff’s leadership team, medical executive committee, and governing board, corresponding with TLG to demand that TLG reform its deceptive practices and cease and desist reporting deceptive and unfair Safety Grades, and devoting substantial time and resources to facilitate the preparation and prosecution of this Action.

Amended Answer: Subject to the foregoing objections, Plaintiff devoted substantial time and resources that could have otherwise been spent continuing to improve patient care to respond to the significant harm and disruption caused by TLG’s deceptive and unfair Safety Grades. Plaintiff’s response included meeting internally with Plaintiff’s leadership team, medical executive

committee, and governing board, corresponding through Plaintiff's corporate parent with TLG to demand that TLG reform its deceptive practices and cease and desist reporting deceptive and unfair Safety Grades, and devoting substantial time and resources to facilitate the preparation and prosecution of this Action. Plaintiff has also held many phone calls and meetings with physicians and other stakeholders about the TLG grades, explaining how the grades were deceptive and did not accurately reflect the hospital quality and patient safety at Plaintiff.

Interrogatory No. 8: Identify any and all persons, whether internal or external (e.g., patients, vendors, affiliates, parents, agents, partners, media) with whom You communicated in any way with respect to the Safety Grade or the Hospital Survey. In so answering, state the date of the communication, the individuals involved in the communication, the medium of the communication (i.e. telephone, video conference, email, letter, etc.) and the content of the communication.

Plaintiff objects to this Interrogatory as overly broad, unduly burdensome, and not proportional to the needs of this Action to the extent it seeks the identity of "any and all persons, whether internal or external." Plaintiff will disclose the categories of individuals with whom Plaintiff communicated about the Safety Grade or Hospital Survey during the Relevant Time Period. Plaintiff also objects to this Interrogatory to the extent it seeks protected health information that Health Insurance Portability and Accountability Act ("HIPAA"), among other statutes and regulations, bars Plaintiff from disclosing. Plaintiff further objects to this Interrogatory to the extent it seeks information that is subject to a claim of privilege or otherwise protected from disclosure, including seeking information protected by the attorney-client privilege, work-product doctrine, or other immunity.

Answer: Subject to the foregoing objections, Plaintiff communicated with the following categories of people regarding the Safety Grade or the Hospital Survey: Plaintiff's governing board, its medical executive committee, department directors, and physicians and nurses when

asked about the Safety Grade or Hospital Survey. These communications occurred in and after Fall 2024, after TLG released its deceptive and unfair Safety Grade for Plaintiff's hospital. Most of these communications occurred during regularly scheduled meetings, during which attendees were told about TLG's release of the deceptive and unfair Safety Grade, that Plaintiff does not participate in the Hospital Survey because it is unreliable and not an accurate reflection of hospital quality and safety or patient outcomes, and that the Safety Grade, which was not based on any information provided by Plaintiff, was misleading. The Palm Beach Health Network also issued a press release and since then, has engaged in various social networking and other marketing campaigns to counteract TLG's deceptive scores on behalf of Plaintiff and other affected members of the network.

Amended Answer: Subject to the foregoing objections, Plaintiff communicated with the following categories of people regarding the Safety Grade or the Hospital Survey: Plaintiff's governing board, its medical executive committee, department directors, physicians and nurses, and patients when asked about the Safety Grades or Hospital Survey. These communications occurred in and after Fall 2024, after TLG released its deceptive and unfair Safety Grades for Plaintiff's hospital. Most of these communications occurred during regularly scheduled meetings, during which attendees were told about TLG's release of the deceptive and unfair Safety Grade, that Plaintiff does not participate in the Hospital Survey because it is unreliable and not an accurate reflection of hospital quality and safety or patient outcomes, and that the Safety Grade, which was not based on any information provided by Plaintiff, was misleading. The Palm Beach Health Network also issued a press release and has engaged in marketing efforts, including through social media, to counteract TLG's deceptive scores on behalf of Plaintiff and other affected members of

the network. Plaintiff also engaged in email discussions about TLG's misleading grades, either as sender or recipient, which TLG has through Plaintiff's production of documents.

Interrogatory No. 9: Describe all instances in which a third party declined to contract with, refer patients to, or work with Your hospital, where Leapfrog's grade was cited or discussed. In so identifying list the name of the individuals involved in the communication, the medium of the communication (i.e. telephone, video conference, email, letter, etc.), the date of the communication and the content of the communication.

Answer: Plaintiff objects to this Interrogatory as overly broad, unduly burdensome, and not proportional to the needs of this Action to the extent it requires Plaintiff to "[d]escribe all instances" in which a third party took an action in response to TLG's deceptive grade.

Subject to the foregoing objection, Plaintiff is not aware of any responsive instances.

Interrogatory No. 10: Describe with specificity the basis for each and every category of damage You claim You incurred as a result of the Leapfrog Safety Grade. In so identifying, list each category of damages and the dollar value of each category of damage You claim.

Plaintiff objects to this Interrogatory to the extent it seeks information that is the subject of expert testimony.

Answer: Plaintiff will submit expert reports on August 7, 2025, per the Pretrial Scheduling Order.

Amended Answer: Plaintiff has served the expert report of Thomas Chakurda, which addresses the issue of reputational harm and harm to Plaintiff's goodwill. Plaintiff further objects to this Interrogatory as overbroad and unduly burdensome to the extent it seeks "each and every" category of claimed damages.

Subject to the foregoing objections and as agreed during the parties' September 3, 2025 meet and confer, Plaintiff will limit its response to the live non-monetary claims, including

injunctive and declaratory relief, to remedy harm to Plaintiff's reputation and goodwill. Plaintiff's reputation and goodwill has been damaged by TLG's false and misleading methodology and resulting Safety Grades. Plaintiff's claim for reputational harm is based on, among other things, concerns raised by patients, doctors, staff, and community members, as well as false and misleading statements based on TLG's false and misleading methodology and Safety Grades made in newspapers, viral social-media videos, television programs, and blogs.

By way of example, our Medical Executive Committee has received direct inquiries from patients regarding their concerns with TLG's grades and related public reports. An emergency-department patient, who needed surgery, said that he was leaving because of the Leapfrog grade. The harm caused by TLG's false and misleading Safety Grade is ongoing.

Interrogatory No. 11: Identify all adverse patient events which occurred at Your hospital, including any citations received from regulatory agencies, accrediting agencies, and third party payors such as The Joint Commission, CMS, state health departments, etc. during the period covered by each Leapfrog Safety Grade publication of which You complain (i.e., Fall 2024, Fall 2025, etc.), as well as any complaints received from patients regarding the same.

Plaintiff objects to this Interrogatory because it is overly broad, unduly burdensome, seeks discovery of information that is irrelevant to the claims and defenses in this Action, seeks information that is beyond the scope of Leapfrog's Hospital Survey, and is not reasonably calculated to lead to the discovery of admissible evidence. TLG does not include "all adverse patient events," "citations received from" agencies or payors, or "complaints received from patients" in TLG's determination of its Hospital Safety Grades or request such information in the Hospital Survey, so any such information is irrelevant to whether TLG's actions constitute unfair or deceptive trade practices. TLG has, therefore, only propounded this Interrogatory for purposes of harassment. Plaintiff also objects to this Interrogatory to the extent it seeks protected health information that HIPAA, among other statutes and regulations, bars Plaintiff from disclosing.

Answer: Plaintiff declines to respond to this Interrogatory.

Amended Answer: Defendant has agreed to withdraw this Interrogatory.

Interrogatory No. 12: Describe in detail how Your hospital compares nationally on on [sic] any other ranking of patient safety performance, including but not limited to Vizient, Inc., Premier, Inc., HealthTrust Purchasing Group, The Joint Commission, HealthGrades, US News, Newsweek, Statista, Definitive Healthcare, or any other quality benchmarking entity including benchmarking on patient safety including on adverse events and on healthcare-acquired infections.

Plaintiff objects to this Interrogatory's request that Plaintiff "[d]escribe in detail how Your hospital compares nationally" based on undisclosed "benchmarking" as vague and confusing. To the extent this Interrogatory seeks the top-line rankings of the identified organizations, Plaintiff objects to this Interrogatory because such information is publicly and equally available to TLG. To the extent this Interrogatory asks Plaintiff to compare itself to the named and unnamed entities, that request is overly broad, unduly burdensome, and not proportional to the needs of this Action. Plaintiff further objects to this Interrogatory because it seeks discovery of information that is irrelevant to the claims and defenses in this Action and is overly broad, unduly burdensome, and not proportional to the needs of this Action. Other organizations' rankings have nothing to do with the claims and defenses in this case related to the Deceptive Score Categories or TLG's decision to use deceptive business practices.

Answer: Subject to the foregoing objections, Plaintiff has received numerous awards and accolades, including many that are directly relevant to patient care for children and women that we serve. For example, Plaintiff is the only Level III NICU facility in southern Palm Beach County. Level III NICUs provide lifesaving care for babies born before 32 weeks' gestation or babies with specific medical conditions that require surgery or specialized pediatric care. The American College of Radiology accredited Plaintiff for Imaging Modalities including Nuclear

Medicine, Ultrasound, MRI, CT—which provides us the ability to care for the Level III NICU children and at-risk pregnancy mothers that we treat and ensures we are using best practices. Relatedly, Plaintiff has an accredited education program in radiology through Joint Review Committee on Education and Radiologic Technology, which is the only agency recognized by the United States Department of Education and the Council for Higher Education Accreditation for the accreditation of traditional and distance delivery educational programs in radiography, radiation therapy, magnetic resonance, and medical dosimetry. This program provides our clinical staff with educational opportunities to ensure our patients receive quality care.

Plaintiff is accredited by the Joint Commission, the nation’s largest hospital accreditor that evaluates hospitals’ quality performance standards through an objective evaluation process. Plaintiff has also been accredited by Joint Commission for specialization certifications for Joint-Replacement – Hip, Joint Replacement – Shoulder, and Joint Replacement – Knee—a certification designed for hospitals providing the critical elements to achieve long-term success in improving critical medical outcomes—which signifies our services have delivered evidence-based proof of clinical quality sought by patients and payers alike. The entities that award and assign these accreditations visit the healthcare facility and perform regular periodic in-person reviews, audits, surveys, and assessments of the facility.

Plaintiff has also received numerous awards that exemplify its quality such as Get with the Guidelines Silver Plus Stroke Recognition Award and Diabetes Honor Roll. In addition, as a facility that primarily treats mothers and children, it is important to us that we implement the American Academy of Pediatrics best practices and have been recognized for doing so by receiving the Silver designation from the Cribs for Kids’ National Safe Sleep Hospital Certification program, which signifies our facility’s commitment to infant safe sleep to reduce the risk of Sudden

Unexpected Infant Death, Accidental Suffocation and Strangulation in Bed, SIDS, and unsafe sleep injuries.

Healthgrades has awarded Plaintiff numerous Healthgrades accolades. To assess and evaluate hospitals, Healthgrades relies on data from Medicare medical claims records and states' data on Medicare and commercially insured patient outcomes to determine patients' actual clinical outcomes when visiting a given hospital. Plaintiff also received several awards from Healthgrades for various specialties, including:

a. Critical Care

- i. Five-Star Recipient for Treatment of Sepsis for four years in a row (2022-2025)

b. Gastrointestinal

- i. Recipient of the Healthgrades Gastrointestinal Care Excellence Award (2022-2025)
- ii. Recipient of the Healthgrades Gastrointestinal Surgery Excellence Award (2025)
- iii. Top 10% in the Nation for overall Gastrointestinal Services (2025)
- iv. Top 10% in the Nation for Gastrointestinal Surgery (2025)
- v. Five-Star Recipient for Colorectal Surgeries for three years in a row (2023-2025)
- vi. Five-Star Recipient for Treatment of Bowel Obstruction (2025)

c. Labor and Delivery

- i. Five-Star Recipient for C-Section Delivery for 11 years in a row (2015-2025)

- ii. Five-Star Recipient for Vaginal Delivery for 11 years in a row (2015-2025)

d. Pulmonary Care

- i. Five-Star Recipient for Treatment of Respiratory Failure for three years in a row (2023-2025)

In addition, Plaintiff will produce and identify documents reflecting some of Plaintiff's rankings from other organizations.

Amended Answer: Subject to the foregoing objections, Plaintiff has received numerous awards and accolades. For example, the American College of Radiology accredited Plaintiff for Imaging Modalities including Nuclear Medicine, Ultrasound, MRI, and CT. Relatedly, Plaintiff has an accredited education program in radiology through Joint Review Committee on Education and Radiologic Technology.

Plaintiff is accredited by the Joint Commission for specialization certifications for Joint-Replacement – Hip, Joint Replacement – Shoulder, and Joint Replacement – Knee.

Plaintiff has also received Get with the Guidelines Silver Plus Stroke Recognition Award and Diabetes Honor Roll. In addition, Plaintiff has received the Silver designation from the Cribs for Kids' National Safe Sleep Hospital Certification program.

Healthgrades has awarded Plaintiff numerous Healthgrades accolades, including:

a. Critical Care

- i. Five-Star Recipient for Treatment of Sepsis for four years in a row (2022-2025)

b. Gastrointestinal

- i. Recipient of the Healthgrades Gastrointestinal Care Excellence Award (2022-2025)
- ii. Recipient of the Healthgrades Gastrointestinal Surgery Excellence Award (2025)
- iii. Top 10% in the Nation for overall Gastrointestinal Services (2025)
- iv. Top 10% in the Nation for Gastrointestinal Surgery (2025)
- v. Five-Star Recipient for Colorectal Surgeries for three years in a row (2023-2025)
- vi. Five-Star Recipient for Treatment of Bowel Obstruction (2025)

c. Labor and Delivery

- i. Five-Star Recipient for C-Section Delivery for 11 years in a row (2015-2025)
- ii. Five-Star Recipient for Vaginal Delivery for 11 years in a row (2015-2025)

d. Pulmonary Care

- i. Five-Star Recipient for Treatment of Respiratory Failure for three years in a row (2023-2025)

In addition, Plaintiff will produce and identify documents reflecting some of Plaintiff's rankings from other organizations.

Also, Plaintiff does not participate in Vizient and has not done so during the Relevant Time Period.

Interrogatory No. 13: Describe any steps taken by Your hospital to improve any and all of the patient safety measures considered by Leapfrog's Hospital Safety Grade (as set forth on Leapfrog's

published scoring methodology documents; see ECF No. 21-3 at 6-10; ECF No. 21-43 at 6-9), before and after each Safety Grade publication of which You complain.

Plaintiff objects to this Interrogatory as overly broad, unduly burdensome, and not proportional to the needs of this Action to the extent it seeks the identity of Plaintiff's improvements to "any and all" patient safety measures considered by Leapfrog's Hospital Safety Grade. Plaintiff further objects to this Interrogatory because it seeks discovery of information that is irrelevant to the claims and defenses in this Action and is overly broad, unduly burdensome, and not proportional to the needs of this Action to the extent it seeks information on metrics other than TLG's Deceptive Score Categories and to the extent it seeks information that is beyond the scope of Leapfrog's Hospital Survey.

Answer: Plaintiff declines to respond to this Interrogatory.

Amended Answer: Subject to the foregoing objection, Plaintiff is committed to continual improvement of patient safety measures, motivated by our commitment to ensuring the best possible patient safety—not chasing the best possible Leapfrog grade. To achieve this core objective, Plaintiff devotes significant time and resources to improving its delivery of the highest possible quality of care for those in the community it serves, including efforts to improve its performance in areas related to the four metrics Plaintiff has chosen to impute in its survey.

Plaintiff tracks three of these metrics through its patient safety plan or as part of its quality improvement patient safety committee. For example, Plaintiff does random hand washing audits every month on every unit and addresses any negative trends. Plaintiff already has 24/7 ICU coverage for its intensivist unit and has had that coverage for several years, so it does not need to track this metric.

Interrogatory No. 14: State whether You are aware of specific patients who have relied on the Leapfrog Safety Grade in declining to receive healthcare services at Your hospital. In so answering, identify the individual patient that declined to receive services, the date of such declination, the type of service the patient declined to receive, the medium for the communication from the patient (i.e. telephone, video conference, email, letter, etc.), the content of the communication, and the reason given for the stated decision.

Plaintiff objects to this Interrogatory as seeking protected health information that is protected from disclosure by HIPAA, among other statutes and regulations. Plaintiff will only produce this information as needed and subject to a Qualified Protective Order entered by this Court.

Answer: Subject to the foregoing objection, Plaintiff has received reports that patients considered or decided not to use Plaintiff's facility because of TLG's misleading grades.

Amended Answer: Subject to the foregoing objection, since the release of TLG's false and misleading grades, Plaintiff has received numerous reports from doctors that patients considered or decided not to use Plaintiff's facility due to concerns related to TLG's misleading grades.

Interrogatory No. 15: Describe any effort Your hospital has made to influence public perception of Your hospital's performance on patient safety following the publication of the Leapfrog Safety Grade.

Plaintiff objects to this Interrogatory as vague and ambiguous because it does not specify which Leapfrog Safety Grade is at issue. Plaintiff will construe this Interrogatory to reference TLG's deceptive Safety Grades beginning in Fall 2024. Plaintiff objects to this Interrogatory as overly broad, unduly burdensome, and not proportional to the needs of this Action to the extent it seeks "any effort" Plaintiff "has made to influence public perception" after the release of TLG's deceptive and unfair Safety Grades because there have been many such "efforts" and those

“efforts” are ongoing given the significant harm caused by TLG’s deceptive and unfair business practices.

Answer: Subject to the foregoing objections, Plaintiff continues to influence public perception by, among other things, delivering the highest quality care to the community it serves, which, as discussed in response to Interrogatory 12, has led to numerous awards, accreditations, and accolades. In addition, several public statements disputing the misleading nature of the Safety Grade have been made on Plaintiff’s behalf.

Supplemental Answer: In addition to the above, members of hospital leadership have communicated with patients, doctors, or community members on a regular basis to dispel the misleading nature of the Leapfrog Safety Grades. For instance, Plaintiff communicated its governing board, its medical executive committee, department directors, physicians and nurses, and patients when asked about the Safety Grades or Hospital Survey. These communications occurred in and after Fall 2024, after TLG released its deceptive and unfair Safety Grades for Plaintiff’s hospital. The Palm Beach Health Network also issued a press release and has engaged in marketing efforts, including through social media, to counteract TLG’s deceptive scores on behalf of Plaintiff and other affected members of the network. Plaintiff also engaged in email discussions about TLG’s misleading grades, either as sender or recipient, which TLG has through Plaintiff’s production of documents.

Interrogatory No. 16: Describe the due diligence Your hospital undertakes to ensure the accuracy of its own publicly reported safety data (including but not limited to data submitted to CMS, the CDC, and third party organizations).

Plaintiff objects to this Interrogatory as vague and ambiguous due to its use of the undefined term “due diligence.” Plaintiff further objects to this Interrogatory because it seeks

discovery of information that is irrelevant to the claims and defenses in this Action and is overly broad, unduly burdensome, and not proportional to the needs of this Action. Any “due diligence” Plaintiff performs when reporting to *third parties* has nothing to do with the claims and defenses in this case related to TLG’s decision to use deceptive business practices, especially when TLG does nothing to ensure the accuracy of information that hospitals that participate in its survey self-report.

Answer: Plaintiff declines to respond to this Interrogatory.

Amended Answer: Subject to the foregoing objections, Plaintiff makes reasonable efforts to ensure the accuracy of the data it reports to third-party organizations. For instance, Plaintiff employs data abstractors, quality coordinators and a Quality Director, who are all responsible for abstracting, validating, and submitting safety data.

Interrogatory No. 17: Describe in detail how You communicate to the shareholders, board members, collective bargaining representatives and investors of Tenet Healthcare System the outcome of any and all healthcare safety ratings, evaluative publications, studies, or performance analyses that Your Hospital receives.

Plaintiff objects to this Interrogatory because it seeks discovery of information that is irrelevant to the claims and defenses in this Action and is overly broad, unduly burdensome, and not proportional to the needs of this Action. Plaintiff’s communication, if any, with the shareholders, board members, collective bargaining representatives and investors of Tenet Healthcare System, all non-parties to this litigation, has nothing to do with the claims and defenses in this case related to TLG’s decision to use deceptive business practices.

Answer: Plaintiff declines to respond to this Interrogatory.

Amended Answer: Subject to the foregoing objection, Plaintiff communicates with Tenet stakeholders, including employees who work to support the Palm Beach Health Network, on a range of matters, including issues related to patient safety and outcomes and in particular related to TLG and the Safety Grades by email and oral communication. Those communications included discussions about the reasons for particular grades, the method used to calculate Safety Grades, the value of Safety Grades, and responses to the Safety Grades. In addition, identified below are documents Plaintiff produced evidencing communications between the Plaintiff Hospitals and Tenet related to TLG, the Leapfrog survey, and Safety Grades.

Start Page	End Page
PBHN000005541	PBHN000005542
PBHN000002082	PBHN000002085
PBHN000005475	PBHN000005477
PBHN000006746	PBHN000006752
PBHN000006509	PBHN000006513
PBHN000006397	PBHN000006401
PBHN000002090	PBHN000002094
PBHN000002071	PBHN000002071

PBHN000002103	PBHN000002103
PBHN000004562	PBHN000004563
PBHN000004564	PBHN000004564
PBHN000004574	PBHN000004581
PBHN000005509	PBHN000005511
PBHN000005518	PBHN000005521
PBHN000005526	PBHN000005529
PBHN000006414	PBHN000006419
PBHN000006465	PBHN000006466

Discovery is ongoing, and Plaintiff reserves the right to amend, modify or supplement the response to this Interrogatory.

Interrogatory No. 18: State whether the compensation of Your Chief Executive Officer or any other executive-level leadership officers is tied to or related in any way to Your hospital's performance on patient safety, union worker contracts or Your hospital's ratings by third party ratings organizations' ratings publications (including but not limited to the Leapfrog Hospital Safety Grade).

Plaintiff objects to this Interrogatory because it seeks discovery of information that is irrelevant to the claims and defenses in this Action and is overly broad, unduly burdensome, and not proportional to the needs of this Action. Plaintiff's method of compensating its Chief Executive Officer and other executive-level leadership **has nothing to do with the** claims and defenses in this case related to TLG's decision to use deceptive business practices.

Answer: TLG has, therefore, only propounded this Interrogatory for purposes of harassment. Plaintiff declines to respond to this Interrogatory.

Amended Answer: Subject to the foregoing objection, Plaintiff's performance on patient safety, union worker contracts, or ratings by third party ratings organizations' ratings publications is related in some way to the compensation of Plaintiff's Chief Executive Officer or other executive-level leadership officer(s).

Interrogatory No. 19: Identify all hospitals, medical centers, or healthcare systems that you consider to be your direct competitors within the relevant geographic market during the time period covered by the Complaint and describe in detail the criteria you use to determine whether another hospital or healthcare provider is a competitor.

Plaintiff objects to this Interrogatory because it seeks discovery of information that is irrelevant to the claims and defenses in this Action and is not reasonably calculated to lead to the discovery of admissible evidence. The identity of Plaintiff's competitors and "the criteria" used to determine whether a hospital or provide is a competitor has nothing to do with the claims and defenses in this case related to TLG's decision to use deceptive business practices. Plaintiff also objects to this Interrogatory to the extent it seeks confidential, proprietary information, and

commercially sensitive information related to Plaintiff's scoring system and "criteria" used to determine whether a hospital or provide is a competitor.

Answer: Subject to the foregoing objections and on condition that this response is considered "Confidential" under the forthcoming agreed confidentiality order, Baptist Health South Florida, Bethesda Hospital East, Bethesda Hospital West, Boca Raton Regional Hospital, Broward Health Hospital in Coral Springs, and HCA Florida Northwest Hospital are Plaintiff's competitors. Plaintiff considers these hospitals competitors because of their proximity to Plaintiff, their competing services lines, and that patients within Plaintiff's service area go to these hospitals for medical care.

Interrogatory No. 20: State and describe the results of any market analysis, competitive analysis, or consumer perception surveys you have conducted or commissioned regarding your competitors from 2020 to present, and identify the individuals or entities that prepared or participated in such analyses.

Plaintiff objects to this Interrogatory because it seeks discovery of information that is irrelevant to the claims and defenses in this Action and is not is not proportional to the needs of this Action. The results of any market analysis, competitive analysis, or consumer perception surveys and the identity of those who prepared or participated in such analyses has nothing to do with the claims and defenses in this case related to TLG's decision to use deceptive business practices.

Answer: Plaintiff declines to respond to this Interrogatory.

Amended Answer: Plaintiff further objects to this Interrogatory to the extent it requests information from outside of the relevant time period of January 1, 2023, to present. Plaintiff also

objects to this Interrogatory as unduly burdensome to the extent it asks Plaintiff to “state and describe” various market analysis.

As agreed during the parties’ meet and confer on September 3, 2025, Plaintiff will produce documents showing the results of studies or surveys Plaintiff has conducted or commissioned related to internal market analysis, competitive analysis, or consumer perception. Plaintiff will identify the documents responsive to this Interrogatory by Bates number in Plaintiffs’ production cover letter.

Interrogatory No. 21: Identify with specificity any comments or concerns raised by any third party payor, bank or lender, or investor related to Your hospital’s reputation and/or public perception on issues in any way involving patient safety or satisfaction.

Plaintiff objects to this Interrogatory because it seeks discovery of information that is overly broad, unduly burdensome and irrelevant to the claims and defenses in this Action and is not proportional to the needs of this case to the extent it seeks “comments and concerns” from third parties related generally to Plaintiff’s reputation that has nothing to do with the specific and significant reputational harm caused by TLG’s misleading grades.

Answer: Subject to the foregoing objections, Plaintiff will produce and identify documents related to the significant reputational harm caused by TLG’s deceptive and unfair Safety Grades that provide sufficient detail to respond to this Interrogatory.

Amended Answer: Subject to the foregoing objections, Plaintiff is unaware of any documents related to this Interrogatory.

Interrogatory No. 22: Identify and describe any complaints, concerns, or comments from patients, community members, or referring physicians that relate to the hospital’s reputation or comparisons to other hospitals in the region.

Plaintiff objects to this Interrogatory because it seeks discovery of information that is overly broad, unduly burdensome and irrelevant to the claims and defenses in this Action and is not proportional to the needs of this Action to the extent it seeks “comments and concerns” from patients, community members, or referring physicians that have nothing to do with the significant reputational harm caused by TLG’s misleading grades. Plaintiff also objects to this interrogatory as seeking protected health information that is protected from disclosure by HIPAA, among other statutes and regulations. Plaintiff will only produce this information as needed and subject to the agreed protective order entered by this Court.

Answer: Subject to the foregoing objections, Plaintiff has received reports that patients and physicians considered or decided not to use Plaintiff’s facility because of TLG’s misleading grades.

Amended Answer: Subject to the foregoing objections, Plaintiff has received reports that patients and physicians considered or decided not to use Plaintiff’s facility because of TLG’s misleading grades. In addition, concerns have been raised by patients, doctors, staff, and community members, and Plaintiff is aware of false and misleading statements based on TLG’s false and misleading methodology and Safety Grades made in newspapers, viral social-media videos, television programs, and blogs.

Our Medical Executive Committee has received direct inquiries from patients regarding their concerns with TLG’s grades and related public reports. An emergency-department patient, who needed surgery, said that he was leaving because of the Leapfrog grade. The harm caused by TLG’s false and misleading Safety Grade is ongoing.

In addition, the following produced documents evidence such harm.

Start Page	End Page
PBHN000006771	PBHN000006773
PBHN000002082	PBHN000002085
PBHN000002066	PBHN000002070
PBHN000002615	PBHN000002617
PBHN000006397	PBHN000006401
PBHN000002090	PBHN000002094
PBHN000002103	PBHN000002103

PBHN000004484	PBHN000004484
PBHN000004564	PBHN000004564
PBHN000004574	PBHN000004580
PBHN000004557	PBHN000004557
PBHN000008718	PBHN000008718
PBHN000006461	PBHN000006462
PBHN000008914	PBHN000008914
PBHN000008915	PBHN000008915

Discovery is ongoing, and Plaintiff reserves the right to amend, modify or supplement the response to this Interrogatory.

Interrogatory No. 23: List with specific detail each and every concern, complaint or comment made by any union, collective bargaining unit or employee association in any way related to patient safety at Your hospital.

Plaintiff objects to this Interrogatory because it seeks discovery of information that is overly broad, unduly burdensome and irrelevant to the claims and defenses in this Action and is overly broad, unduly burdensome, and not proportional to the needs of this Action to the extent it seeks “each and every concern, complaint or comment ” from third parties that have nothing to do with the significant reputational harm caused by TLG’s misleading grades. Plaintiff also objects to this Interrogatory to the extent it seeks health information that is protected from disclosure by HIPAA, among other statutes and regulations. Plaintiff will only produce this information as needed and subject to the agreed protective order entered by this Court.

Answer: Subject to the foregoing objections, Plaintiff is unaware of any concern, complaint or comment regarding TLG deceptive scores made by the union at Plaintiff’s hospital.

Amended Answer: Subject to the foregoing objections, Plaintiff is unaware of any concern, complaint, or comment regarding TLG's deceptive scores or regarding patient safety made by the union at Plaintiff's hospital.

Interrogatory No. 24: Identify any and all criticism You have received since 2020 from Tenet Healthcare Corporation and/or from any individual executive of Tenet Healthcare Corporation regarding Your hospital's performance in any way.

Answer: Plaintiff objects to this Interrogatory because it seeks discovery of information that is overly broad, unduly burdensome and irrelevant to the claims and defenses in this Action and is not reasonably calculated to lead to the discovery of admissible evidence. Any so-called "criticism" has nothing to do with the claims and defenses related to TLG's decision to use deceptive business practices. TLG has, therefore, only propounded this Interrogatory for purposes of harassment. Plaintiff declines to respond to this Interrogatory.

Amended Answer: As discussed during the parties' meet and confer on September 3, 2025, TLG agreed to narrow this Interrogatory to concern only "criticism...regarding Your hospital's patient safety." After a reasonable and diligent search, Plaintiff is unaware of having received "criticism" from Tenet Health Corporation regarding patient safety. Plaintiff is always working to improve its performance, quality, and safety in a constructive way and engages with Tenet Health Corporation as needed to ensure Plaintiff provides the best patient care possible.

Dated: September 8, 2025

Respectfully submitted,

By: /s/ Lee R. Crain

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CERTIFICATE OF SERVICE

This is to certify that true and correct copies of Plaintiff's Amended and Supplemented Responses and Objections to Defendant The Leapfrog Group's First Sets of Interrogatories to Plaintiff have been served on counsel for The Leapfrog Group by electronic transmission.

/s/ Lee R. Crain
Lee R. Crain

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

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

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

Plaintiffs,

v.

THE LEAPFROG GROUP,

Defendant.

**AFFIDAVIT OF JERAD HANLON IN SUPPORT OF
PLAINTIFF WEST BOCA MEDICAL CENTER, INC.'S
AMENDED AND SUPPLEMENTED RESPONSES AND OBJECTIONS TO
DEFENDANT THE LEAPFROG GROUP'S FIRST SET OF
INTERROGATORIES TO WEST BOCA MEDICAL CENTER**

I, Jerad Hanlon, declare as follows:

1. I am over 21 years of age and competent to give this testimony.
2. I am the Chief Executive Officer of West Boca Medical Center, Inc. ("Plaintiff"). I am the corporate representative of Plaintiff for the purpose of answering Defendant The Leapfrog Group's First Set of Interrogatories to West Boca Medical Center. I have read the foregoing interrogatories and the answers to those interrogatories, which are true according to the best of my knowledge, information, and belief.
3. I declare under penalty of perjury that the foregoing is true and correct.

Executed on September 8, 2025.



Jerad Hanlon

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

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

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

Plaintiffs,

v.

THE LEAPFROG GROUP,

Defendant.

**PLAINTIFF DELRAY MEDICAL CENTER, INC.’S
AMENDED AND SUPPLEMENTED RESPONSES AND OBJECTIONS TO
DEFENDANT THE LEAPFROG GROUP’S FIRST SET OF
INTERROGATORIES TO DELRAY MEDICAL CENTER, INC.**

Pursuant to Federal Rules of Civil Procedure 26 and 33 and the *Pretrial Scheduling Order and Order Referring Case to Mediation* (ECF No. 36) (the “Pretrial Scheduling Order”), Plaintiff Delray Medical Center, Inc. (“Plaintiff” or “Delray”), by and through its undersigned counsel, hereby submit its amended and supplemented responses and objections (“Responses”), to Defendant The Leapfrog Group’s (“TLG”) First Set of Interrogatories, dated July 11, 2025 (the “Interrogatories” and each numbered interrogatory, an “Interrogatory”) in the above-captioned action (the “Action”).

Plaintiff’s Responses to the Interrogatories are made solely for purposes of this Action and to the best of Plaintiff’s present knowledge, information, and belief regarding the matters about which inquiry have been made. Discovery is ongoing, and Plaintiff reserves the right to amend, supplement, clarify, or further explain its Responses at any time prior to the trial in

this Action. Plaintiff further reserves the right to raise any additional objections deemed necessary or appropriate in light of any further review.

OBJECTIONS TO INSTRUCTIONS AND DEFINITIONS

1. Plaintiff objects to the definition of terms “Plaintiffs” and “Plaintiff Hospitals” as overbroad, unduly burdensome, and not proportional to the needs of the case to the extent it seeks to require Plaintiffs to respond on behalf of entities or individuals other than themselves.

2. Plaintiff objects to the definition of the terms “Delray,” “Delray Medical Center,” “Plaintiff,” “You,” and “Your” to the extent each term seeks to require Plaintiff to respond on behalf of entities or individuals other than itself, including on behalf of agents, employees, directors, or other non-party entities that are not part of this litigation. Such information is overbroad and beyond the scope of permissible discovery. Accordingly, Plaintiff states that its Responses are on behalf of itself only.

3. Plaintiff objects to the definition of the terms “Tenet Healthcare” and “Tenet” to the extent it seeks to require Plaintiff to respond on behalf of entities or individuals other than itself, including on behalf of Tenet, Tenet’s agents, employees, directors, or other non-party entities that are not part of this litigation. Such information is overbroad and beyond the scope of permissible discovery. Accordingly, Plaintiff states that its Responses are on behalf of itself only.

4. Plaintiff objects to the definition of “identify, when referring to a person,” as overbroad and unduly burdensome to the extent it calls for the “address” and “present or last-known employer” of identified individuals. Such information is overbroad and beyond the scope of permissible discovery.

5. Plaintiff objects to the instruction that the relevant time period for the Interrogatories begins on January 1, 2020. Plaintiff will apply to each Interrogatory the time period

of November 1, 2023 to present (the “Relevant Time Period”). Any response to an Interrogatory that provides information that falls outside of the Relevant Time Period should not be construed as an admission that the Relevant Time Period begins prior to November 1, 2023.

SPECIFIC RESPONSES TO INTERROGATORIES

Interrogatory No. 1: State the full name, address, job title or position, and hospital or employer affiliation of all individuals that assisted with responding to these interrogatories.

Answer: The following individuals assisted with responding to these Interrogatories.

Full Name	Address	Job Title / Position	Hospital or Employer Affiliation
Heather Havericak	c/o Gibson, Dunn & Crutcher LLP 200 Park Avenue New York, NY 10166	Chief Executive Officer	Delray Medical Center
Regina West	c/o Gibson, Dunn & Crutcher LLP 200 Park Avenue New York, NY 10166	Market Quality Director	Palm Beach Health Network and St. Mary’s Medical Center

Interrogatory No. 2: Identify every individual not identified in Your Rule 26(a) initial disclosures with knowledge of facts pertaining to the allegations in Your Complaint in this Lawsuit (and any subsequent amendments) and/or whom You believe may have discoverable knowledge, information or data regarding this matter, including those who You expect to call as a fact or opinion witness at any hearing in this proceeding or whose testimony (by affidavit, deposition or testimony) You intended to submit in connection with this proceeding, and the substance of his/her testimony or affidavit, and, with respect to each person identified, provide:

- A. full name,
- B. address,
- C. telephone number,
- D. job title or position,
- E. hospital or employer affiliation,
- F. and describe in detail the facts possessed by each such person.

Plaintiff objects to this Interrogatory as overly broad, unduly burdensome, and not proportional to the needs of this Action to the extent it seeks the identity of “every individual...with knowledge” or who “may have discoverable knowledge, information or data regarding this matter.” Plaintiff will not provide more than the identity of individuals most likely to have knowledge regarding this matter. Plaintiff further objects to this Interrogatory as premature because it requests disclosure of Plaintiff’s witnesses for hearings and the substance of witness testimony before such disclosure is required under applicable law or the Pretrial Scheduling Order. Plaintiff will submit its trial witness list on October 2, 2025, per the Pretrial Scheduling Order, and disclose any other witnesses and witness testimony as further ordered by the Court or otherwise required by applicable law. Plaintiff also objects to this Interrogatory’s request for the identity of “opinion witness[es]” as vague, since witnesses are either “fact” or “expert” witnesses. Plaintiff will interpret “opinion witness” to mean “expert witness.” Plaintiff submitted expert reports on August 7, 2025, per the Pretrial Scheduling Order.

Answer: Subject to the foregoing objection, Plaintiff will amend its Rule 26(a)(1) Initial Disclosures to identify additional individuals who may have knowledge of facts pertaining to the allegations in the Complaint.

Amended Answer: In addition to those disclosed in Plaintiff’s supplemental disclosures, the following individuals may have relevant factual knowledge:

Full Name	Address	Job Title / Position	Hospital or Employer Affiliation
Regina West	c/o Gibson, Dunn & Crutcher LLP 200 Park Avenue New York, NY 10166	Market Quality Director	Palm Beach Health Network and St. Mary’s Medical Center

Full Name	Address	Job Title / Position	Hospital or Employer Affiliation
Stephany Johnson	c/o Gibson, Dunn & Crutcher LLP 200 Park Avenue New York, NY 10166	Quality Director	Delray Medical Center

In addition to the individuals identified above, persons identified in documents produced in this dispute have knowledge of facts pertaining to the allegations in the Amended Complaint. *See* Fed. R. Civ. P. 33(d). Discovery is ongoing, and Plaintiff reserves the right to supplement, amend, correct, clarify, or modify this Response as further information becomes available.

Interrogatory No. 3: Describe in detail all factual bases for Your contention that Leapfrog’s published Safety Grade for Your hospital was false, inaccurate, misleading, deceptive, or unfair. In so answering, identify with particularity each measure, data point, or metric that You contend was inaccurately reported, calculated, or misrepresented by Leapfrog in calculating the Safety Grade for Your hospital.

Answer: Plaintiff objects to this Interrogatory as overly broad, unduly burdensome, and not proportional to the needs of this Action to the extent it seeks “all factual bases” for Plaintiff’s contention. *See Megdal Assocs., LLC v. La-Z-Boy, Inc.*, 2016 WL 4503337, at *6 (S.D. Fla. Feb. 1, 2016) (finding interrogatories asking for “‘all’ facts or witnesses that support an opposing party’s case” to be “unduly broad”) (citing 8B Wright, Miller, & Kane, Federal Practice and Procedure: Civil 3d § 2167 (2015)). Plaintiff further objects to this Interrogatory as premature to the extent it requests that Plaintiff “[d]escribe in detail all factual bases” to support its contention. *In re Reliance Fin. & Inv. Grp., Inc.*, 2006 WL 8435541, at *4 (S.D. Fla. Feb. 14, 2006) (Contention interrogatories “are more appropriately used after a substantial amount of discovery has been conducted--typically, at the end of the discovery period.”). Plaintiff also objects to this

Interrogatory to the extent it attempts to limit or mischaracterize Plaintiff's claim as just challenging the false, inaccurate, misleading, deceptive, or unfair nature of TLG's Safety Grade. As the Court explained in its order denying TLG's motion to dismiss, the core of the Complaint is "a challenge to Defendant's representations about its methodology, which they claim mislead consumers by failing to distinguish between absent data and damning data, and professing that grades are not influenced by a hospital's lack of survey participation." *Order on Motion to Dismiss* 6 (ECF No. 41). Plaintiff also challenges the provably false facts and deceptive scoring system underlying these grades, which TLG admits it relies on to arrive at its deceptive Safety Grades.

Subject to the foregoing objections and as more fully stated in the *Amended Complaint* (ECF No. 74) ("Complaint"), TLG has engaged in deceptive and unfair business practices and misrepresentations when issuing the Safety Grade for Plaintiff's hospital as part of TLG's annual "Hospital Survey." TLG posts these Safety Grades online at hospitalsafetygrade.org.

To arrive at these Safety Grades, TLG uses CMS data, survey responses from participating hospitals, and other supplemental data sources. For participating hospitals, TLG uses the hospitals' self-reported responses to the Hospital Survey for 12 of the 22 measures. For non-participating hospitals, TLG uses other sources for those 12 measures. For the remaining four measures—Computerized Physician Order Entry, Bar Code Medication Administration, ICU Physician Staffing, and Hand Hygiene Score (the "Deceptive Score Categories")—TLG devised and uses a so-called "imputation model." Prior to Fall 2024, TLG's imputation model assigned non-participating hospitals a score based on the average score applicable to a similarly situated hospital. Beginning in Fall 2024, TLG modified its imputation model. TLG now assigns the lowest possible score to non-participating hospitals, which has the effect of punishing non-participating hospitals and artificially deflating their Safety Grades. TLG has even admitted the changes in Fall 2024

were designed to penalize non-participating hospitals. TLG also misleads consumers about how it grades hospitals, stating “[t]he Hospital Safety Grade reflects how well a hospital does on safety, not whether they complete the [TLG] Hospital Survey.” *Declaration of Lee Crain* (ECF No. 21) (“Crain Decl.”), Ex. 1 at 4 (“Frequently Asked Questions About the Leapfrog Hospital Safety Grade”).

As TLG explains, “not all hospitals have enough data publicly available to be eligible for a grade.” Crain Decl. Ex. 1 at 5. “As per the National Expert Panel guidance, [TLG] has requirements for the minimum amount of data [it] need[s] to issue an accurate grade.” Crain Decl. Ex. 1 at 5. According to TLG, “[h]ospitals missing more than six process measures” are “not graded.” Crain Decl. Ex. 2 at 6. Non-participating hospitals should fall easily into that “not graded” bucket, because their decision not to participate in TLG’s survey necessarily means TLG is missing seven process measures that rely on voluntary submission of hospital data.¹

TLG then deceptively conceals how it makes up grades for the four “imputation” measures and even suggests on its website that TLG *does* have data sufficient to score TLG on those four measures. By way of example, TLG acknowledges that Plaintiff “Declined to Report” information in response to questions about “Staff work[ing] together,” but then tells consumers—as if it were a fact—that Plaintiff is “Worse Than Average” on “Handwashing,” “Communication,” “medication administration,” and the like—even though TLG has no basis whatsoever to adopt those conclusions. Crain Decl. Ex. 32 at 2. TLG itself says handwashing is among the “most important” measures in its survey, Crain Decl. Ex. 15 at 4, yet it deceptively conceals that it has no data with which to grade the Plaintiff hospital on that measure. *Defendant The Leapfrog*

¹ Those seven include CPOE, BCMA, IPS, Safe Practice 1: Culture of Leadership Structures and Systems; Safe Practice 2: Culture Measurement, Feedback & Intervention; Total Nursing Care Hours per Patient Day; and Hand Hygiene.

Group's Responses to Plaintiffs' Requests for Production at 7 ("Leapfrog is not itself in possession of data showing Plaintiffs' performance on the 'imputed metrics' considered by the methodology."). Of course, Plaintiff in fact has a comprehensive and thorough handwashing policy. And had Plaintiff merely filled out TLG's survey, it would have received a full two letter grades higher on TLG's score. *Expert Report of Professor Sean Nicholson* (Aug. 7, 2025), Ex. 6.

Based on the foregoing, and as more fully set forth in the Complaint, TLG engages in deceptive trade practices by, among other things, deceiving consumers about its grading methods by implying that Plaintiff has failed on certain measures that, in truth, TLG has no data or other basis to evaluate; deceiving consumers by telling them the Hospital Safety Grade reflects how well a hospital does on safety, not whether they complete the Hospital Survey; deceiving consumers when it represents that it does not grade hospitals if it lacks sufficient data, when, in truth, it does grade hospitals by "imputing" or making up a grade for the Deceptive Score Categories; hiding the truth about its "imputation model" from consumers by burying it in fine print on a separate website; punishing non-participating hospitals by "imputing" scores, which artificially deflate a hospital's Safety Grade; and favoring participating hospitals. Additional factual bases for the Plaintiff's claims are presented in the Complaint.

Interrogatory No. 4: Describe the scoring or grading methodology You believe Leapfrog should have used to assess Your hospital's patient safety performance and explain why that method would yield a different result.

Plaintiff objects to this Interrogatory because it seeks discovery of information that is irrelevant to the claims and defenses in this Action and is overly broad, unduly burdensome, and not proportional to the needs of this Action. Plaintiff's provision of an alternative scoring or grading methodology has nothing to do with the claims and defenses in this case related to TLG's

decision to use deceptive business practices. Plaintiff further objects to this Interrogatory to the extent it calls for speculation.

Answer: Plaintiff declines to respond to this Interrogatory.

Amended Answer: Subject to the foregoing objections, Plaintiff responds that TLG should use a scoring system that is not unfair or deceptive. By way of example only, TLG could decline to grade hospitals that do not participate in TLG's survey, because their decision not to participate means TLG is missing seven process measures that rely on voluntary submission of hospital data. This would yield a different result, because the hospitals would not receive a grade at all. TLG's methodology certainly should not affirmatively assign an arbitrary low score to a particular metric just because a hospital does not provide data for that metric.

Interrogatory No. 5: State whether You submitted any data, corrections, or appeals to Leapfrog regarding the Safety Grade Your hospital received, and for each such submission, identify the date of the submission, the medium of the submission (i.e. telephone, video conference, email, letter, etc.), who was involved in the submission, and the content of the submission.

Plaintiff objects to this Interrogatory because it seeks discovery of information that is irrelevant to the claims and defenses in this Action and is overly broad, unduly burdensome, and not proportional to the needs of this Action. Whether or not Plaintiff submitted "any data, corrections, or appeals to Leapfrog regarding the Safety Grade" Plaintiff hospital received has nothing to do with the claims and defenses in this case related to TLG's decision to use deceptive business practices. Plaintiff further objects to this Interrogatory to the extent it seeks information that is already in TLG's possession, custody and control, or equally available to TLG.

Answer: Subject to the foregoing objections, Plaintiff engaged in correspondence prior to the commencement of this case demanding that TLG reform its deceptive practices and cease and desist reporting deceptive and unfair Safety Grades, but at every turn TLG refused.

Amended Answer: Subject to the foregoing objections, Plaintiff did not submit any data, corrections or appeals to Leapfrog regarding the Safety Grades it has received.

Interrogatory No. 6: State whether You provided any comment or input in any form during Leapfrog's requests for public comments for planned updates to the Leapfrog Hospital Safety Grade methodology that was proposed for the calculation of Hospital Safety Grades (including but not limited to for the Fall 2024 methodology update). If yes, please identify the date of the comment, the medium of the submission (i.e. telephone, video conference, email, letter, etc.), who was involved in the comment and the content of the comment. If no, please state the reason why You chose not to comment.

Answer: Plaintiff objects to this Interrogatory because it seeks discovery of information that is irrelevant to the claims and defenses in this Action and is overly broad, unduly burdensome, and not proportional to the needs of this Action. Whether or not Plaintiff submitted "any comment or input" in response to TLG's request for public comments has nothing to do with claims and defenses in this case related to TLG's decision to use deceptive business practices. Plaintiff further objects to this Interrogatory to the extent it seeks information that is already in TLG's possession, custody and control, or equally available to TLG.

Subject to the foregoing objections, Plaintiff did not provide comments in response to Leapfrog's requests for public comments for planned updates to the Leapfrog Hospital Safety Grade scoring system because Plaintiff generally does not respond to requests for public comment from private entities like TLG.

Interrogatory No. 7: Describe all actions Your hospital took in response to (or in deciding not to respond to) its Safety Grade or the Hospital Survey, including internal meetings, media statements, or public relations efforts. In so answering, state the date of the action, the individuals involved in the action and the content of the action.

Plaintiff objects to this Interrogatory as overly broad, unduly burdensome, and not proportional to the needs of this Action to the extent it seeks “all actions” Plaintiffs may have taken in response to TLG’s Safety Grades. *See Megdal Assocs., LLC v. La-Z-Boy, Inc.*, No. 14-81476-CIV, 2016 WL 4503337, at *6 (S.D. Fla. Feb. 1, 2016) (finding interrogatories asking for “‘all’ facts or witnesses that support an opposing party’s case” to be “unduly broad”) (citing 8B Wright, Miller, & Kane, Federal Practice and Procedure: Civil 3d § 2167 (2015)). Plaintiff further objects to this Interrogatory to the extent it seeks information that is subject to a claim of privilege or otherwise protected from disclosure, including seeking information protected by the attorney-client privilege, work-product doctrine, or other immunity.

Answer: Subject to the foregoing objections, Plaintiff devoted substantial time and resources that could have otherwise been spent continuing to improve patient care to respond to the significant harm and disruption caused by TLG’s deceptive and unfair Safety Grade. Plaintiff’s response included meeting internally with Plaintiff’s leadership team, medical executive committee, and governing board, corresponding with TLG to demand that TLG reform its deceptive practices and cease and desist reporting deceptive and unfair Safety Grades, and devoting substantial time and resources to facilitate the preparation and prosecution of this Action.

Amended Answer: Subject to the foregoing objections, Plaintiff devoted substantial time and resources that could have otherwise been spent continuing to improve patient care to respond to the significant harm and disruption caused by TLG’s deceptive and unfair Safety Grades. Plaintiff’s response included meeting internally with Plaintiff’s leadership team, medical executive

committee, and governing board, corresponding through Plaintiff's corporate parent with TLG to demand that TLG reform its deceptive practices and cease and desist reporting deceptive and unfair Safety Grades, and devoting substantial time and resources to facilitate the preparation and prosecution of this Action. Plaintiff has also held many phone calls and meetings with physicians and other stakeholders about the TLG grades, explaining how the grades were deceptive and did not accurately reflect the hospital quality and patient safety at Plaintiff.

Interrogatory No. 8: Identify any and all persons, whether internal or external (e.g., patients, vendors, affiliates, parents, agents, partners, media) with whom You communicated in any way with respect to the Safety Grade or the Hospital Survey. In so answering, state the date of the communication, the individuals involved in the communication, the medium of the communication (i.e. telephone, video conference, email, letter, etc.) and the content of the communication.

Plaintiff objects to this Interrogatory as overly broad, unduly burdensome, and not proportional to the needs of this Action to the extent it seeks the identity of "any and all persons, whether internal or external." Plaintiff will disclose the categories of individuals with whom Plaintiff communicated about the Safety Grade or Hospital Survey during the Relevant Time Period. Plaintiff also objects to this Interrogatory to the extent it seeks protected health information that Health Insurance Portability and Accountability Act ("HIPAA"), among other statutes and regulations, bars Plaintiff from disclosing. Plaintiff further objects to this Interrogatory to the extent it seeks information that is subject to a claim of privilege or otherwise protected from disclosure, including seeking information protected by the attorney-client privilege, work-product doctrine, or other immunity.

Answer: Subject to the foregoing objections, Plaintiff communicated with the following categories of people regarding the Safety Grade or the Hospital Survey: Plaintiff's governing board, its medical executive committee, department directors, and physicians and nurses when

asked about the Safety Grade or Hospital Survey. These communications occurred in and after Fall 2024, after TLG released its deceptive and unfair Safety Grade for Plaintiff's hospital. Most of these communications occurred during regularly scheduled meetings, during which attendees were told about TLG's release of the deceptive and unfair Safety Grade, that Plaintiff does not participate in the Hospital Survey because it is unreliable and not an accurate reflection of hospital quality and safety or patient outcomes, and that the Safety Grade, which was not based on any information provided by Plaintiff, was misleading. The Palm Beach Health Network also issued a press release and since then, has engaged in various social networking and other marketing campaigns to counteract TLG's deceptive scores on behalf of Plaintiff and other affected members of the network.

Amended Answer: Subject to the foregoing objections, Plaintiff communicated with the following categories of people regarding the Safety Grade or the Hospital Survey: Plaintiff's governing board, its medical executive committee, department directors, physicians and nurses, and patients when asked about the Safety Grades or Hospital Survey. These communications occurred in and after Fall 2024, after TLG released its deceptive and unfair Safety Grades for Plaintiff's hospital. Most of these communications occurred during regularly scheduled meetings, during which attendees were told about TLG's release of the deceptive and unfair Safety Grade, that Plaintiff does not participate in the Hospital Survey because it is unreliable and not an accurate reflection of hospital quality and safety or patient outcomes, and that the Safety Grade, which was not based on any information provided by Plaintiff, was misleading. The Palm Beach Health Network also issued a press release and has engaged in marketing efforts, including through social media, to counteract TLG's deceptive scores on behalf of Plaintiff and other affected members of

the network. Plaintiff also engaged in email discussions about TLG's misleading grades, either as sender or recipient, which TLG has through Plaintiff's production of documents.

Interrogatory No. 9: Describe all instances in which a third party declined to contract with, refer patients to, or work with Your hospital, where Leapfrog's grade was cited or discussed. In so identifying list the name of the individuals involved in the communication, the medium of the communication (i.e. telephone, video conference, email, letter, etc.), the date of the communication and the content of the communication.

Plaintiff objects to this Interrogatory as overly broad, unduly burdensome, and not proportional to the needs of this Action to the extent it requires Plaintiff to "[d]escribe all instances" in which a third party took an action in response to TLG's deceptive grade.

Answer: Subject to the foregoing objection, Plaintiff is not aware of any responsive instances.

Amended Answer:

Subject to the forgoing objection, by way of example, medical professionals have expressed concern about working with the Medical Center due to the grade TLG assigned it.

Interrogatory No. 10: Describe with specificity the basis for each and every category of damage You claim You incurred as a result of the Leapfrog Safety Grade. In so identifying, list each category of damages and the dollar value of each category of damage You claim.

Plaintiff objects to this Interrogatory to the extent it seeks information that is the subject of expert testimony.

Answer: Plaintiff will submit expert reports on August 7, 2025, per the Pretrial Scheduling Order.

Amended Answer: Plaintiff has served the expert report of Thomas Chakurda, which addresses the issue of reputational harm and harm to Plaintiff's goodwill. Plaintiff further objects

to this Interrogatory as overbroad and unduly burdensome to the extent it seeks “each and every” category of claimed damages.

Subject to the foregoing objections and as agreed during the parties’ September 3, 2025 meet and confer, Plaintiff will limit its response to the live non-monetary claims, including injunctive and declaratory relief, to remedy harm to Plaintiff’s reputation and goodwill. Plaintiff’s reputation and goodwill has been damaged by TLG’s false and misleading methodology and resulting Safety Grades. Plaintiff’s claim for reputational harm is based on, among other things, concerns raised by patients, doctors, staff, and community members, as well as false and misleading statements based on TLG’s false and misleading methodology and Safety Grades made in newspapers, viral social-media videos, television programs, and blogs.

By way of example, our Medical Executive Committee has received direct inquiries from patients regarding their concerns as to TLG’s grades and related public reports. Patients have told physicians that they do not want to go to the Medical Center for surgeries after seeing TLG’s grade and associated press reports. Medical professionals have expressed concern about working with the Medical Center due to the grade TLG assigned it. Further, we have received reports from patients and doctors that patients have planned to drive past the Medical Center to a farther away medical facility due to the grade assigned by TLG to the Medical Center. Community members have given negative feedback related to the rating. The harm caused by TLG’s false and misleading Safety Grade is ongoing.

Interrogatory No. 11: Identify all adverse patient events which occurred at Your hospital, including any citations received from regulatory agencies, accrediting agencies, and third party payors such as The Joint Commission, CMS, state health departments, etc. during the period covered by each Leapfrog Safety Grade publication of which You complain (i.e., Fall 2024, Fall 2025, etc.), as well as any complaints received from patients regarding the same.

Plaintiff objects to this Interrogatory because it is overly broad, unduly burdensome, seeks discovery of information that is irrelevant to the claims and defenses in this Action, seeks information that is beyond the scope of Leapfrog's Hospital Survey, and is not reasonably calculated to lead to the discovery of admissible evidence. TLG does not include "all adverse patient events," "citations received from" agencies or payors, or "complaints received from patients" in TLG's determination of its Hospital Safety Grades or request such information in the Hospital Survey, so any such information is irrelevant to whether TLG's actions constitute unfair or deceptive trade practices. TLG has, therefore, only propounded this Interrogatory for purposes of harassment. Plaintiff also objects to this Interrogatory to the extent it seeks protected health information that HIPAA, among other statutes and regulations, bars Plaintiff from disclosing.

Answer: Plaintiff declines to respond to this Interrogatory.

Amended Answer: Defendant has agreed to withdraw this Interrogatory.

Interrogatory No. 12: Describe in detail how Your hospital compares nationally on on [sic] any other ranking of patient safety performance, including but not limited to Vizient, Inc., Premier, Inc., HealthTrust Purchasing Group, The Joint Commission, HealthGrades, US News, Newsweek, Statista, Definitive Healthcare, or any other quality benchmarking entity including benchmarking on patient safety including on adverse events and on healthcare-acquired infections.

Plaintiff objects to this Interrogatory's request that Plaintiff "[d]escribe in detail how Your hospital compares nationally" based on undisclosed "benchmarking" as vague and confusing. To the extent this Interrogatory seeks the top-line rankings of the identified organizations, Plaintiff objects to this Interrogatory because such information is publicly and equally available to TLG. To the extent this Interrogatory asks Plaintiff to compare itself to the named and unnamed entities, that request is overly broad, unduly burdensome, and not proportional to the needs of this Action. Plaintiff further objects to this Interrogatory because it seeks discovery of information that is

irrelevant to the claims and defenses in this Action and is overly broad, unduly burdensome, and not proportional to the needs of this Action. Other organizations' rankings have nothing to do with the claims and defenses in this case related to the Deceptive Score Categories or TLG's decision to use deceptive business practices.

Answer: Subject to the foregoing objections, Plaintiff has received numerous awards and accolades. For example, Plaintiff was awarded the Resuscitation Center of Excellence award for 2025, becoming the first hospital in Palm Beach County to be named a Florida Resuscitation Center of Excellence. To do so, Plaintiff met approximately 15 criteria for patient care that were established by the Florida Resuscitation Center Committee, including intensive neurological monitoring, strong collaboration with Emergency Medical Services partners, and community outreach programs to promote health and lifestyle modifications to decrease the prevalence of cardiac disease. Additionally, the American College of Surgeons awarded Plaintiff the Metabolic and Bariatric Surgery Accreditation and Quality Improvement Program ("MBSAQIP") Surgery Center of Excellence award, which is dedicated to enhancing the safety and quality of care for bariatric patients in the United States and Canada. MBSAQIP accreditation promotes uniform standards and continuous quality improvement.

Plaintiff also earned DNV GL Comprehensive Stroke certification, which means Plaintiff gives the highest quality of care to most complete patient cases and offers evidence-based treatments with cutting-edge research protocols. Additionally, Plaintiff earned the VQI (Vascular Quality Initiative) Carotid Care Champion this year, which honors participants that are dedicated to improving the safety and effectiveness of vascular care. Plaintiff is also accredited by the Joint Commission, the nation's largest hospital accreditor that evaluates hospitals' quality performance standards through an objective evaluation process. Plaintiff also earned a Certification for the

American Association of Cardiovascular and Pulmonary Rehabilitation Program. This accreditation is peer-reviewed and designed to review individual facilities.

The American Heart Association honored Plaintiff with “Get with the Guidelines” Gold Plus awards in three specializations. First, Plaintiff earned the Target Stroke Honor Roll Elite, meaning Plaintiff is able to achieve door-to-needle times of within 60 minutes for at least 85% of applicable patients. Second, Plaintiff earned the Target Stroke Honor Roll Advanced Therapy, meaning that 50% of applicable patients are able to achieve door-to-device times of 90 minutes or less in the case of directly arriving patients, and 60 minutes or less for transfer patients. Third, Plaintiff earned the Target Type II Diabetes Honor Roll, meaning that Plaintiff met numerous requirements, including qualifying for a Silver level or higher Achievement Award in the “Get with the Guidelines-Heart Failure, Stroke, and/or Coronary Artery Disease” modules. The entities that award and assign these accreditations and certifications visit the healthcare facility and perform regular periodic in-person reviews, audits, surveys, and assessments of the facility.

In 2025, the medical ranking organization Healthgrades named Plaintiff one of the top 250 hospitals in the country. To assess and evaluate hospitals, Healthgrades relies on data from Medicare medical claims records and states’ data on Medicare and commercially insured patient outcomes to determine patients’ actual clinical outcomes when visiting a given hospital. Healthgrades also assigned Plaintiff the following awards:

a. Cardiac Care

- i. Five-Star Recipient for Valve Surgery (2024-2025, two years in a row)
- ii. Five-Star Recipient for Treatment of Heart Attack (2024-2025, two years in a row)

- iii. Five-Star Recipient for Treatment of Heart Failure (2003-2025, 23 years in a row)
- iv. Five-Star Recipient for Defibrillator Procedures (2024-2025, two years in a row)
- v. Five-Star Recipient for Treatment of Stroke (2008-2025, 18 years in a row)
- vi. Five-Star Recipient for Coronary Interventional Procedures (2024)

b. Pulmonary Care

- i. One of Healthgrades America's 100 Best Hospitals for Pulmonary Care in 2025
- ii. Recipient of the Healthgrades 2025 Pulmonary Care Excellence Award
- iii. Top 5% in the Nation for Overall Pulmonary Services (2025)
- iv. Top 10% in the Nation for Overall Pulmonary Services (2025)
- v. Five-Star Recipient for Treatment of Pneumonia (2024-2025, two years in a row)

c. Critical Care

- i. Recipient of the Healthgrades 2025 Critical Care Excellence Award
- ii. Top 5% in the Nation for Critical Care (2025)
- iii. Top 10% in the Nation for Critical Care (2025)
- iv. Five-Star Recipient for Treatment of Sepsis (2004-2025, 22 years in a row)
- v. Five-Star Recipient for Treatment of Respiratory Failure (2023-2025, three years in a row)

d. Gastrointestinal

- i. Five-Star Recipient for Upper Gastrointestinal Surgery (2022-2024, three years in a row)
- ii. Five-Star Recipient for Small Intestine Surgeries (2017-2021 (five years in a row), 2024)

e. Neurosurgery

- i. Five-Star Recipient for Cranial Neurosurgery (2024)

In addition, Plaintiff will produce and identify documents reflecting some of Plaintiff's rankings from other organizations.

Amended Answer: Subject to the foregoing objections, Plaintiff has received numerous awards and accolades. For example, Plaintiff was awarded the Resuscitation Center of Excellence award for 2025, becoming the first hospital in Palm Beach County to be named a Florida Resuscitation Center of Excellence. Additionally, the American College of Surgeons awarded Plaintiff the Metabolic and Bariatric Surgery Accreditation and Quality Improvement Program ("MBSAQIP") Surgery Center of Excellence award, which is dedicated to enhancing the safety and quality of care for bariatric patients in the United States and Canada.

Plaintiff also earned DNV GL Comprehensive Stroke certification. Additionally, Plaintiff earned the VQI (Vascular Quality Initiative) Carotid Care Champion this year, which honors participants that are dedicated to improving the safety and effectiveness of vascular care. Plaintiff is also accredited by the Joint Commission, the nation's largest hospital accreditor that evaluates hospitals' quality performance standards through an objective evaluation process. Plaintiff also earned a Certification for the American Association of Cardiovascular and Pulmonary Rehabilitation Program.

The American Heart Association honored Plaintiff with “Get with the Guidelines” Gold Plus awards in three specializations: Target Stroke Honor Roll Elite, Target Stroke Honor Roll Advanced Therapy, and Target Type II Diabetes Honor Roll.

In 2025, the medical ranking organization Healthgrades named Plaintiff one of the top 250 hospitals in the country. Healthgrades also assigned Plaintiff the following awards:

a. Cardiac Care

- i. Five-Star Recipient for Valve Surgery (2024-2025, two years in a row)
- ii. Five-Star Recipient for Treatment of Heart Attack (2024-2025, two years in a row)
- iii. Five-Star Recipient for Treatment of Heart Failure (2003-2025, 23 years in a row)
- iv. Five-Star Recipient for Defibrillator Procedures (2024-2025, two years in a row)
- v. Five-Star Recipient for Treatment of Stroke (2008-2025, 18 years in a row)
- vi. Five-Star Recipient for Coronary Interventional Procedures (2024)

b. Pulmonary Care

- i. One of Healthgrades America’s 100 Best Hospitals for Pulmonary Care in 2025
- ii. Recipient of the Healthgrades 2025 Pulmonary Care Excellence Award
- iii. Top 5% in the Nation for Overall Pulmonary Services (2025)
- iv. Top 10% in the Nation for Overall Pulmonary Services (2025)

- v. Five-Star Recipient for Treatment of Pneumonia (2024-2025, two years in a row)

c. Critical Care

- i. Recipient of the Healthgrades 2025 Critical Care Excellence Award
- ii. Top 5% in the Nation for Critical Care (2025)
- iii. Top 10% in the Nation for Critical Care (2025)
- iv. Five-Star Recipient for Treatment of Sepsis (2004-2025, 22 years in a row)
- v. Five-Star Recipient for Treatment of Respiratory Failure (2023-2025, three years in a row)

d. Gastrointestinal

- i. Five-Star Recipient for Upper Gastrointestinal Surgery (2022-2024, three years in a row)
- ii. Five-Star Recipient for Small Intestine Surgeries (2017-2021 (five years in a row), 2024)

e. Neurosurgery

- i. Five-Star Recipient for Cranial Neurosurgery (2024)

In addition, Plaintiff will produce and identify documents reflecting some of Plaintiff's rankings from other organizations.

Also, Plaintiff does not participate in Vizient and has not done so during the Relevant Time Period.

Interrogatory No. 13: Describe any steps taken by Your hospital to improve any and all of the patient safety measures considered by Leapfrog's Hospital Safety Grade (as set forth on Leapfrog's

published scoring methodology documents; see ECF No. 21-3 at 6-10; ECF No. 21-43 at 6-9), before and after each Safety Grade publication of which You complain.

Plaintiff objects to this Interrogatory as overly broad, unduly burdensome, and not proportional to the needs of this Action to the extent it seeks the identity of Plaintiff's improvements to "any and all" patient safety measures considered by Leapfrog's Hospital Safety Grade. Plaintiff further objects to this Interrogatory because it seeks discovery of information that is irrelevant to the claims and defenses in this Action and is overly broad, unduly burdensome, and not proportional to the needs of this Action to the extent it seeks information on metrics other than TLG's Deceptive Score Categories and to the extent it seeks information that is beyond the scope of Leapfrog's Hospital Survey.

Answer: Plaintiff declines to respond to this Interrogatory.

Amended Answer: Subject to the foregoing objection, Plaintiff is committed to continual improvement of patient safety measures, motivated by our commitment to ensuring the best possible patient safety—not chasing the best possible Leapfrog grade. To achieve this core objective, Plaintiff devotes significant time and resources to improving its delivery of the highest possible quality of care for those in the community it serves, including efforts to improve its performance in areas related to the four metrics Plaintiff has chosen to impute in its survey.

Hand hygiene is reviewed at Plaintiff's monthly quality meeting by unit and by discipline. BCMA by unit is reviewed monthly by Plaintiffs' Chief Nursing Officer, and CPOE compliance is reviewed monthly through its hospitalists meetings, ensuring that providers are meeting metric.

ICU staffing is not something that needs to be monitored ongoing because Plaintiff has ICU coverage onsite 24/7 for regular critical care patients and trauma critical care patients.

Interrogatory No. 14: State whether You are aware of specific patients who have relied on the Leapfrog Safety Grade in declining to receive healthcare services at Your hospital. In so answering, identify the individual patient that declined to receive services, the date of such declination, the type of service the patient declined to receive, the medium for the communication from the patient (i.e. telephone, video conference, email, letter, etc.), the content of the communication, and the reason given for the stated decision.

Plaintiff objects to this Interrogatory as seeking protected health information that is protected from disclosure by HIPAA, among other statutes and regulations. Plaintiff will only produce this information as needed and subject to a Qualified Protective Order entered by this Court.

Answer: Subject to the foregoing objection, Plaintiff has received reports that patients considered or decided not to use Plaintiff's facility because of TLG's misleading grades.

Amended Answer: Subject to the foregoing objection, since the release of TLG's false and misleading grades, Plaintiff has received numerous reports from doctors that patients considered or decided not to use Plaintiff's facility due to concerns related to TLG's misleading grades.

Interrogatory No. 15: Describe any effort Your hospital has made to influence public perception of Your hospital's performance on patient safety following the publication of the Leapfrog Safety Grade.

Plaintiff objects to this Interrogatory as vague and ambiguous because it does not specify which Leapfrog Safety Grade is at issue. Plaintiff will construe this Interrogatory to reference TLG's deceptive Safety Grades beginning in Fall 2024. Plaintiff objects to this Interrogatory as overly broad, unduly burdensome, and not proportional to the needs of this Action to the extent it seeks "any effort" Plaintiff "has made to influence public perception" after the release of TLG's deceptive and unfair Safety Grades because there have been many such "efforts" and those

“efforts” are ongoing given the significant harm caused by TLG’s deceptive and unfair business practices.

Answer: Subject to the foregoing objections, Plaintiff continues to influence public perception by, among other things, delivering the highest quality care to the community it serves, which, as discussed in response to Interrogatory 12, has led to numerous awards, accreditations, and accolades. In addition, several public statements disputing the misleading nature of the Safety Grade have been made on Plaintiff’s behalf.

Supplemental Answer: In addition to the above, members of hospital leadership have communicated with patients, doctors, or community members on a regular basis to dispel the misleading nature of the Leapfrog Safety Grades. For instance, Plaintiff communicated its governing board, its medical executive committee, department directors, physicians and nurses, and patients when asked about the Safety Grades or Hospital Survey. These communications occurred in and after Fall 2024, after TLG released its deceptive and unfair Safety Grades for Plaintiff’s hospital. The Palm Beach Health Network also issued a press release and has engaged in marketing efforts, including through social media, to counteract TLG’s deceptive scores on behalf of Plaintiff and other affected members of the network. Plaintiff also engaged in email discussions about TLG’s misleading grades, either as sender or recipient, which TLG has through Plaintiff’s production of documents.

Interrogatory No. 16: Describe the due diligence Your hospital undertakes to ensure the accuracy of its own publicly reported safety data (including but not limited to data submitted to CMS, the CDC, and third party organizations).

Plaintiff objects to this Interrogatory as vague and ambiguous due to its use of the undefined term “due diligence.” Plaintiff further objects to this Interrogatory because it seeks

discovery of information that is irrelevant to the claims and defenses in this Action and is overly broad, unduly burdensome, and not proportional to the needs of this Action. Any “due diligence” Plaintiff performs when reporting to *third parties* has nothing to do with the claims and defenses in this case related to TLG’s decision to use deceptive business practices, especially when TLG does nothing to ensure the accuracy of information that hospitals that participate in its survey self-report.

Answer: Plaintiff declines to respond to this Interrogatory.

Amended Answer: Subject to the foregoing objections, Plaintiff makes reasonable efforts to ensure the accuracy of the data it reports to third-party organizations. For instance, Plaintiff employs data abstractors, quality coordinators and a Quality Director, who are all responsible for abstracting, validating, and submitting safety data.

Interrogatory No. 17: Describe in detail how You communicate to the shareholders, board members, collective bargaining representatives and investors of Tenet Healthcare System the outcome of any and all healthcare safety ratings, evaluative publications, studies, or performance analyses that Your Hospital receives.

Plaintiff objects to this Interrogatory because it seeks discovery of information that is irrelevant to the claims and defenses in this Action and is overly broad, unduly burdensome, and not proportional to the needs of this Action. Plaintiff’s communication, if any, with the shareholders, board members, collective bargaining representatives and investors of Tenet Healthcare System, all non-parties to this litigation, has nothing to do with the claims and defenses in this case related to TLG’s decision to use deceptive business practices.

Answer: Plaintiff declines to respond to this Interrogatory.

Amended Answer: Subject to the foregoing objection, Plaintiff communicates with Tenet stakeholders, including employees who work to support the Palm Beach Health Network, on a range of matters, including issues related to patient safety and outcomes and in particular related to TLG and the Safety Grades by email and oral communication. Those communications included discussions about the reasons for particular grades, the method used to calculate Safety Grades, the value of Safety Grades, and responses to the Safety Grades. In addition, identified below are documents Plaintiff produced evidencing communications between the Plaintiff and Tenet related to TLG, the Leapfrog survey, and Safety Grades.

Start Page	End Page
PBHN000004822	PBHN000004822
PBHN000004890	PBHN000004892
PBHN000004924	PBHN000004926
PBHN000006397	PBHN000006401
PBHN000002090	PBHN000002094
PBHN000002071	PBHN000002071
PBHN000004919	PBHN000004919
PBHN000004562	PBHN000004563
PBHN000004564	PBHN000004564
PBHN000004574	PBHN000004581

PBHN000004889	PBHN000004889
PBHN000004485	PBHN000004485
PBHN000004565	PBHN000004569
PBHN000004704	PBHN000004704
PBHN000004715	PBHN000004719
PBHN000004887	PBHN000004887
PBHN000005509	PBHN000005511
PBHN000005518	PBHN000005521
PBHN000005526	PBHN000005529
PBHN000006465	PBHN000006466

Discovery is ongoing, and Plaintiff reserves the right to amend, modify or supplement the response to this Interrogatory.

Interrogatory No. 18: State whether the compensation of Your Chief Executive Officer or any other executive-level leadership officers is tied to or related in any way to Your hospital's

performance on patient safety, union worker contracts or Your hospital's ratings by third party ratings organizations' ratings publications (including but not limited to the Leapfrog Hospital Safety Grade).

Plaintiff objects to this Interrogatory because it seeks discovery of information that is irrelevant to the claims and defenses in this Action and is overly broad, unduly burdensome, and not proportional to the needs of this Action. Plaintiff's method of compensating its Chief Executive Officer and other executive-level leadership **has nothing to do with the** claims and defenses in this case related to TLG's decision to use deceptive business practices.

Answer: TLG has, therefore, only propounded this Interrogatory for purposes of harassment. Plaintiff declines to respond to this Interrogatory.

Amended Answer: Subject to the foregoing objection, Plaintiff's performance on patient safety, union worker contracts, or ratings by third party ratings organizations' ratings publications is related in some way to the compensation of Plaintiff's Chief Executive Officer or other executive-level leadership officer(s).

Interrogatory No. 19: Identify all hospitals, medical centers, or healthcare systems that you consider to be your direct competitors within the relevant geographic market during the time period covered by the Complaint and describe in detail the criteria you use to determine whether another hospital or healthcare provider is a competitor.

Answer: Plaintiff objects to this Interrogatory because it seeks discovery of information that is irrelevant to the claims and defenses in this Action and is not reasonably calculated to lead to the discovery of admissible evidence. The identity of Plaintiff's competitors and "the criteria" used to determine whether a hospital or provide is a competitor has nothing to do with the claims and defenses in this case related to TLG's decision to use deceptive business practices. Plaintiff

also objects to this Interrogatory to the extent it seeks confidential, proprietary information, and commercially sensitive information related to Plaintiff's scoring system and "criteria" used to determine whether a hospital or provide is a competitor.

Subject to the foregoing objections and on condition that this response is considered "Confidential" under the forthcoming agreed confidentiality order, Bethesda Hospital East, Bethesda Hospital West, Boca Raton Regional Hospital, and HCA Florida JFK Hospital are Plaintiff's competitors. Plaintiff considers these hospitals competitors because of their proximity to Plaintiff, their competing services lines, and that patients within Plaintiff's service area go to these hospitals for medical care.

Interrogatory No. 20: State and describe the results of any market analysis, competitive analysis, or consumer perception surveys you have conducted or commissioned regarding your competitors from 2020 to present, and identify the individuals or entities that prepared or participated in such analyses.

Plaintiff objects to this Interrogatory because it seeks discovery of information that is irrelevant to the claims and defenses in this Action and is not is not proportional to the needs of this Action. The results of any market analysis, competitive analysis, or consumer perception surveys and the identity of those who prepared or participated in such analyses has nothing to do with the claims and defenses in this case related to TLG's decision to use deceptive business practices.

Answer: Plaintiff declines to respond to this Interrogatory.

Amended Answer: Plaintiff further objects to this Interrogatory to the extent it requests information from outside of the relevant time period of January 1, 2023, to present. Plaintiff also

objects to this Interrogatory as unduly burdensome to the extent it asks Plaintiff to “state and describe” various market analysis.

As agreed during the parties’ meet and confer on September 3, 2025, Plaintiff will produce documents showing the results of studies or surveys Plaintiff has conducted or commissioned related to internal market analysis, competitive analysis, or consumer perception. Plaintiff will identify the documents responsive to this Interrogatory by Bates number in Plaintiffs’ production cover letter.

Interrogatory No. 21: Identify with specificity any comments or concerns raised by any third party payor, bank or lender, or investor related to Your hospital’s reputation and/or public perception on issues in any way involving patient safety or satisfaction.

Plaintiff objects to this Interrogatory because it seeks discovery of information that is overly broad, unduly burdensome and irrelevant to the claims and defenses in this Action and is not proportional to the needs of this case to the extent it seeks “comments and concerns” from third parties related generally to Plaintiff’s reputation that has nothing to do with the specific and significant reputational harm caused by TLG’s misleading grades.

Answer: Subject to the foregoing objections, Plaintiff will produce and identify documents related to the significant reputational harm caused by TLG’s deceptive and unfair Safety Grades that provide sufficient detail to respond to this Interrogatory.

Amended Answer: Subject to the foregoing objections, Plaintiff is unaware of any documents related to this Interrogatory.

Interrogatory No. 22: Identify and describe any complaints, concerns, or comments from patients, community members, or referring physicians that relate to the hospital’s reputation or comparisons to other hospitals in the region.

Plaintiff objects to this Interrogatory because it seeks discovery of information that is overly broad, unduly burdensome and irrelevant to the claims and defenses in this Action and is not proportional to the needs of this Action to the extent it seeks “comments and concerns” from patients, community members, or referring physicians that have nothing to do with the significant reputational harm caused by TLG’s misleading grades. Plaintiff also objects to this interrogatory as seeking protected health information that is protected from disclosure by HIPAA, among other statutes and regulations. Plaintiff will only produce this information as needed and subject to the agreed protective order entered by this Court.

Answer: Subject to the foregoing objections, Plaintiff has received reports that patients and physicians considered or decided not to use Plaintiff’s facility because of TLG’s misleading grades.

Amended Answer: Subject to the foregoing objections, Plaintiff has received reports that patients and physicians considered or decided not to use Plaintiff’s facility because of TLG’s misleading grades. In addition, concerns have been raised by patients, doctors, staff, and community members, and Plaintiff is aware of false and misleading statements based on TLG’s false and misleading methodology and Safety Grades made in newspapers, viral social-media videos, television programs, and blogs.

Our Medical Executive Committee has received direct inquiries from patients regarding their concerns as to TLG’s grades and related public reports. Patients have told physicians that they do not want to go to the Medical Center for surgeries after seeing TLG’s grade and associated press reports. Medical professionals have expressed concern about working with the Medical Center due to the grade TLG assigned it. Further, we have received reports from patients and

doctors that patients have planned to drive past the Medical Center to a farther away medical facility due to the grade assigned by TLG to the Medical Center. Community members have given negative feedback related to the rating. The harm caused by TLG's false and misleading Safety Grade is ongoing.

In addition, the following produced documents evidence such harm.

Start Page	End Page
PBHN000006771	PBHN000006773
PBHN000002082	PBHN000002085
PBHN000002066	PBHN000002070
PBHN000002615	PBHN000002617
PBHN000006397	PBHN000006401
PBHN000002090	PBHN000002094
PBHN000002071	PBHN000002071
PBHN000004919	PBHN000004919

PBHN000004484	PBHN000004484
PBHN000004564	PBHN000004564
PBHN000004574	PBHN000004580
PBHN000004557	PBHN000004557
PBHN000004887	PBHN000004887
PBHN000008718	PBHN000008718
PBHN000006461	PBHN000006462
PBHN000008914	PBHN000008914
PBHN000008915	PBHN000008915

Discovery is ongoing, and Plaintiff reserves the right to amend, modify or supplement the response to this Interrogatory.

Interrogatory No. 23: List with specific detail each and every concern, complaint or comment made by any union, collective bargaining unit or employee association in any way related to patient safety at Your hospital.

Answer: Plaintiff objects to this Interrogatory because it seeks discovery of information that is overly broad, unduly burdensome and irrelevant to the claims and defenses in this Action and is overly broad, unduly burdensome, and not proportional to the needs of this Action to the extent it seeks "each and every concern, complaint or comment " from third parties that have

nothing to do with the significant reputational harm caused by TLG's misleading grades. Plaintiff also objects to this Interrogatory to the extent it seeks health information that is protected from disclosure by HIPAA, among other statutes and regulations. Plaintiff will only produce this information as needed and subject to the agreed protective order entered by this Court.

Subject to the foregoing objections, there is no union, collective bargaining unit, or employee association at Plaintiff.

Interrogatory No. 24: Identify any and all criticism You have received since 2020 from Tenet Healthcare Corporation and/or from any individual executive of Tenet Healthcare Corporation regarding Your hospital's performance in any way.

Answer: Plaintiff objects to this Interrogatory because it seeks discovery of information that is overly broad, unduly burdensome and irrelevant to the claims and defenses in this Action and is not reasonably calculated to lead to the discovery of admissible evidence. Any so-called "criticism" has nothing to do with the claims and defenses related to TLG's decision to use deceptive business practices. TLG has, therefore, only propounded this Interrogatory for purposes of harassment. Plaintiff declines to respond to this Interrogatory.

Amended Answer: As discussed during the parties' meet and confer on September 3, 2025, TLG agreed to narrow this Interrogatory to concern only "criticism...regarding Your hospital's patient safety." After a reasonable and diligent search, Plaintiff is unaware of having received "criticism" from Tenet Health Corporation regarding patient safety. Plaintiff is always working to improve its performance, quality, and safety in a constructive way and engages with Tenet Health Corporation as needed to ensure Plaintiff provides the best patient care possible.

Dated: September 8, 2025

Respectfully submitted,

By: /s/ Lee R. Crain

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CERTIFICATE OF SERVICE

This is to certify that true and correct copies of Plaintiff's Amended and Supplemented Responses and Objections to Defendant The Leapfrog Group's First Sets of Interrogatories to Plaintiff have been served on counsel for The Leapfrog Group by electronic transmission.

/s/ Lee R. Crain
Lee R. Crain

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

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

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

Plaintiffs,

v.

THE LEAPFROG GROUP,

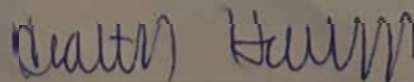
Defendant.

**AFFIDAVIT OF HEATHER HAVERICAK IN SUPPORT OF
PLAINTIFF DELRAY MEDICAL CENTER, INC.'S
AMENDED AND SUPPLEMENTED RESPONSES AND OBJECTIONS TO
DEFENDANT THE LEAPFROG GROUP'S FIRST SET OF
INTERROGATORIES TO DELRAY MEDICAL CENTER**

I, Heather Havericak, declare as follows:

1. I am over 21 years of age and competent to give this testimony.
2. I am the Chief Executive Officer of Delray Medical Center, Inc. ("Plaintiff"). I am the corporate representative of Plaintiff for the purpose of answering Defendant The Leapfrog Group's First Set of Interrogatories to Delray Medical Center. I have read the foregoing interrogatories and the answers to those interrogatories, which are true according to the best of my knowledge, information, and belief.
3. I declare under penalty of perjury that the foregoing is true and correct.

Executed on September 8, 2025.



Heather Havericak

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

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

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

Plaintiffs,

v.

THE LEAPFROG GROUP,

Defendant.

**PLAINTIFF GOOD SAMARITAN MEDICAL CENTER, INC.’S
AMENDED AND SUPPLEMENTED RESPONSES AND OBJECTIONS TO
DEFENDANT THE LEAPFROG GROUP’S FIRST SET OF
INTERROGATORIES TO GOOD SAMARITAN MEDICAL CENTER, INC.**

Pursuant to Federal Rules of Civil Procedure 26 and 33 and the *Pretrial Scheduling Order and Order Referring Case to Mediation* (ECF No. 36) (the “Pretrial Scheduling Order”), Plaintiff Good Samaritan Medical Center, Inc. (“Plaintiff” or “Good Samaritan”), by and through its undersigned counsel, hereby submit its amended and supplemented responses and objections (“Responses”), to Defendant The Leapfrog Group’s (“TLG”) First Set of Interrogatories, dated July 11, 2025 (the “Interrogatories” and each numbered interrogatory, an “Interrogatory”) in the above-captioned action (the “Action”).

Plaintiff’s Responses to the Interrogatories are made solely for purposes of this Action and to the best of Plaintiff’s present knowledge, information, and belief regarding the matters about which inquiry have been made. Discovery is ongoing, and Plaintiff reserves the right to amend, supplement, clarify, or further explain its Responses at any time prior to the trial in

this Action. Plaintiff further reserves the right to raise any additional objections deemed necessary or appropriate in light of any further review.

OBJECTIONS TO INSTRUCTIONS AND DEFINITIONS

1. Plaintiff objects to the definition of terms “Plaintiffs” and “Plaintiff Hospitals” as overbroad, unduly burdensome, and not proportional to the needs of the case to the extent it seeks to require Plaintiffs to respond on behalf of entities or individuals other than themselves.

2. Plaintiff objects to the definition of the terms “Good Samaritan”, “GSMC” “Plaintiff,” “You,” and “Your” to the extent each term seeks to require Plaintiff to respond on behalf of entities or individuals other than itself, including on behalf of agents, employees, directors, or other non-party entities that are not part of this litigation. Such information is overbroad and beyond the scope of permissible discovery. Accordingly, Plaintiff states that its Responses are on behalf of itself only.

3. Plaintiff objects to the definition of the terms “Tenet Healthcare” and “Tenet” to the extent it seeks to require Plaintiff to respond on behalf of entities or individuals other than itself, including on behalf of Tenet, Tenet’s agents, employees, directors, or other non-party entities that are not part of this litigation. Such information is overbroad and beyond the scope of permissible discovery. Accordingly, Plaintiff states that its Responses are on behalf of itself only.

4. Plaintiff objects to the definition of “identify, when referring to a person,” as overbroad and unduly burdensome to the extent it calls for the “address” and “present or last-known employer” of identified individuals. Such information is overbroad and beyond the scope of permissible discovery.

5. Plaintiff objects to the instruction that the relevant time period for the Interrogatories begins on January 1, 2020. Plaintiff will apply to each Interrogatory the time period

of November 1, 2023 to present (the “Relevant Time Period”). Any response to an Interrogatory that provides information that falls outside of the Relevant Time Period should not be construed as an admission that the Relevant Time Period begins prior to November 1, 2023.

SPECIFIC RESPONSES TO INTERROGATORIES

Interrogatory No. 1: State the full name, address, job title or position, and hospital or employer affiliation of all individuals that assisted with responding to these interrogatories.

Answer: The following individuals assisted with responding to these Interrogatories.

Full Name	Address	Job Title / Position	Hospital or Employer Affiliation
Sheri Montgomery	c/o Gibson, Dunn & Crutcher LLP 200 Park Avenue New York, NY 10166	Chief Executive Officer	Good Samaritan Medical Center
Regina West	c/o Gibson, Dunn & Crutcher LLP 200 Park Avenue New York, NY 10166	Market Quality Director	Palm Beach Health Network and St. Mary’s Medical Center

Interrogatory No. 2: Identify every individual not identified in Your Rule 26(a) initial disclosures with knowledge of facts pertaining to the allegations in Your Complaint in this Lawsuit (and any subsequent amendments) and/or whom You believe may have discoverable knowledge, information or data regarding this matter, including those who You expect to call as a fact or opinion witness at any hearing in this proceeding or whose testimony (by affidavit, deposition or testimony) You intended to submit in connection with this proceeding, and the substance of his/her testimony or affidavit, and, with respect to each person identified, provide:

- A. full name,
- B. address,
- C. telephone number,
- D. job title or position,
- E. hospital or employer affiliation,
- F. and describe in detail the facts possessed by each such person.

Plaintiff objects to this Interrogatory as overly broad, unduly burdensome, and not proportional to the needs of this Action to the extent it seeks the identity of “every individual...with knowledge” or who “may have discoverable knowledge, information or data regarding this matter.” Plaintiff will not provide more than the identity of individuals most likely to have knowledge regarding this matter. Plaintiff further objects to this Interrogatory as premature because it requests disclosure of Plaintiff’s witnesses for hearings and the substance of witness testimony before such disclosure is required under applicable law or the Pretrial Scheduling Order. Plaintiff will submit its trial witness list on October 2, 2025, per the Pretrial Scheduling Order, and disclose any other witnesses and witness testimony as further ordered by the Court or otherwise required by applicable law. Plaintiff also objects to this Interrogatory’s request for the identity of “opinion witness[es]” as vague, since witnesses are either “fact” or “expert” witnesses. Plaintiff will interpret “opinion witness” to mean “expert witness.” Plaintiff submitted expert reports on August 7, 2025, per the Pretrial Scheduling Order.

Answer: Subject to the foregoing objection, Plaintiff will amend its Rule 26(a)(1) Initial Disclosures to identify additional individuals who may have knowledge of facts pertaining to the allegations in the Complaint.

Amended Answer: In addition to those disclosed in Plaintiff’s supplemental disclosures, the following individuals may have relevant factual knowledge:

Full Name	Address	Job Title / Position	Hospital or Employer Affiliation
Regina West	c/o Gibson, Dunn & Crutcher LLP 200 Park Avenue New York, NY 10166	Market Quality Director	Palm Beach Health Network and St. Mary’s Medical Center

Full Name	Address	Job Title / Position	Hospital or Employer Affiliation
Erin Britt	c/o Gibson, Dunn & Crutcher LLP 200 Park Avenue New York, NY 10166	Quality Director	Good Samaritan Medical Center

In addition to the individuals identified above, persons identified in documents produced in this dispute have knowledge of facts pertaining to the allegations in the Amended Complaint. *See* Fed. R. Civ. P. 33(d). Discovery is ongoing, and Plaintiff reserves the right to supplement, amend, correct, clarify, or modify this Response as further information becomes available.

Interrogatory No. 3: Describe in detail all factual bases for Your contention that Leapfrog’s published Safety Grade for Your hospital was false, inaccurate, misleading, deceptive, or unfair. In so answering, identify with particularity each measure, data point, or metric that You contend was inaccurately reported, calculated, or misrepresented by Leapfrog in calculating the Safety Grade for Your hospital.

Answer: Plaintiff objects to this Interrogatory as overly broad, unduly burdensome, and not proportional to the needs of this Action to the extent it seeks “all factual bases” for Plaintiff’s contention. *See Megdal Assocs., LLC v. La-Z-Boy, Inc.*, 2016 WL 4503337, at *6 (S.D. Fla. Feb. 1, 2016) (finding interrogatories asking for “‘all’ facts or witnesses that support an opposing party’s case” to be “unduly broad”) (citing 8B Wright, Miller, & Kane, Federal Practice and Procedure: Civil 3d § 2167 (2015)). Plaintiff further objects to this Interrogatory as premature to the extent it requests that Plaintiff “[d]escribe in detail all factual bases” to support its contention. *In re Reliance Fin. & Inv. Grp., Inc.*, 2006 WL 8435541, at *4 (S.D. Fla. Feb. 14, 2006) (Contention interrogatories “are more appropriately used after a substantial amount of discovery has been conducted--typically, at the end of the discovery period.”). Plaintiff also objects to this Interrogatory to the extent it attempts to limit or mischaracterize Plaintiff’s claim as just

challenging the false, inaccurate, misleading, deceptive, or unfair nature of TLG's Safety Grade. As the Court explained in its order denying TLG's motion to dismiss, the core of the Complaint is "a challenge to Defendant's representations about its methodology, which they claim mislead consumers by failing to distinguish between absent data and damning data, and professing that grades are not influenced by a hospital's lack of survey participation." *Order on Motion to Dismiss* 6 (ECF No. 41). Plaintiff also challenges the provably false facts and deceptive scoring system underlying these grades, which TLG admits it relies on to arrive at its deceptive Safety Grades.

Subject to the foregoing objections and as more fully stated in the *Amended Complaint* (ECF No. 74) ("Complaint"), TLG has engaged in deceptive and unfair business practices and misrepresentations when issuing the Safety Grade for Plaintiff's hospital as part of TLG's annual "Hospital Survey." TLG posts these Safety Grades online at hospitalsafetygrade.org.

To arrive at these Safety Grades, TLG uses CMS data, survey responses from participating hospitals, and other supplemental data sources. For participating hospitals, TLG uses the hospitals' self-reported responses to the Hospital Survey for 12 of the 22 measures. For non-participating hospitals, TLG uses other sources for those 12 measures. For the remaining four measures—Computerized Physician Order Entry, Bar Code Medication Administration, ICU Physician Staffing, and Hand Hygiene Score (the "Deceptive Score Categories")—TLG devised and uses a so-called "imputation model." Prior to Fall 2024, TLG's imputation model assigned non-participating hospitals a score based on the average score applicable to a similarly situated hospital. Beginning in Fall 2024, TLG modified its imputation model. TLG now assigns the lowest possible score to non-participating hospitals, which has the effect of punishing non-participating hospitals and artificially deflating their Safety Grades. TLG has even admitted the changes in Fall 2024 were designed to penalize non-participating hospitals. TLG also misleads consumers about how

it grades hospitals, stating “[t]he Hospital Safety Grade reflects how well a hospital does on safety, not whether they complete the [TLG] Hospital Survey.” *Declaration of Lee Crain* (ECF No. 21) (“Crain Decl.”), Ex. 1 at 4 (“Frequently Asked Questions About the Leapfrog Hospital Safety Grade”).

As TLG explains, “not all hospitals have enough data publicly available to be eligible for a grade.” Crain Decl. Ex. 1 at 5. “As per the National Expert Panel guidance, [TLG] has requirements for the minimum amount of data [it] need[s] to issue an accurate grade.” Crain Decl. Ex. 1 at 5. According to TLG, “[h]ospitals missing more than six process measures” are “not graded.” Crain Decl. Ex. 2 at 6. Non-participating hospitals should fall easily into that “not graded” bucket, because their decision not to participate in TLG’s survey necessarily means TLG is missing seven process measures that rely on voluntary submission of hospital data.¹

TLG then deceptively conceals how it makes up grades for the four “imputation” measures and even suggests on its website that TLG *does* have data sufficient to score TLG on those four measures. By way of example, TLG acknowledges that Plaintiff “Declined to Report” information in response to questions about “Staff work[ing] together,” but then tells consumers—as if it were a fact—that Plaintiff is “Worse Than Average” on “Handwashing,” “Communication,” “medication administration,” and the like—even though TLG has no basis whatsoever to adopt those conclusions. Crain Decl. Ex. 32 at 2. TLG itself says handwashing is among the “most important” measures in its survey, Crain Decl. Ex. 15 at 4, yet it deceptively conceals that it has no data with which to grade the Plaintiff hospital on that measure. *Defendant The Leapfrog Group’s Responses to Plaintiffs’ Requests for Production* at 7 (“Leapfrog is not itself in possession

¹ Those seven include CPOE, BCMA, IPS, Safe Practice 1: Culture of Leadership Structures and Systems; Safe Practice 2: Culture Measurement, Feedback & Intervention; Total Nursing Care Hours per Patient Day; and Hand Hygiene.

of data showing Plaintiffs' performance on the 'imputed metrics' considered by the methodology.")). Of course, Plaintiff in fact has a comprehensive and thorough handwashing policy. And had Plaintiff merely filled out TLG's survey, it would have received a full letter grade higher on TLG's score. *Expert Report of Professor Sean Nicholson* (Aug. 7, 2025), Ex. 6.

Based on the foregoing, and as more fully set forth in the Complaint, TLG engages in deceptive trade practices by, among other things, deceiving consumers about its grading methods by implying that Plaintiff has failed on certain measures that, in truth, TLG has no data or other basis to evaluate; deceiving consumers by telling them the Hospital Safety Grade reflects how well a hospital does on safety, not whether they complete the Hospital Survey; deceiving consumers when it represents that it does not grade hospitals if it lacks sufficient data, when, in truth, it does grade hospitals by "imputing" or making up a grade for the Deceptive Score Categories; hiding the truth about its "imputation model" from consumers by burying it in fine print on a separate website; punishing non-participating hospitals by "imputing" scores, which artificially deflate a hospital's Safety Grade; and favoring participating hospitals. Additional factual bases for the Plaintiff's claims are presented in the Complaint.

Interrogatory No. 4: Describe the scoring or grading methodology You believe Leapfrog should have used to assess Your hospital's patient safety performance and explain why that method would yield a different result.

Plaintiff objects to this Interrogatory because it seeks discovery of information that is irrelevant to the claims and defenses in this Action and is overly broad, unduly burdensome, and not proportional to the needs of this Action. Plaintiff's provision of an alternative scoring or grading methodology has nothing to do with the claims and defenses in this case related to TLG's

decision to use deceptive business practices. Plaintiff further objects to this Interrogatory to the extent it calls for speculation.

Answer: Plaintiff declines to respond to this Interrogatory.

Amended Answer: Subject to the foregoing objections, Plaintiff responds that TLG should use a scoring system that is not unfair or deceptive. By way of example only, TLG could decline to grade hospitals that do not participate in TLG's survey, because their decision not to participate means TLG is missing seven process measures that rely on voluntary submission of hospital data. This would yield a different result, because the hospitals would not receive a grade at all. TLG's methodology certainly should not affirmatively assign an arbitrary low score to a particular metric just because a hospital does not provide data for that metric.

Interrogatory No. 5: State whether You submitted any data, corrections, or appeals to Leapfrog regarding the Safety Grade Your hospital received, and for each such submission, identify the date of the submission, the medium of the submission (i.e. telephone, video conference, email, letter, etc.), who was involved in the submission, and the content of the submission.

Plaintiff objects to this Interrogatory because it seeks discovery of information that is irrelevant to the claims and defenses in this Action and is overly broad, unduly burdensome, and not proportional to the needs of this Action. Whether or not Plaintiff submitted "any data, corrections, or appeals to Leapfrog regarding the Safety Grade" Plaintiff hospital received has nothing to do with the claims and defenses in this case related to TLG's decision to use deceptive business practices. Plaintiff further objects to this Interrogatory to the extent it seeks information that is already in TLG's possession, custody and control, or equally available to TLG.

Answer: Subject to the foregoing objections, Plaintiff engaged in correspondence prior to the commencement of this case demanding that TLG reform its deceptive practices and cease and desist reporting deceptive and unfair Safety Grades, but at every turn TLG refused.

Amended Answer: Subject to the foregoing objections, Plaintiff did not submit any data, corrections or appeals to Leapfrog regarding the Safety Grades it has received.

Interrogatory No. 6: State whether You provided any comment or input in any form during Leapfrog's requests for public comments for planned updates to the Leapfrog Hospital Safety Grade methodology that was proposed for the calculation of Hospital Safety Grades (including but not limited to for the Fall 2024 methodology update). If yes, please identify the date of the comment, the medium of the submission (i.e. telephone, video conference, email, letter, etc.), who was involved in the comment and the content of the comment. If no, please state the reason why You chose not to comment.

Answer: Plaintiff objects to this Interrogatory because it seeks discovery of information that is irrelevant to the claims and defenses in this Action and is overly broad, unduly burdensome, and not proportional to the needs of this Action. Whether or not Plaintiff submitted "any comment or input" in response to TLG's request for public comments has nothing to do with claims and defenses in this case related to TLG's decision to use deceptive business practices. Plaintiff further objects to this Interrogatory to the extent it seeks information that is already in TLG's possession, custody and control, or equally available to TLG.

Subject to the foregoing objections, Plaintiff did not provide comments in response to Leapfrog's requests for public comments for planned updates to the Leapfrog Hospital Safety Grade scoring system because Plaintiff generally does not respond to requests for public comment from private entities like TLG.

Interrogatory No. 7: Describe all actions Your hospital took in response to (or in deciding not to respond to) its Safety Grade or the Hospital Survey, including internal meetings, media statements, or public relations efforts. In so answering, state the date of the action, the individuals involved in the action and the content of the action.

Plaintiff objects to this Interrogatory as overly broad, unduly burdensome, and not proportional to the needs of this Action to the extent it seeks “all actions” Plaintiffs may have taken in response to TLG’s Safety Grades. *See Megdal Assocs., LLC v. La-Z-Boy, Inc.*, No. 14-81476-CIV, 2016 WL 4503337, at *6 (S.D. Fla. Feb. 1, 2016) (finding interrogatories asking for “‘all’ facts or witnesses that support an opposing party’s case” to be “unduly broad”) (citing 8B Wright, Miller, & Kane, Federal Practice and Procedure: Civil 3d § 2167 (2015)). Plaintiff further objects to this Interrogatory to the extent it seeks information that is subject to a claim of privilege or otherwise protected from disclosure, including seeking information protected by the attorney-client privilege, work-product doctrine, or other immunity.

Answer: Subject to the foregoing objections, Plaintiff devoted substantial time and resources that could have otherwise been spent continuing to improve patient care to respond to the significant harm and disruption caused by TLG’s deceptive and unfair Safety Grade. Plaintiff’s response included meeting internally with Plaintiff’s leadership team, medical executive committee, and governing board, corresponding with TLG to demand that TLG reform its deceptive practices and cease and desist reporting deceptive and unfair Safety Grades, and devoting substantial time and resources to facilitate the preparation and prosecution of this Action.

Amended Answer: Subject to the foregoing objections, Plaintiff devoted substantial time and resources that could have otherwise been spent continuing to improve patient care to respond to the significant harm and disruption caused by TLG’s deceptive and unfair Safety Grades. Plaintiff’s response included meeting internally with Plaintiff’s leadership team, medical executive

committee, and governing board, corresponding through Plaintiff's corporate parent with TLG to demand that TLG reform its deceptive practices and cease and desist reporting deceptive and unfair Safety Grades, and devoting substantial time and resources to facilitate the preparation and prosecution of this Action. Plaintiff has also held many phone calls and meetings with physicians and other stakeholders about the TLG grades, explaining how the grades were deceptive and did not accurately reflect the hospital quality and patient safety at Plaintiff.

Interrogatory No. 8: Identify any and all persons, whether internal or external (e.g., patients, vendors, affiliates, parents, agents, partners, media) with whom You communicated in any way with respect to the Safety Grade or the Hospital Survey. In so answering, state the date of the communication, the individuals involved in the communication, the medium of the communication (i.e. telephone, video conference, email, letter, etc.) and the content of the communication.

Plaintiff objects to this Interrogatory as overly broad, unduly burdensome, and not proportional to the needs of this Action to the extent it seeks the identity of "any and all persons, whether internal or external." Plaintiff will disclose the categories of individuals with whom Plaintiff communicated about the Safety Grade or Hospital Survey during the Relevant Time Period. Plaintiff also objects to this Interrogatory to the extent it seeks protected health information that Health Insurance Portability and Accountability Act ("HIPAA"), among other statutes and regulations, bars Plaintiff from disclosing. Plaintiff further objects to this Interrogatory to the extent it seeks information that is subject to a claim of privilege or otherwise protected from disclosure, including seeking information protected by the attorney-client privilege, work-product doctrine, or other immunity.

Answer: Subject to the foregoing objections, Plaintiff communicated with the following categories of people regarding the Safety Grade or the Hospital Survey: Plaintiff's governing board, its medical executive committee, department directors, and physicians and nurses when

asked about the Safety Grade or Hospital Survey. These communications occurred in and after Fall 2024, after TLG released its deceptive and unfair Safety Grade for Plaintiff's hospital. Most of these communications occurred during regularly scheduled meetings, during which attendees were told about TLG's release of the deceptive and unfair Safety Grade, that Plaintiff does not participate in the Hospital Survey because it is unreliable and not an accurate reflection of hospital quality and safety or patient outcomes, and that the Safety Grade, which was not based on any information provided by Plaintiff, was misleading. The Palm Beach Health Network also issued a press release and since then, has engaged in various social networking and other marketing campaigns to counteract TLG's deceptive scores on behalf of Plaintiff and other affected members of the network.

Amended Answer: Subject to the foregoing objections, Plaintiff communicated with the following categories of people regarding the Safety Grade or the Hospital Survey: Plaintiff's governing board, its medical executive committee, department directors, physicians and nurses, and patients when asked about the Safety Grades or Hospital Survey. These communications occurred in and after Fall 2024, after TLG released its deceptive and unfair Safety Grades for Plaintiff's hospital. Most of these communications occurred during regularly scheduled meetings, during which attendees were told about TLG's release of the deceptive and unfair Safety Grade, that Plaintiff does not participate in the Hospital Survey because it is unreliable and not an accurate reflection of hospital quality and safety or patient outcomes, and that the Safety Grade, which was not based on any information provided by Plaintiff, was misleading. The Palm Beach Health Network also issued a press release and has engaged in marketing efforts, including through social media, to counteract TLG's deceptive scores on behalf of Plaintiff and other affected members of

the network. Plaintiff also engaged in email discussions about TLG's misleading grades, either as sender or recipient, which TLG has through Plaintiff's production of documents.

Interrogatory No. 9: Describe all instances in which a third party declined to contract with, refer patients to, or work with Your hospital, where Leapfrog's grade was cited or discussed. In so identifying list the name of the individuals involved in the communication, the medium of the communication (i.e. telephone, video conference, email, letter, etc.), the date of the communication and the content of the communication.

Plaintiff objects to this Interrogatory as overly broad, unduly burdensome, and not proportional to the needs of this Action to the extent it requires Plaintiff to "[d]escribe all instances" in which a third party took an action in response to TLG's deceptive grade.

Answer: Subject to the foregoing objection, Plaintiff is not aware of any responsive instances.

Amended Answer: Subject to the forgoing objection, by way of example, our Chief Nursing Officer reported that a nursing candidate questioned the quality of care of the hospital in her interview for a job opening. In addition, the recently hired Director of Cardiac Cathater Lab shared with the Chief Operating Officer that he considered rescinding his acceptance of the position after learning that the hospital had received an F from TLG, but he was glad that he didn't do so because Good Samaritan is a high-quality hospital and he is happy to be part of the organization.

Interrogatory No. 10: Describe with specificity the basis for each and every category of damage You claim You incurred as a result of the Leapfrog Safety Grade. In so identifying, list each category of damages and the dollar value of each category of damage You claim.

Plaintiff objects to this Interrogatory to the extent it seeks information that is the subject of expert testimony.

Answer: Plaintiff will submit expert reports on August 7, 2025, per the Pretrial Scheduling Order.

Amended Answer: Plaintiff has served the expert report of Thomas Chakurda, which addresses the issue of reputational harm and harm to Plaintiff's goodwill. Plaintiff further objects to this Interrogatory as overbroad and unduly burdensome to the extent it seeks "each and every" category of claimed damages.

Subject to the foregoing objections and as agreed during the parties' September 3, 2025 meet and confer, Plaintiff will limit its response to the live non-monetary claims, including injunctive and declaratory relief, to remedy harm to Plaintiff's reputation and goodwill. Plaintiff's reputation and goodwill has been damaged by TLG's false and misleading methodology and resulting Safety Grades. Plaintiff's claim for reputational harm is based on, among other things, concerns raised by patients, doctors, staff, and community members, as well as false and misleading statements based on TLG's false and misleading methodology and Safety Grades made in newspapers, viral social-media videos, television programs, and blogs.

By way of example, our Medical Executive Committee has received direct inquiries from patients regarding their concerns as TLG's grades and related public reports. Our Chief Nursing Officer reported that a nursing candidate questioned the quality of care of the hospital in her interview for a job opening. Patients have asked independent physicians that use both our facilities and those of Jupiter Medical Center (a nearby hospital) to schedule their surgeries at Jupiter Medical Center and not at ours. Those patients chose not to use our hospital specifically because of the Leapfrog grades. These independent surgeons have told us that they believe TLG has misled these patients about the quality of the Medical Center. The harm caused by TLG's false and misleading Safety Grade is ongoing.

Interrogatory No. 11: Identify all adverse patient events which occurred at Your hospital, including any citations received from regulatory agencies, accrediting agencies, and third party payors such as The Joint Commission, CMS, state health departments, etc. during the period covered by each Leapfrog Safety Grade publication of which You complain (i.e., Fall 2024, Fall 2025, etc.), as well as any complaints received from patients regarding the same.

Plaintiff objects to this Interrogatory because it is overly broad, unduly burdensome, seeks discovery of information that is irrelevant to the claims and defenses in this Action, seeks information that is beyond the scope of Leapfrog's Hospital Survey, and is not reasonably calculated to lead to the discovery of admissible evidence. TLG does not include "all adverse patient events," "citations received from" agencies or payors, or "complaints received from patients" in TLG's determination of its Hospital Safety Grades or request such information in the Hospital Survey, so any such information is irrelevant to whether TLG's actions constitute unfair or deceptive trade practices. TLG has, therefore, only propounded this Interrogatory for purposes of harassment. Plaintiff also objects to this Interrogatory to the extent it seeks protected health information that HIPAA, among other statutes and regulations, bars Plaintiff from disclosing.

Answer: Plaintiff declines to respond to this Interrogatory.

Amended Answer: Defendant has agreed to withdraw this Interrogatory.

Interrogatory No. 12: Describe in detail how Your hospital compares nationally on on [sic] any other ranking of patient safety performance, including but not limited to Vizient, Inc., Premier, Inc., HealthTrust Purchasing Group, The Joint Commission, HealthGrades, US News, Newsweek, Statista, Definitive Healthcare, or any other quality benchmarking entity including benchmarking on patient safety including on adverse events and on healthcare-acquired infections.

Plaintiff objects to this Interrogatory's request that Plaintiff "[d]escribe in detail how Your hospital compares nationally" based on undisclosed "benchmarking" as vague and confusing. To the extent this Interrogatory seeks the top-line rankings of the identified organizations, Plaintiff objects to this Interrogatory because such information is publicly and equally available to TLG.

To the extent this Interrogatory asks Plaintiff to compare itself to the named and unnamed entities, that request is overly broad, unduly burdensome, and not proportional to the needs of this Action. Plaintiff further objects to this Interrogatory because it seeks discovery of information that is irrelevant to the claims and defenses in this Action and is overly broad, unduly burdensome, and not proportional to the needs of this Action. Other organizations' rankings have nothing to do with the claims and defenses in this case related to the Deceptive Score Categories or TLG's decision to use deceptive business practices.

Answer: Subject to the foregoing objections, Plaintiff has received numerous awards and accolades, including many that are directly relevant to patient care for the community we serve. As a full-service cancer hospital, it is important to Plaintiff that it is accredited by the Commission on Cancer (CoC). In order to be accredited, Plaintiff had to undergo an on-site visit on a triennial basis, in which a trained CoC reviewer visited Plaintiff and reviewed its required cancer program activity documentation to ensure compliance with the standards.

The American College of Surgeons has designated Plaintiff a National Accreditation Program for Breast Centers for 13 years in a row. The American College of Radiology designated Plaintiff a Breast Imaging Center of Excellence, which it received only after accomplishing the highest level of care in breast imaging, including being committed to patients, providers, and payers. Plaintiff has been accredited as a Comprehensive Center by the Metabolic and Bariatric Surgery Accreditation and Quality Improvement Program, a joint Quality Program of the American College of Surgeons and the American Society for Metabolic and Bariatric Surgery.

Plaintiff is accredited by the Joint Commission, the nation's largest hospital accreditor that evaluates hospitals' quality performance standards through an objective evaluation process. Plaintiff has also been accredited by Joint Commission for specialization certifications for Gold

Seal of Approval for Total Hip and Knee Replacement, Shoulder Replacement and Spine Surgery—certification designed for hospitals providing the critical elements to achieve long-term success in improving critical medical outcomes—which signifies our services have delivered evidence-based proof of clinical quality sought by patients and payers alike. The entities that award and assign these accreditations and certifications visit the healthcare facility and perform regular periodic in-person reviews, audits surveys and assessments of the facility.

Plaintiff has also recently received the Florida Department of Health and Florida Agency for Health Care Administration Excellence for Maternal Care Award, which highlights hospitals that surpass Florida Department of Health’s goal of reducing the rate of C-sections among first-time mothers with low-risk pregnancies. Plaintiff was recognized by BlueCross BlueShield with a Blue Distinction Centers for Bariatric Surgery designation, as part of the Blue Distinction Specialty Care program, and for Knee and Hip Replacement. Plaintiff earned this recognition by providing a full range of bariatric surgical care services, including inpatient care, postoperative care, follow-up, and patient education that operate to standards set by BlueCross BlueShield, in partnership with physician experts and medical organizations. Aetna has also designated Plaintiff as an Aetna Institute of Quality orthopedic facility for total joint replacement and spine surgery, which it earned by consistently delivering safe and effective orthopedic care.

Healthgrades has awarded Plaintiff numerous Healthgrades accolades. To assess and evaluate hospitals, Healthgrades relies on data from Medicare medical claims records and states’ data on Medicare and commercially insured patient outcomes to determine patients’ actual clinical outcomes when visiting a given hospital. Plaintiff also received several awards from Healthgrades for various specialties, including:

a. Labor and Delivery

- i. Five-Star Recipient for C-Section Delivery for four years in a row (2022-2025)
- ii. Five-Star Recipient for Vaginal Delivery for 12 years in a row (2014-2025)

b. Outpatient Orthopedic

- i. Five-Star Recipient for Outpatient Back and Neck Surgery (except Spinal Fusion) (2025)
- ii. Recipient of the Healthgrades Outpatient Orthopedic Surgery Excellence Award (2025)

c. Spine Surgery

- i. Five-Star Recipient for Spinal Fusion
- ii. Recipient of the Healthgrades America's 100 Best Hospitals for Spine Surgery Award (2025)
- iii. Top 10% in the Nation for Spine Surgery (2025)
- iv. Recipient of the Healthgrades 2025 Spine Surgery Excellence Award

d. Gastrointestinal

- i. Five-Star Recipient for Treatment of Gastrointestinal Bleed (2024)

In addition, Plaintiff will produce and identify documents reflecting some of Plaintiff's rankings from other organizations.

Amended Answer: Subject to the foregoing objections, Plaintiff has received numerous awards and accolades. For example, Plaintiff has been accredited by the Commission on Cancer (CoC) for 31 years. The American College of Surgeons has designated Plaintiff a National

Accreditation Program for Breast Centers for 13 years in a row. The American College of Radiology designated Plaintiff a Breast Imaging Center of Excellence. Plaintiff has been accredited as a Comprehensive Center by the Metabolic and Bariatric Surgery Accreditation and Quality Improvement Program, a joint Quality Program of the American College of Surgeons and the American Society for Metabolic and Bariatric Surgery. Plaintiff received the American Heart Association Stroke Gold Plus award for 2025.

Plaintiff is accredited by the Joint Commission. Plaintiff has also been accredited by Joint Commission for specialization certifications for Gold Seal of Approval for Total Hip and Knee Replacement, Shoulder Replacement and Spine Surgery.

Plaintiff has also recently received the Florida Department of Health and Florida Agency for Health Care Administration Excellence for Maternal Care Award. Plaintiff was recognized by BlueCross BlueShield with a Blue Distinction Centers for Bariatric Surgery designation, as part of the Blue Distinction Specialty Care program, and for Knee and Hip Replacement. Aetna has also designated Plaintiff as an Aetna Institute of Quality orthopedic facility for total joint replacement and spine surgery.

Healthgrades has awarded Plaintiff numerous Healthgrades accolades. Plaintiff also received several awards from Healthgrades for various specialties, including:

a. Labor and Delivery

- i. Five-Star Recipient for C-Section Delivery for four years in a row (2022-2025)
- ii. Five-Star Recipient for Vaginal Delivery for 12 years in a row (2014-2025)

b. Outpatient Orthopedic

- iii. Five-Star Recipient for Outpatient Back and Neck Surgery (except Spinal Fusion) (2025)
- iv. Recipient of the Healthgrades Outpatient Orthopedic Surgery Excellence Award (2025)

c. Spine Surgery

- i. Five-Star Recipient for Spinal Fusion
- ii. Recipient of the Healthgrades America's 100 Best Hospitals for Spine Surgery Award (2025)
- iii. Top 10% in the Nation for Spine Surgery (2025)
- iv. Recipient of the Healthgrades 2025 Spine Surgery Excellence Award

d. Gastrointestinal

- i. Five-Star Recipient for Treatment of Gastrointestinal Bleed (2024)

In addition, Plaintiff will produce and identify documents reflecting some of Plaintiff's rankings from other organizations.

Also, Plaintiff does not participate in Vizient and has not done so during the Relevant Time Period.

Interrogatory No. 13: Describe any steps taken by Your hospital to improve any and all of the patient safety measures considered by Leapfrog's Hospital Safety Grade (as set forth on Leapfrog's published scoring methodology documents; see ECF No. 21-3 at 6-10; ECF No. 21-43 at 6-9), before and after each Safety Grade publication of which You complain.

Plaintiff objects to this Interrogatory as overly broad, unduly burdensome, and not proportional to the needs of this Action to the extent it seeks the identity of Plaintiff's improvements to "any and all" patient safety measures considered by Leapfrog's Hospital Safety

Grade. Plaintiff further objects to this Interrogatory because it seeks discovery of information that is irrelevant to the claims and defenses in this Action and is overly broad, unduly burdensome, and not proportional to the needs of this Action to the extent it seeks information on metrics other than TLG's Deceptive Score Categories and to the extent it seeks information that is beyond the scope of Leapfrog's Hospital Survey.

Answer: Plaintiff declines to respond to this Interrogatory.

Amended Answer: Subject to the foregoing objection, Plaintiff is committed to continual improvement of patient safety measures, motivated by our commitment to ensuring the best possible patient safety—not chasing the best possible Leapfrog grade. To achieve this core objective, Plaintiff devotes significant time and resources to improving its delivery of the highest possible quality of care for those in the community it serves, including efforts to improve its performance in areas related to the four metrics Plaintiff has chosen to impute in its survey.

Plaintiff monitors its BCMA rate, but the rate is already nearly 100%, so there is very little scope for improvement. Plaintiff consistently tracks CPOE and hand hygiene. For CPOE, Plaintiff trains new hires one-on-one on how to implement CPOE properly, meets with providers to address any barriers, shares compliance reports with individual providers, and clinical informatics educators visit physicians' offices to address any access issues. Plaintiff also trains new hires in proper compliance with Plaintiff's hand hygiene policy and requires annual continuing education on it. Plaintiff surveils hand hygiene compliance monthly and provides real time education on the importance of hand hygiene. Compliance with Plaintiff's hand hygiene policy is also reviewed at periodic committee meetings, and leadership shares data with staff and holds them accountable for the results.

Plaintiff already has 24/7 ICU coverage for its intensivist unit and has had that coverage for several years, so it does not need to track this metric.

Interrogatory No. 14: State whether You are aware of specific patients who have relied on the Leapfrog Safety Grade in declining to receive healthcare services at Your hospital. In so answering, identify the individual patient that declined to receive services, the date of such declination, the type of service the patient declined to receive, the medium for the communication from the patient (i.e. telephone, video conference, email, letter, etc.), the content of the communication, and the reason given for the stated decision.

Plaintiff objects to this Interrogatory as seeking protected health information that is protected from disclosure by HIPAA, among other statutes and regulations. Plaintiff will only produce this information as needed and subject to a Qualified Protective Order entered by this Court.

Answer: Subject to the foregoing objection, Plaintiff has received reports that patients considered or decided not to use Plaintiff's facility because of TLG's misleading grades.

Amended Answer: Subject to the foregoing objection, since the release of TLG's false and misleading grades, Plaintiff has received numerous reports from doctors that patients considered or decided not to use Plaintiff's facility due to concerns related to TLG's misleading grades.

Interrogatory No. 15: Describe any effort Your hospital has made to influence public perception of Your hospital's performance on patient safety following the publication of the Leapfrog Safety Grade.

Plaintiff objects to this Interrogatory as vague and ambiguous because it does not specify which Leapfrog Safety Grade is at issue. Plaintiff will construe this Interrogatory to reference TLG's deceptive Safety Grades beginning in Fall 2024. Plaintiff objects to this Interrogatory as overly broad, unduly burdensome, and not proportional to the needs of this Action to the extent it seeks "any effort" Plaintiff "has made to influence public perception" after the release of TLG's

deceptive and unfair Safety Grades because there have been many such “efforts” and those “efforts” are ongoing given the significant harm caused by TLG’s deceptive and unfair business practices.

Answer: Subject to the foregoing objections, Plaintiff continues to influence public perception by, among other things, delivering the highest quality care to the community it serves, which, as discussed in response to Interrogatory 12, has led to numerous awards, accreditations, and accolades. In addition, several public statements disputing the misleading nature of the Safety Grade have been made on Plaintiff’s behalf.

Supplemental Answer: In addition to the above, members of hospital leadership have communicated with patients, doctors, or community members on a regular basis to dispel the misleading nature of the Leapfrog Safety Grades. For instance, Plaintiff communicated its governing board, its medical executive committee, department directors, physicians and nurses, and patients when asked about the Safety Grades or Hospital Survey. These communications occurred in and after Fall 2024, after TLG released its deceptive and unfair Safety Grades for Plaintiff’s hospital. The Palm Beach Health Network also issued a press release and has engaged in marketing efforts, including through social media, to counteract TLG’s deceptive scores on behalf of Plaintiff and other affected members of the network. Plaintiff also engaged in email discussions about TLG’s misleading grades, either as sender or recipient, which TLG has through Plaintiff’s production of documents.

Interrogatory No. 16: Describe the due diligence Your hospital undertakes to ensure the accuracy of its own publicly reported safety data (including but not limited to data submitted to CMS, the CDC, and third party organizations).

Plaintiff objects to this Interrogatory as vague and ambiguous due to its use of the undefined term “due diligence.” Plaintiff further objects to this Interrogatory because it seeks discovery of information that is irrelevant to the claims and defenses in this Action and is overly broad, unduly burdensome, and not proportional to the needs of this Action. Any “due diligence” Plaintiff performs when reporting to *third parties* has nothing to do with the claims and defenses in this case related to TLG’s decision to use deceptive business practices, especially when TLG does nothing to ensure the accuracy of information that hospitals that participate in its survey self-report.

Answer: Plaintiff declines to respond to this Interrogatory.

Amended Answer: Subject to the foregoing objections, Plaintiff makes reasonable efforts to ensure the accuracy of the data it reports to third-party organizations. For instance, Plaintiff employs data abstractors, quality coordinators and a Quality Director, who are all responsible for abstracting, validating, and submitting safety data.

Interrogatory No. 17: Describe in detail how You communicate to the shareholders, board members, collective bargaining representatives and investors of Tenet Healthcare System the outcome of any and all healthcare safety ratings, evaluative publications, studies, or performance analyses that Your Hospital receives.

Plaintiff objects to this Interrogatory because it seeks discovery of information that is irrelevant to the claims and defenses in this Action and is overly broad, unduly burdensome, and not proportional to the needs of this Action. Plaintiff’s communication, if any, with the shareholders, board members, collective bargaining representatives and investors of Tenet Healthcare System, all non-parties to this litigation, has nothing to do with the claims and defenses in this case related to TLG’s decision to use deceptive business practices.

Answer: Plaintiff declines to respond to this Interrogatory.

Amended Answer: Subject to the foregoing objection, Plaintiff communicates with Tenet stakeholders, including employees who work to support the Palm Beach Health Network, on a range of matters, including issues related to patient safety and outcomes and in particular related to TLG and the Safety Grades by email and oral communication. Those communications included discussions about the reasons for particular grades, the method used to calculate Safety Grades, the value of Safety Grades, and responses to the Safety Grades. In addition, identified below are documents Plaintiff produced evidencing communications between the Plaintiff Hospitals and Tenet related to TLG, the Leapfrog survey, and Safety Grades.

Start Page	End Page
PBHN000006509	PBHN000006513
PBHN000005132	PBHN000005137
PBHN000002076	PBHN000002078
PBHN000005043	PBHN000005050
PBHN000005060	PBHN000005068
PBHN000006397	PBHN000006401
PBHN000002090	PBHN000002094
PBHN000002095	PBHN000002102
PBHN000002071	PBHN000002071
PBHN000005083	PBHN000005085

PBHN000004562	PBHN000004563
PBHN000004564	PBHN000004564
PBHN000004574	PBHN000004581
PBHN000004556	PBHN000004556
PBHN000004565	PBHN000004569
PBHN000004704	PBHN000004704
PBHN000004715	PBHN000004719
PBHN000005036	PBHN000005042
PBHN000005138	PBHN000005140
PBHN000006465	PBHN000006466

Discovery is ongoing, and Plaintiff reserves the right to amend, modify or supplement the response to this Interrogatory.

Interrogatory No. 18: State whether the compensation of Your Chief Executive Officer or any other executive-level leadership officers is tied to or related in any way to Your hospital's performance on patient safety, union worker contracts or Your hospital's ratings by third party ratings organizations' ratings publications (including but not limited to the Leapfrog Hospital Safety Grade).

Plaintiff objects to this Interrogatory because it seeks discovery of information that is irrelevant to the claims and defenses in this Action and is overly broad, unduly burdensome, and not proportional to the needs of this Action. Plaintiff's method of compensating its Chief Executive Officer and other executive-level leadership **has nothing to do with the** claims and defenses in this case related to TLG's decision to use deceptive business practices.

Answer: TLG has, therefore, only propounded this Interrogatory for purposes of harassment. Plaintiff declines to respond to this Interrogatory.

Amended Answer: Subject to the foregoing objection, Plaintiff's performance on patient safety, union worker contracts, or ratings by third party ratings organizations' ratings publications is related in some way to the compensation of Plaintiff's Chief Executive Officer or other executive-level leadership officer(s).

Interrogatory No. 19: Identify all hospitals, medical centers, or healthcare systems that you consider to be your direct competitors within the relevant geographic market during the time period covered by the Complaint and describe in detail the criteria you use to determine whether another hospital or healthcare provider is a competitor.

Plaintiff objects to this Interrogatory because it seeks discovery of information that is irrelevant to the claims and defenses in this Action and is not reasonably calculated to lead to the discovery of admissible evidence. The identity of Plaintiff's competitors and "the criteria" used to determine whether a hospital or provide is a competitor has nothing to do with the claims and

defenses in this case related to TLG's decision to use deceptive business practices. Plaintiff also objects to this Interrogatory to the extent it seeks confidential, proprietary information, and commercially sensitive information related to Plaintiff's scoring system and "criteria" used to determine whether a hospital or provide is a competitor.

Answer: Subject to the foregoing objections and on condition that this response is considered "Confidential" under the forthcoming agreed confidentiality order, HCA Florida JFK Hospital, HCA Florida Palms West Hospital, Jupiter Medical Center, and Wellington Regional Medical Center are Plaintiff's competitors. Plaintiff considers these hospitals competitors because of their proximity to Plaintiff, their competing services lines, and that patients within Plaintiff's service area go to these hospitals for medical care.

Supplemental Answer: Cleveland Clinic and NYU Langone are also Plaintiff's competitors.

Interrogatory No. 20: State and describe the results of any market analysis, competitive analysis, or consumer perception surveys you have conducted or commissioned regarding your competitors from 2020 to present, and identify the individuals or entities that prepared or participated in such analyses.

Plaintiff objects to this Interrogatory because it seeks discovery of information that is irrelevant to the claims and defenses in this Action and is not is not proportional to the needs of this Action. The results of any market analysis, competitive analysis, or consumer perception surveys and the identity of those who prepared or participated in such analyses has nothing to do with the claims and defenses in this case related to TLG's decision to use deceptive business practices.

Answer: Plaintiff declines to respond to this Interrogatory.

Amended Answer: Plaintiff further objects to this Interrogatory to the extent it requests information from outside of the relevant time period of January 1, 2023, to present. Plaintiff also objects to this Interrogatory as unduly burdensome to the extent it asks Plaintiff to “state and describe” various market analysis.

As agreed during the parties’ meet and confer on September 3, 2025, Plaintiff will produce documents showing the results of studies or surveys Plaintiff has conducted or commissioned related to internal market analysis, competitive analysis, or consumer perception. Plaintiff will identify the documents responsive to this Interrogatory by Bates number in Plaintiffs’ production cover letter.

Interrogatory No. 21: Identify with specificity any comments or concerns raised by any third party payor, bank or lender, or investor related to Your hospital’s reputation and/or public perception on issues in any way involving patient safety or satisfaction.

Plaintiff objects to this Interrogatory because it seeks discovery of information that is overly broad, unduly burdensome and irrelevant to the claims and defenses in this Action and is not proportional to the needs of this case to the extent it seeks “comments and concerns” from third parties related generally to Plaintiff’s reputation that has nothing to do with the specific and significant reputational harm caused by TLG’s misleading grades.

Answer: Subject to the foregoing objections, Plaintiff will produce and identify documents related to the significant reputational harm caused by TLG’s deceptive and unfair Safety Grades that provide sufficient detail to respond to this Interrogatory.

Amended Answer: Subject to the foregoing objections, Plaintiff is unaware of any documents related to this Interrogatory.

Interrogatory No. 22: Identify and describe any complaints, concerns, or comments from patients, community members, or referring physicians that relate to the hospital's reputation or comparisons to other hospitals in the region.

Plaintiff objects to this Interrogatory because it seeks discovery of information that is overly broad, unduly burdensome and irrelevant to the claims and defenses in this Action and is not proportional to the needs of this Action to the extent it seeks "comments and concerns" from patients, community members, or referring physicians that have nothing to do with the significant reputational harm caused by TLG's misleading grades. Plaintiff also objects to this interrogatory as seeking protected health information that is protected from disclosure by HIPAA, among other statutes and regulations. Plaintiff will only produce this information as needed and subject to the agreed protective order entered by this Court.

Answer: Subject to the foregoing objections, Plaintiff has received reports that patients and physicians considered or decided not to use Plaintiff's facility because of TLG's misleading grades.

Amended Answer: Subject to the foregoing objections, Plaintiff has received reports that patients and physicians considered or decided not to use Plaintiff's facility because of TLG's misleading grades. In addition, concerns have been raised by patients, doctors, staff, and community members, and Plaintiff is aware of false and misleading statements based on TLG's false and misleading methodology and Safety Grades made in newspapers, viral social-media videos, television programs, and blogs.

Our Medical Executive Committee has received direct inquiries from patients regarding their concerns as TLG's grades and related public reports. Our Chief Nursing Officer reported that a nursing candidate questioned the quality of care of the hospital in her interview for a job opening.

Patients have asked independent physicians that use both our facilities and those of Jupiter Medical Center (a nearby hospital) to schedule their surgeries at Jupiter Medical Center and not at ours. Those patients chose not to use our hospital specifically because of the Leapfrog grades. These independent surgeons have told us that they believe TLG has misled these patients about the quality of the Medical Center. The harm caused by TLG's false and misleading Safety Grade is ongoing.

In addition, the following produced documents evidence such harm.

Start Page	End Page
PBHN000006771	PBHN000006773
PBHN000002082	PBHN000002085
PBHN000002066	PBHN000002070
PBHN000002076	PBHN000002078
PBHN000002615	PBHN000002617
PBHN000005016	PBHN000005021
PBHN000005022	PBHN000005028
PBHN000005043	PBHN000005050
PBHN000005060	PBHN000005068
PBHN000005169	PBHN000005175
PBHN000006397	PBHN000006401

PBHN000002090	PBHN000002094
PBHN000002095	PBHN000002102
PBHN000004484	PBHN000004484
PBHN000004564	PBHN000004564
PBHN000004574	PBHN000004580
PBHN000004557	PBHN000004557
PBHN000005138	PBHN000005140
PBHN000008718	PBHN000008718
PBHN000002079	PBHN000002081
PBHN000006461	PBHN000006462
PBHN000008914	PBHN000008914
PBHN000008915	PBHN000008915

Discovery is ongoing, and Plaintiff reserves the right to amend, modify or supplement the response to this Interrogatory.

Interrogatory No. 23: List with specific detail each and every concern, complaint or comment made by any union, collective bargaining unit or employee association in any way related to patient safety at Your hospital.

Plaintiff objects to this Interrogatory because it seeks discovery of information that is overly broad, unduly burdensome and irrelevant to the claims and defenses in this Action and is overly broad, unduly burdensome, and not proportional to the needs of this Action to the extent it seeks “each and every concern, complaint or comment ” from third parties that have nothing to do with the significant reputational harm caused by TLG’s misleading grades. Plaintiff also objects to this Interrogatory to the extent it seeks health information that is protected from disclosure by HIPAA, among other statutes and regulations. Plaintiff will only produce this information as needed and subject to the agreed protective order entered by this Court.

Answer: Subject to the foregoing objections, Plaintiff is unaware of any concern, complaint or comment regarding TLG deceptive scores made by the union at Plaintiff’s hospital.

Amended Answer: Subject to the foregoing objections, Plaintiff is unaware of any concern, complaint, or comment regarding TLG’s deceptive scores or regarding patient safety made by the union at Plaintiff’s hospital.

Interrogatory No. 24: Identify any and all criticism You have received since 2020 from Tenet Healthcare Corporation and/or from any individual executive of Tenet Healthcare Corporation regarding Your hospital’s performance in any way.

Answer: Plaintiff objects to this Interrogatory because it seeks discovery of information that is overly broad, unduly burdensome and irrelevant to the claims and defenses in this Action and is not reasonably calculated to lead to the discovery of admissible evidence. Any so-called “criticism” has nothing to do with the claims and defenses related to TLG’s decision to use deceptive business practices. TLG has, therefore, only propounded this Interrogatory for purposes of harassment. Plaintiff declines to respond to this Interrogatory.

Amended Answer: As discussed during the parties' meet and confer on September 3, 2025, TLG agreed to narrow this Interrogatory to concern only "criticism...regarding Your hospital's patient safety." After a reasonable and diligent search, Plaintiff is unaware of having received "criticism" from Tenet Health Corporation regarding patient safety. Plaintiff is always working to improve its performance, quality, and safety in a constructive way and engages with Tenet Health Corporation as needed to ensure Plaintiff provides the best patient care possible.

Dated: September 8, 2025

Respectfully submitted,

By: /s/ Lee R. Crain

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Inc.*

CERTIFICATE OF SERVICE

This is to certify that true and correct copies of Plaintiff's Amended and Supplemented Responses and Objections to Defendant The Leapfrog Group's First Sets of Interrogatories to Plaintiff have been served on counsel for The Leapfrog Group by electronic transmission.

/s/ Lee R. Crain
Lee R. Crain

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

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

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

Plaintiffs,

v.

THE LEAPFROG GROUP,

Defendant.

**AFFIDAVIT OF SHERI MONTGOMERY IN SUPPORT OF
PLAINTIFF GOOD SAMARITAN MEDICAL CENTER, INC.'S
AMENDED AND SUPPLEMENTED RESPONSES AND OBJECTIONS TO
DEFENDANT THE LEAPFROG GROUP'S FIRST SET OF
INTERROGATORIES TO GOOD SAMARITAN MEDICAL CENTER, INC.**

I, Sheri Montgomery, declare as follows:

1. I am over 21 years of age and competent to give this testimony.
2. I am the Chief Executive Officer of Good Samaritan Medical Center, Inc. ("Plaintiff"). I am the corporate representative of Plaintiff for the purpose of answering Defendant The Leapfrog Group's First Set of Interrogatories to Good Samaritan Medical Center, Inc. I have read the foregoing interrogatories and the answers to those interrogatories, which are true according to the best of my knowledge, information, and belief.
3. I declare under penalty of perjury that the foregoing is true and correct.

Executed on September 8, 2025.


Sheri Montgomery

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

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

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

Plaintiffs,

v.

THE LEAPFROG GROUP,

Defendant.

**PLAINTIFF PALM BEACH GARDENS MEDICAL CENTER’S
AMENDED AND SUPPLEMENTED RESPONSES AND OBJECTIONS TO
DEFENDANT THE LEAPFROG GROUP’S FIRST SET OF
INTERROGATORIES TO PALM BEACH GARDENS MEDICAL CENTER**

Pursuant to Federal Rules of Civil Procedure 26 and 33 and the *Pretrial Scheduling Order and Order Referring Case to Mediation* (ECF No. 36) (the “Pretrial Scheduling Order”), Plaintiff Palm Beach Gardens Medical Center (“Plaintiff” or “Palm Beach Gardens”), by and through its undersigned counsel, hereby submit its amended and supplemented responses and objections (“Responses”), to Defendant The Leapfrog Group’s (“TLG”) First Set of Interrogatories, dated July 11, 2025 (the “Interrogatories” and each numbered interrogatory, an “Interrogatory”) in the above-captioned action (the “Action”).

Plaintiff’s Responses to the Interrogatories are made solely for purposes of this Action and to the best of Plaintiff’s present knowledge, information, and belief regarding the matters about which inquiry have been made. Discovery is ongoing, and Plaintiff reserves the right to amend, supplement, clarify, or further explain its Responses at any time prior to the trial in

this Action. Plaintiff further reserves the right to raise any additional objections deemed necessary or appropriate in light of any further review.

OBJECTIONS TO INSTRUCTIONS AND DEFINITIONS

1. Plaintiff objects to the definition of terms “Plaintiffs” and “Plaintiff Hospitals” as overbroad, unduly burdensome, and not proportional to the needs of the case to the extent it seeks to require Plaintiffs to respond on behalf of entities or individuals other than themselves.

2. Plaintiff objects to the definition of the terms “Palm Beach Gardens,” “Palm Beach Gardens Medical Center,” “Plaintiff,” “You,” and “Your” to the extent each term seeks to require Plaintiff to respond on behalf of entities or individuals other than itself, including on behalf of agents, employees, directors, or other non-party entities that are not part of this litigation. Such information is overbroad and beyond the scope of permissible discovery. Accordingly, Plaintiff states that its Responses are on behalf of itself only.

3. Plaintiff objects to the definition of the terms “Tenet Healthcare” and “Tenet” to the extent it seeks to require Plaintiff to respond on behalf of entities or individuals other than itself, including on behalf of Tenet, Tenet’s agents, employees, directors, or other non-party entities that are not part of this litigation. Such information is overbroad and beyond the scope of permissible discovery. Accordingly, Plaintiff states that its Responses are on behalf of itself only.

4. Plaintiff objects to the definition of “identify, when referring to a person,” as overbroad and unduly burdensome to the extent it calls for the “address” and “present or last-known employer” of identified individuals. Such information is overbroad and beyond the scope of permissible discovery.

5. Plaintiff objects to the instruction that the relevant time period for the Interrogatories begins on January 1, 2020. Plaintiff will apply to each Interrogatory the time period

of November 1, 2023 to present (the “Relevant Time Period”). Any response to an Interrogatory that provides information that falls outside of the Relevant Time Period should not be construed as an admission that the Relevant Time Period begins prior to November 1, 2023.

SPECIFIC RESPONSES TO INTERROGATORIES

Interrogatory No. 1: State the full name, address, job title or position, and hospital or employer affiliation of all individuals that assisted with responding to these interrogatories.

Answer: The following individuals assisted with responding to these Interrogatories.

Full Name	Address	Job Title / Position	Hospital or Employer Affiliation
Erik Cazares	c/o Gibson, Dunn & Crutcher LLP 200 Park Avenue New York, NY 10166	Chief Executive Officer	Palm Beach Gardens Community Hospital
Regina West	c/o Gibson, Dunn & Crutcher LLP 200 Park Avenue New York, NY 10166	Market Quality Director	Palm Beach Health Network and St. Mary’s Medical Center

Interrogatory No. 2: Identify every individual not identified in Your Rule 26(a) initial disclosures with knowledge of facts pertaining to the allegations in Your Complaint in this Lawsuit (and any subsequent amendments) and/or whom You believe may have discoverable knowledge, information or data regarding this matter, including those who You expect to call as a fact or opinion witness at any hearing in this proceeding or whose testimony (by affidavit, deposition or testimony) You intended to submit in connection with this proceeding, and the substance of his/her testimony or affidavit, and, with respect to each person identified, provide:

- A. full name,
- B. address,
- C. telephone number,
- D. job title or position,
- E. hospital or employer affiliation,
- F. and describe in detail the facts possessed by each such person.

Plaintiff objects to this Interrogatory as overly broad, unduly burdensome, and not proportional to the needs of this Action to the extent it seeks the identity of “every individual...with knowledge” or who “may have discoverable knowledge, information or data regarding this matter.” Plaintiff will not provide more than the identity of individuals most likely to have knowledge regarding this matter. Plaintiff further objects to this Interrogatory as premature because it requests disclosure of Plaintiff’s witnesses for hearings and the substance of witness testimony before such disclosure is required under applicable law or the Pretrial Scheduling Order. Plaintiff will submit its trial witness list on October 2, 2025, per the Pretrial Scheduling Order, and disclose any other witnesses and witness testimony as further ordered by the Court or otherwise required by applicable law. Plaintiff also objects to this Interrogatory’s request for the identity of “opinion witness[es]” as vague, since witnesses are either “fact” or “expert” witnesses. Plaintiff will interpret “opinion witness” to mean “expert witness.” Plaintiff submitted expert reports on August 7, 2025, per the Pretrial Scheduling Order.

Answer: Subject to the foregoing objection, Plaintiff will amend its Rule 26(a)(1) Initial Disclosures to identify additional individuals who may have knowledge of facts pertaining to the allegations in the Complaint.

Amended Answer: In addition to those disclosed in Plaintiff’s supplemental disclosures, the following individuals may have relevant factual knowledge:

Full Name	Address	Job Title / Position	Hospital or Employer Affiliation
Regina West	c/o Gibson, Dunn & Crutcher LLP 200 Park Avenue New York, NY 10166	Market Quality Director	Palm Beach Health Network and St. Mary’s Medical Center

Full Name	Address	Job Title / Position	Hospital or Employer Affiliation
Kathleen McDonald	c/o Gibson, Dunn & Crutcher LLP 200 Park Avenue New York, NY 10166	Quality Director	Palm Beach Gardens Community Hospital

In addition to the individuals identified above, persons identified in documents produced in this dispute have knowledge of facts pertaining to the allegations in the Amended Complaint. *See* Fed. R. Civ. P. 33(d). Discovery is ongoing, and Plaintiff reserves the right to supplement, amend, correct, clarify, or modify this Response as further information becomes available.

Interrogatory No. 3: Describe in detail all factual bases for Your contention that Leapfrog’s published Safety Grade for Your hospital was false, inaccurate, misleading, deceptive, or unfair. In so answering, identify with particularity each measure, data point, or metric that You contend was inaccurately reported, calculated, or misrepresented by Leapfrog in calculating the Safety Grade for Your hospital.

Answer: Plaintiff objects to this Interrogatory as overly broad, unduly burdensome, and not proportional to the needs of this Action to the extent it seeks “all factual bases” for Plaintiff’s contention. *See Megdal Assocs., LLC v. La-Z-Boy, Inc.*, 2016 WL 4503337, at *6 (S.D. Fla. Feb. 1, 2016) (finding interrogatories asking for “‘all’ facts or witnesses that support an opposing party’s case” to be “unduly broad”) (citing 8B Wright, Miller, & Kane, Federal Practice and Procedure: Civil 3d § 2167 (2015)). Plaintiff further objects to this Interrogatory as premature to the extent it requests that Plaintiff “[d]escribe in detail all factual bases” to support its contention. *In re Reliance Fin. & Inv. Grp., Inc.*, 2006 WL 8435541, at *4 (S.D. Fla. Feb. 14, 2006) (Contention interrogatories “are more appropriately used after a substantial amount of discovery has been conducted--typically, at the end of the discovery period.”). Plaintiff also objects to this Interrogatory to the extent it attempts to limit or mischaracterize Plaintiff’s claim as just

challenging the false, inaccurate, misleading, deceptive, or unfair nature of TLG's Safety Grade. As the Court explained in its order denying TLG's motion to dismiss, the core of the Complaint is "a challenge to Defendant's representations about its methodology, which they claim mislead consumers by failing to distinguish between absent data and damning data, and professing that grades are not influenced by a hospital's lack of survey participation." *Order on Motion to Dismiss* 6 (ECF No. 41). Plaintiff also challenges the provably false facts and deceptive scoring system underlying these grades, which TLG admits it relies on to arrive at its deceptive Safety Grades.

Subject to the foregoing objections and as more fully stated in the *Amended Complaint* (ECF No. 74) ("Complaint"), TLG has engaged in deceptive and unfair business practices and misrepresentations when issuing the Safety Grade for Plaintiff's hospital as part of TLG's annual "Hospital Survey." TLG posts these Safety Grades online at hospitalsafetygrade.org.

To arrive at these Safety Grades, TLG uses CMS data, survey responses from participating hospitals, and other supplemental data sources. For participating hospitals, TLG uses the hospitals' self-reported responses to the Hospital Survey for 12 of the 22 measures. For non-participating hospitals, TLG uses other sources for those 12 measures. For the remaining four measures—Computerized Physician Order Entry, Bar Code Medication Administration, ICU Physician Staffing, and Hand Hygiene Score (the "Deceptive Score Categories")—TLG devised and uses a so-called "imputation model." Prior to Fall 2024, TLG's imputation model assigned non-participating hospitals a score based on the average score applicable to a similarly situated hospital. Beginning in Fall 2024, TLG modified its imputation model. TLG now assigns the lowest possible score to non-participating hospitals, which has the effect of punishing non-participating hospitals and artificially deflating their Safety Grades. TLG has even admitted the changes in Fall 2024 were designed to penalize non-participating hospitals. TLG also misleads consumers about how

it grades hospitals, stating “[t]he Hospital Safety Grade reflects how well a hospital does on safety, not whether they complete the [TLG] Hospital Survey.” *Declaration of Lee Crain* (ECF No. 21) (“Crain Decl.”), Ex. 1 at 4 (“Frequently Asked Questions About the Leapfrog Hospital Safety Grade”).

As TLG explains, “not all hospitals have enough data publicly available to be eligible for a grade.” Crain Decl. Ex. 1 at 5. “As per the National Expert Panel guidance, [TLG] has requirements for the minimum amount of data [it] need[s] to issue an accurate grade.” Crain Decl. Ex. 1 at 5. According to TLG, “[h]ospitals missing more than six process measures” are “not graded.” Crain Decl. Ex. 2 at 6. Non-participating hospitals should fall easily into that “not graded” bucket, because their decision not to participate in TLG’s survey necessarily means TLG is missing seven process measures that rely on voluntary submission of hospital data.¹

TLG then deceptively conceals how it makes up grades for the four “imputation” measures and even suggests on its website that TLG *does* have data sufficient to score TLG on those four measures. By way of example, TLG acknowledges that Plaintiff “Declined to Report” information in response to questions about “Staff work[ing] together,” but then tells consumers—as if it were a fact—that Plaintiff is “Worse Than Average” on “Handwashing,” “Communication,” “medication administration,” and the like—even though TLG has no basis whatsoever to adopt those conclusions. Crain Decl. Ex. 32 at 2. TLG itself says handwashing is among the “most important” measures in its survey, Crain Decl. Ex. 15 at 4, yet it deceptively conceals that it has no data with which to grade the Plaintiff hospital on that measure. *Defendant The Leapfrog Group’s Responses to Plaintiffs’ Requests for Production* at 7 (“Leapfrog is not itself in possession

¹ Those seven include CPOE, BCMA, IPS, Safe Practice 1: Culture of Leadership Structures and Systems; Safe Practice 2: Culture Measurement, Feedback & Intervention; Total Nursing Care Hours per Patient Day; and Hand Hygiene.

of data showing Plaintiffs' performance on the 'imputed metrics' considered by the methodology."'). Of course, Plaintiff in fact has a comprehensive and thorough handwashing policy. And had Plaintiff merely filled out TLG's survey, it would have received a full two letter grades higher on TLG's score. *Expert Report of Professor Sean Nicholson* (Aug. 7, 2025), Ex. 6.

Based on the foregoing, and as more fully set forth in the Complaint, TLG engages in deceptive trade practices by, among other things, deceiving consumers about its grading methods by implying that Plaintiff has failed on certain measures that, in truth, TLG has no data or other basis to evaluate; deceiving consumers by telling them the Hospital Safety Grade reflects how well a hospital does on safety, not whether they complete the Hospital Survey; deceiving consumers when it represents that it does not grade hospitals if it lacks sufficient data, when, in truth, it does grade hospitals by "imputing" or making up a grade for the Deceptive Score Categories; hiding the truth about its "imputation model" from consumers by burying it in fine print on a separate website; punishing non-participating hospitals by "imputing" scores, which artificially deflate a hospital's Safety Grade; and favoring participating hospitals. Additional factual bases for the Plaintiff's claims are presented in the Complaint.

Interrogatory No. 4: Describe the scoring or grading methodology You believe Leapfrog should have used to assess Your hospital's patient safety performance and explain why that method would yield a different result.

Plaintiff objects to this Interrogatory because it seeks discovery of information that is irrelevant to the claims and defenses in this Action and is overly broad, unduly burdensome, and not proportional to the needs of this Action. Plaintiff's provision of an alternative scoring or grading methodology has nothing to do with the claims and defenses in this case related to TLG's

decision to use deceptive business practices. Plaintiff further objects to this Interrogatory to the extent it calls for speculation.

Answer: Plaintiff declines to respond to this Interrogatory.

Amended Answer: Subject to the foregoing objections, Plaintiff responds that TLG should use a scoring system that is not unfair or deceptive. By way of example only, TLG could decline to grade hospitals that do not participate in TLG's survey, because their decision not to participate means TLG is missing seven process measures that rely on voluntary submission of hospital data. This would yield a different result, because the hospitals would not receive a grade at all. TLG's methodology certainly should not affirmatively assign an arbitrary low score to a particular metric just because a hospital does not provide data for that metric.

Interrogatory No. 5: State whether You submitted any data, corrections, or appeals to Leapfrog regarding the Safety Grade Your hospital received, and for each such submission, identify the date of the submission, the medium of the submission (i.e. telephone, video conference, email, letter, etc.), who was involved in the submission, and the content of the submission.

Plaintiff objects to this Interrogatory because it seeks discovery of information that is irrelevant to the claims and defenses in this Action and is overly broad, unduly burdensome, and not proportional to the needs of this Action. Whether or not Plaintiff submitted "any data, corrections, or appeals to Leapfrog regarding the Safety Grade" Plaintiff hospital received has nothing to do with the claims and defenses in this case related to TLG's decision to use deceptive business practices. Plaintiff further objects to this Interrogatory to the extent it seeks information that is already in TLG's possession, custody and control, or equally available to TLG.

Answer: Subject to the foregoing objections, Plaintiff engaged in correspondence prior to the commencement of this case demanding that TLG reform its deceptive practices and cease and desist reporting deceptive and unfair Safety Grades, but at every turn TLG refused.

Amended Answer: Subject to the foregoing objections, Plaintiff did not submit any data, corrections or appeals to Leapfrog regarding the Safety Grades it has received.

Interrogatory No. 6: State whether You provided any comment or input in any form during Leapfrog's requests for public comments for planned updates to the Leapfrog Hospital Safety Grade methodology that was proposed for the calculation of Hospital Safety Grades (including but not limited to for the Fall 2024 methodology update). If yes, please identify the date of the comment, the medium of the submission (i.e. telephone, video conference, email, letter, etc.), who was involved in the comment and the content of the comment. If no, please state the reason why You chose not to comment.

Answer: Plaintiff objects to this Interrogatory because it seeks discovery of information that is irrelevant to the claims and defenses in this Action and is overly broad, unduly burdensome, and not proportional to the needs of this Action. Whether or not Plaintiff submitted "any comment or input" in response to TLG's request for public comments has nothing to do with claims and defenses in this case related to TLG's decision to use deceptive business practices. Plaintiff further objects to this Interrogatory to the extent it seeks information that is already in TLG's possession, custody and control, or equally available to TLG.

Subject to the foregoing objections, Plaintiff did not provide comments in response to Leapfrog's requests for public comments for planned updates to the Leapfrog Hospital Safety Grade scoring system because Plaintiff generally does not respond to requests for public comment from private entities like TLG.

Interrogatory No. 7: Describe all actions Your hospital took in response to (or in deciding not to respond to) its Safety Grade or the Hospital Survey, including internal meetings, media statements, or public relations efforts. In so answering, state the date of the action, the individuals involved in the action and the content of the action.

Plaintiff objects to this Interrogatory as overly broad, unduly burdensome, and not proportional to the needs of this Action to the extent it seeks “all actions” Plaintiffs may have taken in response to TLG’s Safety Grades. *See Megdal Assocs., LLC v. La-Z-Boy, Inc.*, No. 14-81476-CIV, 2016 WL 4503337, at *6 (S.D. Fla. Feb. 1, 2016) (finding interrogatories asking for “‘all’ facts or witnesses that support an opposing party’s case” to be “unduly broad”) (citing 8B Wright, Miller, & Kane, Federal Practice and Procedure: Civil 3d § 2167 (2015)). Plaintiff further objects to this Interrogatory to the extent it seeks information that is subject to a claim of privilege or otherwise protected from disclosure, including seeking information protected by the attorney-client privilege, work-product doctrine, or other immunity.

Answer: Subject to the foregoing objections, Plaintiff devoted substantial time and resources that could have otherwise been spent continuing to improve patient care to respond to the significant harm and disruption caused by TLG’s deceptive and unfair Safety Grade. Plaintiff’s response included meeting internally with Plaintiff’s leadership team, medical executive committee, and governing board, corresponding with TLG to demand that TLG reform its deceptive practices and cease and desist reporting deceptive and unfair Safety Grades, and devoting substantial time and resources to facilitate the preparation and prosecution of this Action.

Amended Answer: Subject to the foregoing objections, Plaintiff devoted substantial time and resources that could have otherwise been spent continuing to improve patient care to respond to the significant harm and disruption caused by TLG’s deceptive and unfair Safety Grades. Plaintiff’s response included meeting internally with Plaintiff’s leadership team, medical executive

committee, and governing board, corresponding through Plaintiff's corporate parent with TLG to demand that TLG reform its deceptive practices and cease and desist reporting deceptive and unfair Safety Grades, and devoting substantial time and resources to facilitate the preparation and prosecution of this Action. Plaintiff has also held many phone calls and meetings with physicians and other stakeholders about the TLG grades, explaining how the grades were deceptive and did not accurately reflect the hospital quality and patient safety at Plaintiff.

Interrogatory No. 8: Identify any and all persons, whether internal or external (e.g., patients, vendors, affiliates, parents, agents, partners, media) with whom You communicated in any way with respect to the Safety Grade or the Hospital Survey. In so answering, state the date of the communication, the individuals involved in the communication, the medium of the communication (i.e. telephone, video conference, email, letter, etc.) and the content of the communication.

Plaintiff objects to this Interrogatory as overly broad, unduly burdensome, and not proportional to the needs of this Action to the extent it seeks the identity of "any and all persons, whether internal or external." Plaintiff will disclose the categories of individuals with whom Plaintiff communicated about the Safety Grade or Hospital Survey during the Relevant Time Period. Plaintiff also objects to this Interrogatory to the extent it seeks protected health information that Health Insurance Portability and Accountability Act ("HIPAA"), among other statutes and regulations, bars Plaintiff from disclosing. Plaintiff further objects to this Interrogatory to the extent it seeks information that is subject to a claim of privilege or otherwise protected from disclosure, including seeking information protected by the attorney-client privilege, work-product doctrine, or other immunity.

Answer: Subject to the foregoing objections, Plaintiff communicated with the following categories of people regarding the Safety Grade or the Hospital Survey: Plaintiff's governing board, its medical executive committee, department directors, and physicians and nurses when

asked about the Safety Grade or Hospital Survey. These communications occurred in and after Fall 2024, after TLG released its deceptive and unfair Safety Grade for Plaintiff's hospital. Most of these communications occurred during regularly scheduled meetings, during which attendees were told about TLG's release of the deceptive and unfair Safety Grade, that Plaintiff does not participate in the Hospital Survey because it is unreliable and not an accurate reflection of hospital quality and safety or patient outcomes, and that the Safety Grade, which was not based on any information provided by Plaintiff, was misleading. The Palm Beach Health Network also issued a press release and since then, has engaged in various social networking and other marketing campaigns to counteract TLG's deceptive scores on behalf of Plaintiff and other affected members of the network.

Amended Answer: Subject to the foregoing objections, Plaintiff communicated with the following categories of people regarding the Safety Grade or the Hospital Survey: Plaintiff's governing board, its medical executive committee, department directors, physicians and nurses, and patients when asked about the Safety Grades or Hospital Survey. These communications occurred in and after Fall 2024, after TLG released its deceptive and unfair Safety Grades for Plaintiff's hospital. Most of these communications occurred during regularly scheduled meetings, during which attendees were told about TLG's release of the deceptive and unfair Safety Grade, that Plaintiff does not participate in the Hospital Survey because it is unreliable and not an accurate reflection of hospital quality and safety or patient outcomes, and that the Safety Grade, which was not based on any information provided by Plaintiff, was misleading. The Palm Beach Health Network also issued a press release and has engaged in marketing efforts, including through social media, to counteract TLG's deceptive scores on behalf of Plaintiff and other affected members of

the network. Plaintiff also engaged in email discussions about TLG's misleading grades, either as sender or recipient, which TLG has through Plaintiff's production of documents.

Interrogatory No. 9: Describe all instances in which a third party declined to contract with, refer patients to, or work with Your hospital, where Leapfrog's grade was cited or discussed. In so identifying list the name of the individuals involved in the communication, the medium of the communication (i.e. telephone, video conference, email, letter, etc.), the date of the communication and the content of the communication.

Answer: Plaintiff objects to this Interrogatory as overly broad, unduly burdensome, and not proportional to the needs of this Action to the extent it requires Plaintiff to "[d]escribe all instances" in which a third party took an action in response to TLG's deceptive grade.

Subject to the foregoing objection, Plaintiff is not aware of any responsive instances.

Interrogatory No. 10: Describe with specificity the basis for each and every category of damage You claim You incurred as a result of the Leapfrog Safety Grade. In so identifying, list each category of damages and the dollar value of each category of damage You claim.

Plaintiff objects to this Interrogatory to the extent it seeks information that is the subject of expert testimony.

Answer: Plaintiff will submit expert reports on August 7, 2025, per the Pretrial Scheduling Order.

Amended Answer: Plaintiff has served the expert report of Thomas Chakurda, which addresses the issue of reputational harm and harm to Plaintiff's goodwill. Plaintiff further objects to this Interrogatory as overbroad and unduly burdensome to the extent it seeks "each and every" category of claimed damages.

Subject to the foregoing objections and as agreed during the parties' September 3, 2025 meet and confer, Plaintiff will limit its response to the live non-monetary claims, including

injunctive and declaratory relief, to remedy harm to Plaintiff's reputation and goodwill. Plaintiff's reputation and goodwill has been damaged by TLG's false and misleading methodology and resulting Safety Grades. Plaintiff's claim for reputational harm is based on, among other things, concerns raised by patients, doctors, staff, and community members, as well as false and misleading statements based on TLG's false and misleading methodology and Safety Grades made in newspapers, viral social-media videos, television programs, and blogs.

By way of example, we have received reports from patients that they decided not to use our hospital due to the misleading grade TLG assigned to the hospital. Our Medical Executive Committee has received direct inquiries from patients regarding their concerns about TLG's grades and related public reports. Patients have asked independent physicians that use both our facilities and those of Jupiter Medical Center (a nearby hospital) to schedule their surgeries at Jupiter Medical Center and not at ours. These independent surgeons have told us that they believe TLG has misled these patients about the quality of the Medical Center because these surgeons believe our hospital provides higher-quality care. Doctors have had patients express that they do not want to come to the Medical Center, specifically because of the Leapfrog grade. The harm caused by TLG's false and misleading Safety Grade is ongoing.

Interrogatory No. 11: Identify all adverse patient events which occurred at Your hospital, including any citations received from regulatory agencies, accrediting agencies, and third party payors such as The Joint Commission, CMS, state health departments, etc. during the period covered by each Leapfrog Safety Grade publication of which You complain (i.e., Fall 2024, Fall 2025, etc.), as well as any complaints received from patients regarding the same.

Plaintiff objects to this Interrogatory because it is overly broad, unduly burdensome, seeks discovery of information that is irrelevant to the claims and defenses in this Action, seeks information that is beyond the scope of Leapfrog's Hospital Survey, and is not reasonably

calculated to lead to the discovery of admissible evidence. TLG does not include “all adverse patient events,” “citations received from” agencies or payors, or “complaints received from patients” in TLG’s determination of its Hospital Safety Grades or request such information in the Hospital Survey, so any such information is irrelevant to whether TLG’s actions constitute unfair or deceptive trade practices. TLG has, therefore, only propounded this Interrogatory for purposes of harassment. Plaintiff also objects to this Interrogatory to the extent it seeks protected health information that HIPAA, among other statutes and regulations, bars Plaintiff from disclosing.

Answer: Plaintiff declines to respond to this Interrogatory.

Amended Answer: Defendant has agreed to withdraw this Interrogatory.

Interrogatory No. 12: Describe in detail how Your hospital compares nationally on on [sic] any other ranking of patient safety performance, including but not limited to Vizient, Inc., Premier, Inc., HealthTrust Purchasing Group, The Joint Commission, HealthGrades, US News, Newsweek, Statista, Definitive Healthcare, or any other quality benchmarking entity including benchmarking on patient safety including on adverse events and on healthcare-acquired infections.

Plaintiff objects to this Interrogatory’s request that Plaintiff “[d]escribe in detail how Your hospital compares nationally” based on undisclosed “benchmarking” as vague and confusing. To the extent this Interrogatory seeks the top-line rankings of the identified organizations, Plaintiff objects to this Interrogatory because such information is publicly and equally available to TLG. To the extent this Interrogatory asks Plaintiff to compare itself to the named and unnamed entities, that request is overly broad, unduly burdensome, and not proportional to the needs of this Action. Plaintiff further objects to this Interrogatory because it seeks discovery of information that is irrelevant to the claims and defenses in this Action and is overly broad, unduly burdensome, and not proportional to the needs of this Action. Other organizations’ rankings have nothing to do with

the claims and defenses in this case related to the Deceptive Score Categories or TLG's decision to use deceptive business practices.

Answer: Subject to the foregoing objections, Plaintiff has received numerous awards and accolades, including many that are especially relevant to patient care for the over-65 patient community that represent over 50% of the patients we serve. Plaintiff is accredited by the Joint Commission, the nation's largest hospital accreditor that evaluates hospitals' quality performance standards through an objective evaluation process. Plaintiff has also been accredited by Joint Commission as an Advanced Primary Stroke Center—a certification designed for hospitals providing the critical elements to achieve long-term success in improving stroke outcomes—and Total Joint Hip/Knee Certification—which signifies our services have delivered evidence-based proof of clinical quality sought by patients and payers alike. Additionally, it has a lab accreditation from the College of American Pathologists—requirement to perform testing on specimens from human beings—and was selected as a certified program with the American Association of Cardiovascular and Pulmonary Rehabilitation (AACVPR)—the only peer-reviewed accreditation process designed to review individual facilities for adherence to standards and guidelines developed and published by the AACVPR. These accreditations and certifications are only awarded after in-person visits to Plaintiff where our health care professionals are interviewed and patient care is reviewed first hand. We are subject to regular periodic in-person reviews, audits, surveys, and assessments of the facility.

Plaintiff has also received numerous awards that exemplify its quality such as Blue Distinction Center+ Designation for Quality and Cost-Efficiency in Knee and Hip Replacement Surgeries by BlueCross BlueShield, the Joint Commission's Gold Seal of Approval for Hip and Knee Replacement, an Aetna Institute of Quality Orthopedic Facility for Total Joint Replacement

and Spine Surgery, Get with the Guidelines Gold Plus Stroke Recognition Award from the American Heart Association for 10 years straight, and the Gold Plus Diabetes Recognition Award for the last three years, among several other awards.

In 2025, the medical ranking organization Healthgrades gave Plaintiff the award for “America’s 100 Best for Spine and Outpatient Orthopedic Excellence Award.” To assess and evaluate hospitals, Healthgrades relies on data from Medicare medical claims records and states’ data on Medicare and commercially insured patient outcomes to determine patients’ actual clinical outcomes when visiting a given hospital. Healthgrades also assigned Plaintiff five-star awards for various specialties, including:

a. Cardiac Care

- i. Five-Star Recipient for Valve Surgery (2023, 2025)
- ii. Five-Star Recipient for Treatment of Heart Failure for three years in a row (2023-2025)
- iii. Five-Star Recipient for Carotid Procedures for three years in a row (2023-2025)
- iv. Recipient of the Healthgrades 2023 Cardiac Surgery Excellence Award
- v. Top 10% in the Nation for Cardiac Surgery (2023)

b. Critical Care

- i. Five-Star Recipient for Respiratory Failure for two years in a row (2024-2025)

c. Gastrointestinal

- i. Five-Star Recipient for Colorectal Surgeries (2025)
- ii. Five-Star Recipient for Treatment of GI Bleed (2024)

d. Neurosurgery

- i. Five-Star Recipient for Treatment of Stroke (2025)

e. Pulmonary

- i. Five-Star Recipient for Treatment of Pneumonia for three years in a row (2023-2025)
- ii. Recipient of the Healthgrades Pulmonary Care Excellence Award (2024, 2025)
- iii. Top 10% in the Nation for Pulmonary Care (2024, 2025)
- iv. Five Star Recipient for Treatment of Chronic Obstructive Pulmonary Disease (2024).

In addition, Plaintiff will produce and identify documents reflecting some of Plaintiff's rankings from other organizations.

Amended Answer: Plaintiff has received numerous awards and accolades. For example, Plaintiff is accredited by the Joint Commission. Plaintiff has also been accredited by Joint Commission as an Advanced Primary Stroke Center and earned Total Joint Hip/Knee Certification. Additionally, it has a lab accreditation from the College of American Pathologists and was selected as a certified program with the American Association of Cardiovascular and Pulmonary Rehabilitation (AACVPR).

Plaintiff has also received the Blue Distinction Center+ Designation for Quality and Cost-Efficiency in Knee and Hip Replacement Surgeries by BlueCross BlueShield, an Aetna Institute of Quality Award, Get with the Guidelines Gold Plus Stroke Recognition Award from the American Heart Association, and the Gold Plus Diabetes Recognition Award, among several other awards.

In 2025, the medical ranking organization Healthgrades assigned Plaintiff five-star awards for various specialties, including:

a. Cardiac Care

- i. Five-Star Recipient for Valve Surgery (2025)
- ii. Five-Star Recipient for Treatment of Heart Failure for three years in a row (2023-2025)
- iii. Five-Star Recipient for Carotid Procedures for three years in a row (2023-2025)

b. Critical Care

- i. Five-Star Recipient for Respiratory Failure (2024, 2025)

c. Gastrointestinal

- i. Five-Star Recipient for Colorectal Surgeries (2025)

d. Neurosurgery

- i. Five-Star Recipient for Treatment of Stroke (2025)

e. Pulmonary

- i. Five-Star Recipient for Treatment of Pneumonia for three years in a row (2023-2025)
- ii. Recipient of the Healthgrades Pulmonary Care Excellence Award (2024, 2025)

In addition, Plaintiff will produce and identify documents reflecting some of Plaintiff's rankings from other organizations.

Also, Plaintiff does not participate in Vizient and has not done so during the Relevant Time Period.

Interrogatory No. 13: Describe any steps taken by Your hospital to improve any and all of the patient safety measures considered by Leapfrog's Hospital Safety Grade (as set forth on Leapfrog's published scoring methodology documents; see ECF No. 21-3 at 6-10; ECF No. 21-43 at 6-9), before and after each Safety Grade publication of which You complain.

Plaintiff objects to this Interrogatory as overly broad, unduly burdensome, and not proportional to the needs of this Action to the extent it seeks the identity of Plaintiff's improvements to "any and all" patient safety measures considered by Leapfrog's Hospital Safety Grade. Plaintiff further objects to this Interrogatory because it seeks discovery of information that is irrelevant to the claims and defenses in this Action and is overly broad, unduly burdensome, and not proportional to the needs of this Action to the extent it seeks information on metrics other than TLG's Deceptive Score Categories and to the extent it seeks information that is beyond the scope of Leapfrog's Hospital Survey.

Answer: Plaintiff declines to respond to this Interrogatory.

Amended Answer: Subject to the foregoing objection, Plaintiff is committed to continual improvement of patient safety measures, motivated by our commitment to ensuring the best possible patient safety—not chasing the best possible Leapfrog grade. To achieve this core objective, Plaintiff devotes significant time and resources to improving its delivery of the highest possible quality of care for those in the community it serves, including efforts to improve its performance in areas related to the four metrics Plaintiff has chosen to impute in its survey.

Plaintiff reviews its CPOE, BCMA, and Hand Hygiene metrics at periodic meetings to ensure patient safety and compliance and develop and review remedial plans as necessary.

Plaintiff already has 24/7 ICU coverage for its intensivist unit and has on call providers in case additional resources are needed. Plaintiff also continuously reassesses the staffing needs for the department.

Interrogatory No. 14: State whether You are aware of specific patients who have relied on the Leapfrog Safety Grade in declining to receive healthcare services at Your hospital. In so answering, identify the individual patient that declined to receive services, the date of such declination, the type of service the patient declined to receive, the medium for the communication from the patient (i.e. telephone, video conference, email, letter, etc.), the content of the communication, and the reason given for the stated decision.

Plaintiff objects to this Interrogatory as seeking protected health information that is protected from disclosure by HIPAA, among other statutes and regulations. Plaintiff will only produce this information as needed and subject to a Qualified Protective Order entered by this Court.

Answer: Subject to the foregoing objection, Plaintiff has received reports that patients considered or decided not to use Plaintiff's facility because of TLG's misleading grades.

Amended Answer: Subject to the foregoing objection, since the release of TLG's false and misleading grades, Plaintiff has received numerous reports from doctors that patients considered or decided not to use Plaintiff's facility due to concerns related to TLG's misleading grades.

Interrogatory No. 15: Describe any effort Your hospital has made to influence public perception of Your hospital's performance on patient safety following the publication of the Leapfrog Safety Grade.

Plaintiff objects to this Interrogatory as vague and ambiguous because it does not specify which Leapfrog Safety Grade is at issue. Plaintiff will construe this Interrogatory to reference TLG's deceptive Safety Grades beginning in Fall 2024. Plaintiff objects to this Interrogatory as overly broad, unduly burdensome, and not proportional to the needs of this Action to the extent it seeks "any effort" Plaintiff "has made to influence public perception" after the release of TLG's deceptive and unfair Safety Grades because there have been many such "efforts" and those

“efforts” are ongoing given the significant harm caused by TLG’s deceptive and unfair business practices.

Answer: Subject to the foregoing objections, Plaintiff continues to influence public perception by, among other things, delivering the highest quality care to the community it serves, which, as discussed in response to Interrogatory 12, has led to numerous awards, accreditations, and accolades. In addition, several public statements disputing the misleading nature of the Safety Grade have been made on Plaintiff’s behalf.

Supplemental Answer: In addition to the above, members of hospital leadership have communicated with patients, doctors, or community members on a regular basis to dispel the misleading nature of the Leapfrog Safety Grades. For instance, Plaintiff communicated its governing board, its medical executive committee, department directors, physicians and nurses, and patients when asked about the Safety Grades or Hospital Survey. These communications occurred in and after Fall 2024, after TLG released its deceptive and unfair Safety Grades for Plaintiff’s hospital. The Palm Beach Health Network also issued a press release and has engaged in marketing efforts, including through social media, to counteract TLG’s deceptive scores on behalf of Plaintiff and other affected members of the network. Plaintiff also engaged in email discussions about TLG’s misleading grades, either as sender or recipient, which TLG has through Plaintiff’s production of documents.

Interrogatory No. 16: Describe the due diligence Your hospital undertakes to ensure the accuracy of its own publicly reported safety data (including but not limited to data submitted to CMS, the CDC, and third party organizations).

Plaintiff objects to this Interrogatory as vague and ambiguous due to its use of the undefined term “due diligence.” Plaintiff further objects to this Interrogatory because it seeks

discovery of information that is irrelevant to the claims and defenses in this Action and is overly broad, unduly burdensome, and not proportional to the needs of this Action. Any “due diligence” Plaintiff performs when reporting to *third parties* has nothing to do with the claims and defenses in this case related to TLG’s decision to use deceptive business practices, especially when TLG does nothing to ensure the accuracy of information that hospitals that participate in its survey self-report.

Answer: Plaintiff declines to respond to this Interrogatory.

Amended Answer: Subject to the foregoing objections, Plaintiff makes reasonable efforts to ensure the accuracy of the data it reports to third-party organizations. For instance, Plaintiff employs data abstractors, quality coordinators and a Quality Director, who are all responsible for abstracting, validating, and submitting safety data.

Interrogatory No. 17: Describe in detail how You communicate to the shareholders, board members, collective bargaining representatives and investors of Tenet Healthcare System the outcome of any and all healthcare safety ratings, evaluative publications, studies, or performance analyses that Your Hospital receives.

Plaintiff objects to this Interrogatory because it seeks discovery of information that is irrelevant to the claims and defenses in this Action and is overly broad, unduly burdensome, and not proportional to the needs of this Action. Plaintiff’s communication, if any, with the shareholders, board members, collective bargaining representatives and investors of Tenet Healthcare System, all non-parties to this litigation, has nothing to do with the claims and defenses in this case related to TLG’s decision to use deceptive business practices.

Answer: Plaintiff declines to respond to this Interrogatory.

Amended Answer: Subject to the foregoing objection, Plaintiff communicates with Tenet stakeholders, including employees who work to support the Palm Beach Health Network, on a range of matters, including issues related to patient safety and outcomes and in particular related to TLG and the Safety Grades by email and oral communication. Those communications included discussions about the reasons for particular grades, the method used to calculate Safety Grades, the value of Safety Grades, and responses to the Safety Grades. In addition, identified below are documents Plaintiff produced evidencing communications between the Plaintiff Hospitals and Tenet related to TLG, the Leapfrog survey, and Safety Grades.

Start Page	End Page
PBHN000006509	PBHN000006513
PBHN000004819	PBHN000004821
PBHN000006397	PBHN000006401
PBHN000002090	PBHN000002094
PBHN000002071	PBHN000002071
PBHN000004562	PBHN000004563

PBHN000004564	PBHN000004564
PBHN000004574	PBHN000004581
PBHN000004565	PBHN000004569
PBHN000004704	PBHN000004704
PBHN000004715	PBHN000004719
PBHN000006465	PBHN000006466

Discovery is ongoing, and Plaintiff reserves the right to amend, modify or supplement the response to this Interrogatory.

Interrogatory No. 18: State whether the compensation of Your Chief Executive Officer or any other executive-level leadership officers is tied to or related in any way to Your hospital's performance on patient safety, union worker contracts or Your hospital's ratings by third party ratings organizations' ratings publications (including but not limited to the Leapfrog Hospital Safety Grade).

Plaintiff objects to this Interrogatory because it seeks discovery of information that is irrelevant to the claims and defenses in this Action and is overly broad, unduly burdensome, and not proportional to the needs of this Action. Plaintiff's method of compensating its Chief Executive Officer and other executive-level leadership **has nothing to do with the** claims and defenses in this case related to TLG's decision to use deceptive business practices.

Answer: TLG has, therefore, only propounded this Interrogatory for purposes of harassment. Plaintiff declines to respond to this Interrogatory.

Amended Answer: Subject to the foregoing objection, Plaintiff's performance on patient safety, union worker contracts, or ratings by third party ratings organizations' ratings publications is related in some way to the compensation of Plaintiff's Chief Executive Officer or other executive-level leadership officer(s).

Interrogatory No. 19: Identify all hospitals, medical centers, or healthcare systems that you consider to be your direct competitors within the relevant geographic market during the time period covered by the Complaint and describe in detail the criteria you use to determine whether another hospital or healthcare provider is a competitor.

Plaintiff objects to this Interrogatory because it seeks discovery of information that is irrelevant to the claims and defenses in this Action and is not reasonably calculated to lead to the discovery of admissible evidence. The identity of Plaintiff's competitors and "the criteria" used to determine whether a hospital or provide is a competitor has nothing to do with the claims and defenses in this case related to TLG's decision to use deceptive business practices. Plaintiff also objects to this Interrogatory to the extent it seeks confidential, proprietary information, and commercially sensitive information related to Plaintiff's scoring system and "criteria" used to determine whether a hospital or provide is a competitor.

Answer: Subject to the foregoing objections and on condition that this response is considered “Confidential” under the forthcoming agreed confidentiality order.

Jupiter Medical Center is Plaintiff’s competitor. Plaintiff considers this hospital a competitor because of its proximity to Plaintiff, its competing services lines, and that patients within Plaintiff’s service area go to this hospital for medical care.

Interrogatory No. 20: State and describe the results of any market analysis, competitive analysis, or consumer perception surveys you have conducted or commissioned regarding your competitors from 2020 to present, and identify the individuals or entities that prepared or participated in such analyses.

Plaintiff objects to this Interrogatory because it seeks discovery of information that is irrelevant to the claims and defenses in this Action and is not is not proportional to the needs of this Action. The results of any market analysis, competitive analysis, or consumer perception surveys and the identity of those who prepared or participated in such analyses has nothing to do with the claims and defenses in this case related to TLG’s decision to use deceptive business practices.

Answer: Plaintiff declines to respond to this Interrogatory.

Amended Answer: Plaintiff further objects to this Interrogatory to the extent it requests information from outside of the relevant time period of January 1, 2023, to present. Plaintiff also objects to this Interrogatory as unduly burdensome to the extent it asks Plaintiff to “state and describe” various market analysis.

As agreed during the parties’ meet and confer on September 3, 2025, Plaintiff will produce documents showing the results of studies or surveys Plaintiff has conducted or commissioned related to internal market analysis, competitive analysis, or consumer perception. Plaintiff will

identify the documents responsive to this Interrogatory by Bates number in Plaintiffs' production cover letter.

Interrogatory No. 21: Identify with specificity any comments or concerns raised by any third party payor, bank or lender, or investor related to Your hospital's reputation and/or public perception on issues in any way involving patient safety or satisfaction.

Plaintiff objects to this Interrogatory because it seeks discovery of information that is overly broad, unduly burdensome and irrelevant to the claims and defenses in this Action and is not proportional to the needs of this case to the extent it seeks "comments and concerns" from third parties related generally to Plaintiff's reputation that has nothing to do with the specific and significant reputational harm caused by TLG's misleading grades.

Answer: Subject to the foregoing objections, Plaintiff will produce and identify documents related to the significant reputational harm caused by TLG's deceptive and unfair Safety Grades that provide sufficient detail to respond to this Interrogatory.

Amended Answer: Subject to the foregoing objections, Plaintiff is unaware of any documents related to this Interrogatory.

Interrogatory No. 22: Identify and describe any complaints, concerns, or comments from patients, community members, or referring physicians that relate to the hospital's reputation or comparisons to other hospitals in the region.

Plaintiff objects to this Interrogatory because it seeks discovery of information that is overly broad, unduly burdensome and irrelevant to the claims and defenses in this Action and is not proportional to the needs of this Action to the extent it seeks "comments and concerns" from patients, community members, or referring physicians that have nothing to do with the significant

reputational harm caused by TLG's misleading grades. Plaintiff also objects to this interrogatory as seeking protected health information that is protected from disclosure by HIPAA, among other statutes and regulations. Plaintiff will only produce this information as needed and subject to the agreed protective order entered by this Court.

Answer: Subject to the foregoing objections, Plaintiff has received reports that patients and physicians considered or decided not to use Plaintiff's facility because of TLG's misleading grades.

Amended Answer: Subject to the foregoing objections, Plaintiff has received reports that patients and physicians considered or decided not to use Plaintiff's facility because of TLG's misleading grades. In addition, concerns have been raised by patients, doctors, staff, and community members, and Plaintiff is aware of false and misleading statements based on TLG's false and misleading methodology and Safety Grades made in newspapers, viral social-media videos, television programs, and blogs.

We have received reports from patients that they decided not to use our hospital due to the misleading grade TLG assigned to the hospital. Our Medical Executive Committee has received direct inquiries from patients regarding their concerns about TLG's grades and related public reports. Patients have asked independent physicians that use both our facilities and those of Jupiter Medical Center (a nearby hospital) to schedule their surgeries at Jupiter Medical Center and not at ours. These independent surgeons have told us that they believe TLG has misled these patients about the quality of the Medical Center because these surgeons believe our hospital provides higher-quality care. Doctors have had patients express that they do not want to come to the Medical Center, specifically because of the Leapfrog grade. The harm caused by TLG's false and misleading Safety Grade is ongoing.

In addition, the following produced documents evidence such harm.

Start Page	End Page
PBHN000006771	PBHN000006773
PBHN000002082	PBHN000002085
PBHN000002066	PBHN000002070
PBHN000002615	PBHN000002617
PBHN000006397	PBHN000006401
PBHN000002090	PBHN000002094
PBHN000004484	PBHN000004484

PBHN000004562	PBHN000004563
PBHN000004564	PBHN000004564
PBHN000004574	PBHN000004580
PBHN000004557	PBHN000004557
PBHN000008718	PBHN000008718
PBHN000006461	PBHN000006462
PBHN000008914	PBHN000008914
PBHN000008915	PBHN000008915

Discovery is ongoing, and Plaintiff reserves the right to amend, modify or supplement the response to this Interrogatory.

Interrogatory No. 23: List with specific detail each and every concern, complaint or comment made by any union, collective bargaining unit or employee association in any way related to patient safety at Your hospital.

Plaintiff objects to this Interrogatory because it seeks discovery of information that is overly broad, unduly burdensome and irrelevant to the claims and defenses in this Action and is overly broad, unduly burdensome, and not proportional to the needs of this Action to the extent it seeks “each and every concern, complaint or comment ” from third parties that have nothing to do with the significant reputational harm caused by TLG’s misleading grades. Plaintiff also objects to this Interrogatory to the extent it seeks health information that is protected from disclosure by HIPAA, among other statutes and regulations. Plaintiff will only produce this information as needed and subject to the agreed protective order entered by this Court.

Answer: Subject to the foregoing objections, Plaintiff is unaware of any concern, complaint or comment regarding TLG deceptive scores made by the union at Plaintiff's hospital.

Amended Answer: Union personnel have in the past registered complaints or disagreements with Plaintiff's hospital's management, including alleged concerns about patient safety. Plaintiff carefully considers such allegations but finds generally that they are attempts to gain leverage in contract negotiations and are less genuine concern about patients. The union at Plaintiff's hospital made allegations in December 2023, February 2024, and March 2024. On April 5, 2024, the union publicly retracted those statements, rightly saying they were "entirely inappropriate to make," that "the Union should not have made the negative statements," and one after another, that the union did "not have any basis for believing" the accusations were true. After that, the union made only one other accusation of which Plaintiff is aware, and that was on April 10, 2024 concerning allegedly high turnover. But, the union's proposed remedies showed that the accusation was only an ordinary attempt to increase member wages: four of its five recommended "resolution[s]" were raising wages. The last "resolution" was that "hospital must staff based on the acuity of the patient," which Plaintiff already does. Plaintiff looked into the allegations anyways and found they lacked merit.

Interrogatory No. 24: Identify any and all criticism You have received since 2020 from Tenet Healthcare Corporation and/or from any individual executive of Tenet Healthcare Corporation regarding Your hospital's performance in any way.

Answer: Plaintiff objects to this Interrogatory because it seeks discovery of information that is overly broad, unduly burdensome and irrelevant to the claims and defenses in this Action and is not reasonably calculated to lead to the discovery of admissible evidence. Any so-called "criticism" has nothing to do with the claims and defenses related to TLG's decision to use

deceptive business practices. TLG has, therefore, only propounded this Interrogatory for purposes of harassment. Plaintiff declines to respond to this Interrogatory.

Amended Answer: As discussed during the parties' meet and confer on September 3, 2025, TLG agreed to narrow this Interrogatory to concern only "criticism...regarding Your hospital's patient safety." After a reasonable and diligent search, Plaintiff is unaware of having received "criticism" from Tenet Health Corporation regarding patient safety. Plaintiff is always working to improve its performance, quality, and safety in a constructive way and engages with Tenet Health Corporation as needed to ensure Plaintiff provides the best patient care possible.

Dated: September 8, 2025

Respectfully submitted,

By: /s/ Lee R. Crain

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*Attorneys for Palm Beach Gardens Medical
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CERTIFICATE OF SERVICE

This is to certify that true and correct copies of Plaintiff's Amended and Supplemented Responses and Objections to Defendant The Leapfrog Group's First Sets of Interrogatories to Plaintiff have been served on counsel for The Leapfrog Group by electronic transmission.

/s/ Lee R. Crain
Lee R. Crain

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

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

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

Plaintiffs,

v.

THE LEAPFROG GROUP,

Defendant.

**AFFIDAVIT OF ERIK CAZARES IN SUPPORT OF
PLAINTIFF PALM BEACH GARDENS MEDICAL CENTER'S
AMENDED AND SUPPLEMENTED RESPONSES AND OBJECTIONS TO
DEFENDANT THE LEAPFROG GROUP'S FIRST SET OF
INTERROGATORIES TO PALM BEACH GARDENS MEDICAL CENTER**

I, Erik Cazares, declare as follows:

1. I am over 21 years of age and competent to give this testimony.
2. I am the Chief Executive Officer of Palm Beach Gardens Community Hospital, Inc. d/b/a Palm Beach Gardens Medical Center ("Plaintiff"). I am the corporate representative of Plaintiff for the purpose of answering Defendant The Leapfrog Group's First Set of Interrogatories to Palm Beach Gardens Medical Center. I have read the foregoing interrogatories and the answers to those interrogatories, which are true according to the best of my knowledge, information, and belief.

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

Executed on September 8, 2025.



Erik Cazares

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

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

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

Plaintiffs,

v.

THE LEAPFROG GROUP,

Defendant.

**PLAINTIFF ST. MARY'S MEDICAL CENTER, INC.'S
AMENDED AND SUPPLEMENTED RESPONSES AND OBJECTIONS TO
DEFENDANT THE LEAPFROG GROUP'S FIRST SET OF
INTERROGATORIES TO ST. MARY'S MEDICAL CENTER, INC.**

Pursuant to Federal Rules of Civil Procedure 26 and 33 and the *Pretrial Scheduling Order and Order Referring Case to Mediation* (ECF No. 36) (the "Pretrial Scheduling Order"), Plaintiff St. Mary's Medical Center, Inc. ("Plaintiff" or "St. Mary's"), by and through its undersigned counsel, hereby submit its amended and supplemented responses and objections ("Responses"), to Defendant The Leapfrog Group's ("TLG") First Set of Interrogatories, dated July 11, 2025 (the "Interrogatories" and each numbered interrogatory, an "Interrogatory") in the above-captioned action (the "Action").

Plaintiff's Responses to the Interrogatories are made solely for purposes of this Action and to the best of Plaintiff's present knowledge, information, and belief regarding the matters about which inquiry have been made. Discovery is ongoing, and Plaintiff reserves the right to amend, supplement, clarify, or further explain its Responses at any time prior to the trial in

this Action. Plaintiff further reserves the right to raise any additional objections deemed necessary or appropriate in light of any further review.

OBJECTIONS TO INSTRUCTIONS AND DEFINITIONS

1. Plaintiff objects to the definition of terms “Plaintiffs” and “Plaintiff Hospitals” as overbroad, unduly burdensome, and not proportional to the needs of the case to the extent it seeks to require Plaintiffs to respond on behalf of entities or individuals other than themselves.

2. Plaintiff objects to the definition of the terms “St. Mary’s” and “St. Mary’s Medical Center,” “Plaintiff,” “You,” and “Your” to the extent each term seeks to require Plaintiff to respond on behalf of entities or individuals other than itself, including on behalf of agents, employees, directors, or other non-party entities that are not part of this litigation. Such information is overbroad and beyond the scope of permissible discovery. Accordingly, Plaintiff states that its Responses are on behalf of itself only.

3. Plaintiff objects to the definition of the terms “Tenet Healthcare” and “Tenet” to the extent it seeks to require Plaintiff to respond on behalf of entities or individuals other than itself, including on behalf of Tenet, Tenet’s agents, employees, directors, or other non-party entities that are not part of this litigation. Such information is overbroad and beyond the scope of permissible discovery. Accordingly, Plaintiff states that its Responses are on behalf of itself only.

4. Plaintiff objects to the definition of “identify, when referring to a person,” as overbroad and unduly burdensome to the extent it calls for the “address” and “present or last-known employer” of identified individuals. Such information is overbroad and beyond the scope of permissible discovery.

5. Plaintiff objects to the instruction that the relevant time period for the Interrogatories begins on January 1, 2020. Plaintiff will apply to each Interrogatory the time period

of November 1, 2023 to present (the “Relevant Time Period”). Any response to an Interrogatory that provides information that falls outside of the Relevant Time Period should not be construed as an admission that the Relevant Time Period begins prior to November 1, 2023.

SPECIFIC RESPONSES TO INTERROGATORIES

Interrogatory No. 1: State the full name, address, job title or position, and hospital or employer affiliation of all individuals that assisted with responding to these interrogatories.

Answer: The following individuals assisted with responding to these Interrogatories.

Full Name	Address	Job Title / Position	Hospital or Employer Affiliation
Cynthia McCauley	c/o Gibson, Dunn & Crutcher LLP 200 Park Avenue New York, NY 10166	Chief Executive Officer	St. Mary’s Medical Center
Regina West	c/o Gibson, Dunn & Crutcher LLP 200 Park Avenue New York, NY 10166	Market Quality Director	Palm Beach Health Network and St. Mary’s Medical Center

Interrogatory No. 2: Identify every individual not identified in Your Rule 26(a) initial disclosures with knowledge of facts pertaining to the allegations in Your Complaint in this Lawsuit (and any subsequent amendments) and/or whom You believe may have discoverable knowledge, information or data regarding this matter, including those who You expect to call as a fact or opinion witness at any hearing in this proceeding or whose testimony (by affidavit, deposition or testimony) You intended to submit in connection with this proceeding, and the substance of his/her testimony or affidavit, and, with respect to each person identified, provide:

- A. full name,
- B. address,
- C. telephone number,
- D. job title or position,
- E. hospital or employer affiliation,
- F. and describe in detail the facts possessed by each such person.

Plaintiff objects to this Interrogatory as overly broad, unduly burdensome, and not proportional to the needs of this Action to the extent it seeks the identity of “every individual...with knowledge” or who “may have discoverable knowledge, information or data regarding this matter.” Plaintiff will not provide more than the identity of individuals most likely to have knowledge regarding this matter. Plaintiff further objects to this Interrogatory as premature because it requests disclosure of Plaintiff’s witnesses for hearings and the substance of witness testimony before such disclosure is required under applicable law or the Pretrial Scheduling Order. Plaintiff will submit its trial witness list on October 2, 2025, per the Pretrial Scheduling Order, and disclose any other witnesses and witness testimony as further ordered by the Court or otherwise required by applicable law. Plaintiff also objects to this Interrogatory’s request for the identity of “opinion witness[es]” as vague, since witnesses are either “fact” or “expert” witnesses. Plaintiff will interpret “opinion witness” to mean “expert witness.” Plaintiff submitted expert reports on August 7, 2025, per the Pretrial Scheduling Order.

Answer: Subject to the foregoing objection, Plaintiff will amend its Rule 26(a)(1) Initial Disclosures to identify additional individuals who may have knowledge of facts pertaining to the allegations in the Complaint.

Amended Answer: In addition to those disclosed in Plaintiff’s supplemental disclosures, the following individuals may have relevant factual knowledge:

Full Name	Address	Job Title / Position	Hospital or Employer Affiliation
Regina West	c/o Gibson, Dunn & Crutcher LLP 200 Park Avenue New York, NY 10166	Market Quality Director	Palm Beach Health Network and St. Mary’s Medical Center

In addition to the individuals identified above, persons identified in documents produced in this dispute have knowledge of facts pertaining to the allegations in the Amended Complaint. *See* Fed. R. Civ. P. 33(d). Discovery is ongoing, and Plaintiff reserves the right to supplement, amend, correct, clarify, or modify this Response as further information becomes available.

Interrogatory No. 3: Describe in detail all factual bases for Your contention that Leapfrog’s published Safety Grade for Your hospital was false, inaccurate, misleading, deceptive, or unfair. In so answering, identify with particularity each measure, data point, or metric that You contend was inaccurately reported, calculated, or misrepresented by Leapfrog in calculating the Safety Grade for Your hospital.

Answer: Plaintiff objects to this Interrogatory as overly broad, unduly burdensome, and not proportional to the needs of this Action to the extent it seeks “all factual bases” for Plaintiff’s contention. *See Megdal Assocs., LLC v. La-Z-Boy, Inc.*, 2016 WL 4503337, at *6 (S.D. Fla. Feb. 1, 2016) (finding interrogatories asking for “‘all’ facts or witnesses that support an opposing party’s case” to be “unduly broad”) (citing 8B Wright, Miller, & Kane, Federal Practice and Procedure: Civil 3d § 2167 (2015)). Plaintiff further objects to this Interrogatory as premature to the extent it requests that Plaintiff “[d]escribe in detail all factual bases” to support its contention. *In re Reliance Fin. & Inv. Grp., Inc.*, 2006 WL 8435541, at *4 (S.D. Fla. Feb. 14, 2006) (Contention interrogatories “are more appropriately used after a substantial amount of discovery has been conducted--typically, at the end of the discovery period.”). Plaintiff also objects to this Interrogatory to the extent it attempts to limit or mischaracterize Plaintiff’s claim as just challenging the false, inaccurate, misleading, deceptive, or unfair nature of TLG’s Safety Grade. As the Court explained in its order denying TLG’s motion to dismiss, the core of the Complaint is “a challenge to Defendant’s representations about its methodology, which they claim mislead consumers by failing to distinguish between absent data and damning data, and professing that grades are not influenced by a hospital’s lack of survey participation.” *Order on Motion to Dismiss*

6 (ECF No. 41). Plaintiff also challenges the provably false facts and deceptive scoring system underlying these grades, which TLG admits it relies on to arrive at its deceptive Safety Grades.

Subject to the foregoing objections and as more fully stated in the *Amended Complaint* (ECF No. 74) (“Complaint”), TLG has engaged in deceptive and unfair business practices and misrepresentations when issuing the Safety Grade for Plaintiff’s hospital as part of TLG’s annual “Hospital Survey.” TLG posts these Safety Grades online at hospitalsafetygrade.org.

To arrive at these Safety Grades, TLG uses CMS data, survey responses from participating hospitals, and other supplemental data sources. For participating hospitals, TLG uses the hospitals’ self-reported responses to the Hospital Survey for 12 of the 22 measures. For non-participating hospitals, TLG uses other sources for those 12 measures. For the remaining four measures—Computerized Physician Order Entry, Bar Code Medication Administration, ICU Physician Staffing, and Hand Hygiene Score (the “Deceptive Score Categories”)—TLG devised and uses a so-called “imputation model.” Prior to Fall 2024, TLG’s imputation model assigned non-participating hospitals a score based on the average score applicable to a similarly situated hospital. Beginning in Fall 2024, TLG modified its imputation model. TLG now assigns the lowest possible score to non-participating hospitals, which has the effect of punishing non-participating hospitals and artificially deflating their Safety Grades. TLG has even admitted the changes in Fall 2024 were designed to penalize non-participating hospitals. TLG also misleads consumers about how it grades hospitals, stating “[t]he Hospital Safety Grade reflects how well a hospital does on safety, not whether they complete the [TLG] Hospital Survey.” *Declaration of Lee Crain* (ECF No. 21) (“Crain Decl.”), Ex. 1 at 4 (“Frequently Asked Questions About the Leapfrog Hospital Safety Grade”).

As TLG explains, “not all hospitals have enough data publicly available to be eligible for a grade.” Crain Decl. Ex. 1 at 5. “As per the National Expert Panel guidance, [TLG] has requirements for the minimum amount of data [it] need[s] to issue an accurate grade.” Crain Decl. Ex. 1 at 5. According to TLG, “[h]ospitals missing more than six process measures” are “not graded.” Crain Decl. Ex. 2 at 6. Non-participating hospitals should fall easily into that “not graded” bucket, because their decision not to participate in TLG’s survey necessarily means TLG is missing seven process measures that rely on voluntary submission of hospital data.¹

TLG then deceptively conceals how it makes up grades for the four “imputation” measures and even suggests on its website that TLG *does* have data sufficient to score TLG on those four measures. By way of example, TLG acknowledges that Plaintiff “Declined to Report” information in response to questions about “Staff work[ing] together,” but then tells consumers—as if it were a fact—that Plaintiff is “Worse Than Average” on “Handwashing,” “Communication,” “medication administration,” and the like—even though TLG has no basis whatsoever to adopt those conclusions. Crain Decl. Ex. 32 at 2. TLG itself says handwashing is among the “most important” measures in its survey, Crain Decl. Ex. 15 at 4, yet it deceptively conceals that it has no data with which to grade the Plaintiff hospital on that measure. *Defendant The Leapfrog Group’s Responses to Plaintiffs’ Requests for Production* at 7 (“Leapfrog is not itself in possession of data showing Plaintiffs’ performance on the ‘imputed metrics’ considered by the methodology.”). Of course, Plaintiff in fact has a comprehensive and thorough handwashing policy. And had Plaintiff merely filled out TLG’s survey, it would have received a full letter grade higher on TLG’s score. *Expert Report of Professor Sean Nicholson* (Aug. 7, 2025), Ex. 6.

¹ Those seven include CPOE, BCMA, IPS, Safe Practice 1: Culture of Leadership Structures and Systems; Safe Practice 2: Culture Measurement, Feedback & Intervention; Total Nursing Care Hours per Patient Day; and Hand Hygiene.

Based on the foregoing, and as more fully set forth in the Complaint, TLG engages in deceptive trade practices by, among other things, deceiving consumers about its grading methods by implying that Plaintiff has failed on certain measures that, in truth, TLG has no data or other basis to evaluate; deceiving consumers by telling them the Hospital Safety Grade reflects how well a hospital does on safety, not whether they complete the Hospital Survey; deceiving consumers when it represents that it does not grade hospitals if it lacks sufficient data, when, in truth, it does grade hospitals by “imputing” or making up a grade for the Deceptive Score Categories; hiding the truth about its “imputation model” from consumers by burying it in fine print on a separate website; punishing non-participating hospitals by “imputing” scores, which artificially deflate a hospital’s Safety Grade; and favoring participating hospitals. Additional factual bases for the Plaintiff’s claims are presented in the Complaint.

Interrogatory No. 4: Describe the scoring or grading methodology You believe Leapfrog should have used to assess Your hospital’s patient safety performance and explain why that method would yield a different result.

Plaintiff objects to this Interrogatory because it seeks discovery of information that is irrelevant to the claims and defenses in this Action and is overly broad, unduly burdensome, and not proportional to the needs of this Action. Plaintiff’s provision of an alternative scoring or grading methodology has nothing to do with the claims and defenses in this case related to TLG’s decision to use deceptive business practices. Plaintiff further objects to this Interrogatory to the extent it calls for speculation.

Answer: Plaintiff declines to respond to this Interrogatory.

Amended Answer: Subject to the foregoing objections, Plaintiff responds that TLG should use a scoring system that is not unfair or deceptive. By way of example only, TLG could decline

to grade hospitals that do not participate in TLG's survey, because their decision not to participate means TLG is missing seven process measures that rely on voluntary submission of hospital data. This would yield a different result, because the hospitals would not receive a grade at all. TLG's methodology certainly should not affirmatively assign an arbitrary low score to a particular metric just because a hospital does not provide data for that metric.

Interrogatory No. 5: State whether You submitted any data, corrections, or appeals to Leapfrog regarding the Safety Grade Your hospital received, and for each such submission, identify the date of the submission, the medium of the submission (i.e. telephone, video conference, email, letter, etc.), who was involved in the submission, and the content of the submission.

Plaintiff objects to this Interrogatory because it seeks discovery of information that is irrelevant to the claims and defenses in this Action and is overly broad, unduly burdensome, and not proportional to the needs of this Action. Whether or not Plaintiff submitted "any data, corrections, or appeals to Leapfrog regarding the Safety Grade" Plaintiff hospital received has nothing to do with the claims and defenses in this case related to TLG's decision to use deceptive business practices. Plaintiff further objects to this Interrogatory to the extent it seeks information that is already in TLG's possession, custody and control, or equally available to TLG.

Answer: Subject to the foregoing objections, Plaintiff engaged in correspondence prior to the commencement of this case demanding that TLG reform its deceptive practices and cease and desist reporting deceptive and unfair Safety Grades, but at every turn TLG refused.

Amended Answer: Subject to the foregoing objections, Plaintiff did not submit any data, corrections or appeals to Leapfrog regarding the Safety Grades it has received.

Interrogatory No. 6: State whether You provided any comment or input in any form during Leapfrog's requests for public comments for planned updates to the Leapfrog Hospital Safety

Grade methodology that was proposed for the calculation of Hospital Safety Grades (including but not limited to for the Fall 2024 methodology update). If yes, please identify the date of the comment, the medium of the submission (i.e. telephone, video conference, email, letter, etc.), who was involved in the comment and the content of the comment. If no, please state the reason why You chose not to comment.

Answer: Plaintiff objects to this Interrogatory because it seeks discovery of information that is irrelevant to the claims and defenses in this Action and is overly broad, unduly burdensome, and not proportional to the needs of this Action. Whether or not Plaintiff submitted “any comment or input” in response to TLG’s request for public comments has nothing to do with claims and defenses in this case related to TLG’s decision to use deceptive business practices. Plaintiff further objects to this Interrogatory to the extent it seeks information that is already in TLG’s possession, custody and control, or equally available to TLG.

Subject to the foregoing objections, Plaintiff did not provide comments in response to Leapfrog’s requests for public comments for planned updates to the Leapfrog Hospital Safety Grade scoring system because Plaintiff generally does not respond to requests for public comment from private entities like TLG.

Interrogatory No. 7: Describe all actions Your hospital took in response to (or in deciding not to respond to) its Safety Grade or the Hospital Survey, including internal meetings, media statements, or public relations efforts. In so answering, state the date of the action, the individuals involved in the action and the content of the action.

Plaintiff objects to this Interrogatory as overly broad, unduly burdensome, and not proportional to the needs of this Action to the extent it seeks “all actions” Plaintiffs may have taken in response to TLG’s Safety Grades. *See Megdal Assocs., LLC v. La-Z-Boy, Inc.*, No. 14-81476-CIV, 2016 WL 4503337, at *6 (S.D. Fla. Feb. 1, 2016) (finding interrogatories asking for “‘all’

facts or witnesses that support an opposing party's case" to be "unduly broad") (citing 8B Wright, Miller, & Kane, Federal Practice and Procedure: Civil 3d § 2167 (2015)). Plaintiff further objects to this Interrogatory to the extent it seeks information that is subject to a claim of privilege or otherwise protected from disclosure, including seeking information protected by the attorney-client privilege, work-product doctrine, or other immunity.

Answer: Subject to the foregoing objections, Plaintiff devoted substantial time and resources that could have otherwise been spent continuing to improve patient care to respond to the significant harm and disruption caused by TLG's deceptive and unfair Safety Grade. Plaintiff's response included meeting internally with Plaintiff's leadership team, medical executive committee, and governing board, corresponding with TLG to demand that TLG reform its deceptive practices and cease and desist reporting deceptive and unfair Safety Grades, and devoting substantial time and resources to facilitate the preparation and prosecution of this Action.

Amended Answer: Subject to the foregoing objections, Plaintiff devoted substantial time and resources that could have otherwise been spent continuing to improve patient care to respond to the significant harm and disruption caused by TLG's deceptive and unfair Safety Grades. Plaintiff's response included meeting internally with Plaintiff's leadership team, medical executive committee, and governing board, corresponding through Plaintiff's corporate parent with TLG to demand that TLG reform its deceptive practices and cease and desist reporting deceptive and unfair Safety Grades, and devoting substantial time and resources to facilitate the preparation and prosecution of this Action. Plaintiff has also held many phone calls and meetings with physicians and other stakeholders about the TLG grades, explaining how the grades were deceptive and did not accurately reflect the hospital quality and patient safety at Plaintiff.

Interrogatory No. 8: Identify any and all persons, whether internal or external (e.g., patients, vendors, affiliates, parents, agents, partners, media) with whom You communicated in any way with respect to the Safety Grade or the Hospital Survey. In so answering, state the date of the communication, the individuals involved in the communication, the medium of the communication (i.e. telephone, video conference, email, letter, etc.) and the content of the communication.

Plaintiff objects to this Interrogatory as overly broad, unduly burdensome, and not proportional to the needs of this Action to the extent it seeks the identity of “any and all persons, whether internal or external.” Plaintiff will disclose the categories of individuals with whom Plaintiff communicated about the Safety Grade or Hospital Survey during the Relevant Time Period. Plaintiff also objects to this Interrogatory to the extent it seeks protected health information that Health Insurance Portability and Accountability Act (“HIPAA”), among other statutes and regulations, bars Plaintiff from disclosing. Plaintiff further objects to this Interrogatory to the extent it seeks information that is subject to a claim of privilege or otherwise protected from disclosure, including seeking information protected by the attorney-client privilege, work-product doctrine, or other immunity.

Answer: Subject to the foregoing objections, Plaintiff communicated with the following categories of people regarding the Safety Grade or the Hospital Survey: Plaintiff’s governing board, its medical executive committee, department directors, and physicians and nurses when asked about the Safety Grade or Hospital Survey. These communications occurred in and after Fall 2024, after TLG released its deceptive and unfair Safety Grade for Plaintiff’s hospital. Most of these communications occurred during regularly scheduled meetings, during which attendees were told about TLG’s release of the deceptive and unfair Safety Grade, that Plaintiff does not participate in the Hospital Survey because it is unreliable and not an accurate reflection of hospital quality and safety or patient outcomes, and that the Safety Grade, which was not based on any

information provided by Plaintiff, was misleading. The Palm Beach Health Network also issued a press release and since then, has engaged in various social networking and other marketing campaigns to counteract TLG's deceptive scores on behalf of Plaintiff and other affected members of the network.

Amended Answer: Subject to the foregoing objections, Plaintiff communicated with the following categories of people regarding the Safety Grade or the Hospital Survey: Plaintiff's governing board, its medical executive committee, department directors, physicians and nurses, and patients when asked about the Safety Grades or Hospital Survey. These communications occurred in and after Fall 2024, after TLG released its deceptive and unfair Safety Grades for Plaintiff's hospital. Most of these communications occurred during regularly scheduled meetings, during which attendees were told about TLG's release of the deceptive and unfair Safety Grade, that Plaintiff does not participate in the Hospital Survey because it is unreliable and not an accurate reflection of hospital quality and safety or patient outcomes, and that the Safety Grade, which was not based on any information provided by Plaintiff, was misleading. The Palm Beach Health Network also issued a press release and has engaged in marketing efforts, including through social media, to counteract TLG's deceptive scores on behalf of Plaintiff and other affected members of the network. Plaintiff also engaged in email discussions about TLG's misleading grades, either as sender or recipient, which TLG has through Plaintiff's production of documents.

Interrogatory No. 9: Describe all instances in which a third party declined to contract with, refer patients to, or work with Your hospital, where Leapfrog's grade was cited or discussed. In so identifying list the name of the individuals involved in the communication, the medium of the communication (i.e. telephone, video conference, email, letter, etc.), the date of the communication and the content of the communication.

Answer: Plaintiff objects to this Interrogatory as overly broad, unduly burdensome, and not proportional to the needs of this Action to the extent it requires Plaintiff to “[d]escribe all instances” in which a third party took an action in response to TLG’s deceptive grade.

Subject to the foregoing objection, Plaintiff is not aware of any responsive instances.

Interrogatory No. 10: Describe with specificity the basis for each and every category of damage You claim You incurred as a result of the Leapfrog Safety Grade. In so identifying, list each category of damages and the dollar value of each category of damage You claim.

Plaintiff objects to this Interrogatory to the extent it seeks information that is the subject of expert testimony.

Answer: Plaintiff will submit expert reports on August 7, 2025, per the Pretrial Scheduling Order.

Amended Answer: Plaintiff has served the expert report of Thomas Chakurda, which addresses the issue of reputational harm and harm to Plaintiff’s goodwill. Plaintiff further objects to this Interrogatory as overbroad and unduly burdensome to the extent it seeks “each and every” category of claimed damages.

Subject to the foregoing objections and as agreed during the parties’ September 3, 2025 meet and confer, Plaintiff will limit its response to the live non-monetary claims, including injunctive and declaratory relief, to remedy harm to Plaintiff’s reputation and goodwill. Plaintiff’s reputation and goodwill has been damaged by TLG’s false and misleading methodology and resulting Safety Grades. Plaintiff’s claim for reputational harm is based on, among other things, concerns raised by patients, doctors, staff, and community members, as well as false and misleading statements based on TLG’s false and misleading methodology and Safety Grades made in newspapers, viral social-media videos, television programs, and blogs.

By way of example, our Board of Directors has informed me that they have been barraged by community constituents and leaders about the Medical Center's poor TLG Hospital Safety Grade. Further, our medical leadership has received direct inquiries from patients regarding their concerns about TLG's grades and related public reports. The harm caused by TLG's false and misleading Safety Grade is ongoing.

Interrogatory No. 11: Identify all adverse patient events which occurred at Your hospital, including any citations received from regulatory agencies, accrediting agencies, and third party payors such as The Joint Commission, CMS, state health departments, etc. during the period covered by each Leapfrog Safety Grade publication of which You complain (i.e., Fall 2024, Fall 2025, etc.), as well as any complaints received from patients regarding the same.

Plaintiff objects to this Interrogatory because it is overly broad, unduly burdensome, seeks discovery of information that is irrelevant to the claims and defenses in this Action, seeks information that is beyond the scope of Leapfrog's Hospital Survey, and is not reasonably calculated to lead to the discovery of admissible evidence. TLG does not include "all adverse patient events," "citations received from" agencies or payors, or "complaints received from patients" in TLG's determination of its Hospital Safety Grades or request such information in the Hospital Survey, so any such information is irrelevant to whether TLG's actions constitute unfair or deceptive trade practices. TLG has, therefore, only propounded this Interrogatory for purposes of harassment. Plaintiff also objects to this Interrogatory to the extent it seeks protected health information that HIPAA, among other statutes and regulations, bars Plaintiff from disclosing.

Answer: Plaintiff declines to respond to this Interrogatory.

Amended Answer: Defendant has agreed to withdraw this Interrogatory.

Interrogatory No. 12: Describe in detail how Your hospital compares nationally on on [sic] any other ranking of patient safety performance, including but not limited to Vizient, Inc., Premier, Inc., HealthTrust Purchasing Group, The Joint Commission, HealthGrades, US News, Newsweek,

Statista, Definitive Healthcare, or any other quality benchmarking entity including benchmarking on patient safety including on adverse events and on healthcare-acquired infections.

Plaintiff objects to this Interrogatory's request that Plaintiff "[d]escribe in detail how Your hospital compares nationally" based on undisclosed "benchmarking" as vague and confusing. To the extent this Interrogatory seeks the top-line rankings of the identified organizations, Plaintiff objects to this Interrogatory because such information is publicly and equally available to TLG. To the extent this Interrogatory asks Plaintiff to compare itself to the named and unnamed entities, that request is overly broad, unduly burdensome, and not proportional to the needs of this Action. Plaintiff further objects to this Interrogatory because it seeks discovery of information that is irrelevant to the claims and defenses in this Action and is overly broad, unduly burdensome, and not proportional to the needs of this Action. Other organizations' rankings have nothing to do with the claims and defenses in this case related to the Deceptive Score Categories or TLG's decision to use deceptive business practices.

Answer: Subject to the foregoing objections, Plaintiff has received numerous awards and accolades, including many that are directly relevant to patient care for both the low-income underserved community in which it resides and the greater central Florida east coast.

Plaintiff has several accreditations that demonstrate the high-quality of care it provides to pregnant women and children in the community. For example, it is an accredited acute care hospital that is a Level I adult and pediatric Trauma Center. A Level I Trauma Center is a healthcare facility that is central to the trauma system and capable of providing the highest level of care for every aspect of injury for both adults and children. Plaintiff is also a Level III NICU, meaning it provides lifesaving care for babies born before 32 weeks' gestation and / or weighing less than 1,500 grams (approximately 3.3 pounds) or babies with specific medical conditions that require

surgery or specialized pediatric care. Additionally, Plaintiff is one of only 11 designated hospitals by the Florida Department of Health as a Regional Perinatal Intensive Care Center (RPICC) that provides obstetrical services to women who have a high-risk pregnancy and care for newborns with special health needs, such as critical illness or low birth weight. Plaintiff is also certified by the American College of Surgeons for the Verified Pediatric Surgery Program, which recognizes hospitals that properly address the surgical care of infants and children.

Plaintiff is also a Commission on Accreditation of Rehabilitation Facilities (“CARF”) accredited facility for its stroke, brain injury and amputation specialty services. Achieving CARF accreditation means that our hospital meets CARF’s standards and has demonstrated a commitment to being among the best available to patients. We are also a Certified Comprehensive Stroke Center, which means we are dedicated to raising the bar for evaluating and evolving the care of patients at every part of the stroke care continuum. Additionally, Plaintiff has achieved a Det Norske Veritas (DNV) for Comprehensive Stroke Certification. A DNV Comprehensive Stroke Certification demonstrates that Plaintiff provides the highest quality of care and offers evidence-based treatments with cutting-edge research protocols for stroke patients. In order to be accredited, Plaintiff had to undergo an on-site visit on a triennial basis, in which a trained DNV site visit reviewer visits the facility and reviews its required stroke program activity documentation to ensure compliance with the standards. The entities that award and assign these accreditations and certifications visit the healthcare facility and perform regular periodic in-person reviews, audits, surveys and assessments of the facility.

Additionally, Plaintiff is accredited by the Joint Commission, the nation’s largest hospital accreditor that evaluates hospitals’ quality performance standards through an objective evaluation process. Plaintiff has been accredited by the Joint Commission for specialization certifications for

Spine Surgery and Total Joint Replacement for Hip and Knee—a certification designed for hospitals providing the critical elements to achieve long-term success in improving critical medical outcomes—which signifies our services have delivered evidence-based proof of clinical quality sought by patients and payers alike.

These accreditations and certifications are particularly important given Plaintiff's patient population. With its accreditation and specialties, Plaintiff provides patients care they are not able to receive at other facilities. Plaintiff sees more transfers to its facility from nearby hospitals who are unable to provide patients with the care they need than any other Palm Beach County hospital. Also, due to its location in a low-income community, Plaintiff treats a significant number of high-risk pregnancies in which infant mortality is a serious risk and heartbreaking reality.

Plaintiff has also received numerous awards that exemplify its quality. Plaintiff received multiple Get with the Guidelines awards, including Stroke Gold Plus Award 2024 (13th Consecutive Year); Stroke Elite Plus Honor Roll; Stroke Advance Therapy Honor Roll; and Type 2 Diabetes Honor Roll. The Get with the Guidelines Stroke program is designed to improve stroke care by promoting consistent adherence to the latest scientific treatment guidelines.

Additionally, Plaintiff has been recognized by BlueCross BlueShield with a Blue Distinction Centers for Knee, Hip Replacements, Spine Surgery and Maternity Care designation, as part of the Blue Distinction Specialty Care program. The Blue Distinction Specialty Care is a national designation program that recognizes health providers that demonstrate expertise in quality and affordable health care to meet consumers' specialty care needs.

Plaintiff has also received numerous awards that recognize the high-quality care it provides to pregnant women and children. For example, it recently received the Florida Department of Health and Florida Agency for Health Care Administration Excellence for Maternal Care Award,

which highlights hospitals that surpass Florida Department of Health's goal of reducing the rate of C-sections among first-time mothers with low-risk pregnancies. Similarly, the Florida Hospital Association also recently awarded Plaintiff the Excellence in Maternity Care designation, which is awarded to a hospital that demonstrates exceptional dedication to maternal health care.

Additionally, the Palm Beach Post has awarded Plaintiff with Community Choice Awards for Best Hospital, Best Orthopedic/Sports Medicine 2024 and Best Maternity and Childbirth Center 2024 & 2025. The Palm Beach County Community Choice Awards celebrate the best business and organizations in the area, with people in the community voting on these designations.

The medical rankings organization Healthgrades awarded Plaintiff numerous accolades. To assess and evaluate hospitals, Healthgrades relies on data from Medicare medical claims records and states' data on Medicare and commercially insured patient outcomes to determine patients' actual clinical outcomes when visiting a given hospital. Plaintiff has received several awards from Healthgrades for various specialties, including:

a. Labor and Delivery

- i. Five-Star Recipient for C-Section Delivery for 11 years in a row
- ii. Five-Star Recipient for Vaginal Delivery for 11 years in a row

b. Orthopedic

- i. Five-Star Recipient for Hip Fracture Treatment (2024)
- ii. Five-Star Recipient for Knee Replacement (2024)

c. Spine Surgery

- i. Five-Star Recipient for Spinal Fusion (2025)

In addition, Plaintiff will produce and identify documents reflecting some of Plaintiff's rankings from other organizations.

Amended Answer: Subject to the foregoing objections, Plaintiff has received numerous awards and accolades. For example, Plaintiff has several accreditations that demonstrate the high-quality of care it provides to pregnant women and children in the community. For example, it is an accredited acute care hospital that is a Level I adult and pediatric Trauma Center. Additionally, Plaintiff is one of only 11 designated hospitals by the Florida Department of Health as a Regional Perinatal Intensive Care Center (RPICC) that provides obstetrical services to women who have a high-risk pregnancy and care for newborns with special health needs, such as critical illness or low birth weight. Plaintiff is also certified by the American College of Surgeons for the Verified Pediatric Surgery Program, which recognizes hospitals that properly address the surgical care of infants and children.

Plaintiff is also a Commission on Accreditation of Rehabilitation Facilities (“CARF”) accredited facility for its stroke, brain injury and amputation specialty services. We are also a Certified Comprehensive Stroke Center. Additionally, Plaintiff has achieved a Det Norske Veritas (DNV) for Comprehensive Stroke Certification.

Additionally, Plaintiff is accredited by the Joint Commission. Plaintiff also has been accredited by the Joint Commission for specialization certifications for Spine Surgery and Total Joint Replacement for Hip and Knee.

Plaintiff has also received multiple Get with the Guidelines awards, including Stroke Gold Plus Award 2024 (13th Consecutive Year); Stroke Elite Plus Honor Roll; Stroke Advance Therapy Honor Roll; and Type 2 Diabetes Honor Roll.

Additionally, Plaintiff has been recognized by BlueCross BlueShield with a Blue Distinction Centers for Knee, Hip Replacements, Spine Surgery and Maternity Care designation, as part of the Blue Distinction Specialty Care program.

Plaintiff recently received the Florida Department of Health and Florida Agency for Health Care Administration Excellence for Maternal Care Award. Similarly, the Florida Hospital Association also recently awarded Plaintiff the Excellence in Maternity Care designation.

Additionally, the Palm Beach Post has awarded Plaintiff with Community Choice Awards for Best Hospital, Best Orthopedic/Sports Medicine 2024 and Best Maternity and Childbirth Center 2024 & 2025.

The medical rankings organization Healthgrades awarded Plaintiff numerous accolades, including:

a. Labor and Delivery

- i. Five-Star Recipient for C-Section Delivery for 11 years in a row
- ii. Five-Star Recipient for Vaginal Delivery for 11 years in a row

b. Orthopedic

- i. Five-Star Recipient for Hip Fracture Treatment (2024)
- ii. Five-Star Recipient for Knee Replacement (2024)

c. Spine Surgery

- i. Five-Star Recipient for Spinal Fusion (2025)

In addition, Plaintiff will produce and identify documents reflecting some of Plaintiff's rankings from other organizations.

Also, Plaintiff does not participate in Vizient and has not done so during the Relevant Time Period.

Interrogatory No. 13: Describe any steps taken by Your hospital to improve any and all of the patient safety measures considered by Leapfrog's Hospital Safety Grade (as set forth on Leapfrog's published scoring methodology documents; see ECF No. 21-3 at 6-10; ECF No. 21-43 at 6-9), before and after each Safety Grade publication of which You complain.

Plaintiff objects to this Interrogatory as overly broad, unduly burdensome, and not proportional to the needs of this Action to the extent it seeks the identity of Plaintiff's improvements to "any and all" patient safety measures considered by Leapfrog's Hospital Safety Grade. Plaintiff further objects to this Interrogatory because it seeks discovery of information that is irrelevant to the claims and defenses in this Action and is overly broad, unduly burdensome, and not proportional to the needs of this Action to the extent it seeks information on metrics other than TLG's Deceptive Score Categories and to the extent it seeks information that is beyond the scope of Leapfrog's Hospital Survey.

Answer: Plaintiff declines to respond to this Interrogatory.

Amended Answer: Subject to the foregoing objection, Plaintiff is committed to continual improvement of patient safety measures, motivated by our commitment to ensuring the best possible patient safety—not chasing the best possible Leapfrog grade. To achieve this core objective, Plaintiff devotes significant time and resources to improving its delivery of the highest possible quality of care for those in the community it serves, including efforts to improve its performance in areas related to the four metrics Plaintiff has chosen to impute in its survey.

Plaintiff tracks three of these metrics through its patient safety plan or as part of its quality improvement patient safety committee. For example, Plaintiff does random hand washing audits every month on every unit and addresses any negative trends. Plaintiff already has 24/7 ICU coverage for its intensivist unit and has had that coverage for several years, so it does not need to track this metric.

Interrogatory No. 14: State whether You are aware of specific patients who have relied on the Leapfrog Safety Grade in declining to receive healthcare services at Your hospital. In so

answering, identify the individual patient that declined to receive services, the date of such declination, the type of service the patient declined to receive, the medium for the communication from the patient (i.e. telephone, video conference, email, letter, etc.), the content of the communication, and the reason given for the stated decision.

Plaintiff objects to this Interrogatory as seeking protected health information that is protected from disclosure by HIPAA, among other statutes and regulations. Plaintiff will only produce this information as needed and subject to a Qualified Protective Order entered by this Court.

Answer: Subject to the foregoing objection, Plaintiff has received reports that patients considered or decided not to use Plaintiff's facility because of TLG's misleading grades.

Amended Answer: Subject to the foregoing objection, since the release of TLG's false and misleading grades, Plaintiff has received numerous reports from doctors that patients considered or decided not to use Plaintiff's facility due to concerns related to TLG's misleading grades.

Interrogatory No. 15: Describe any effort Your hospital has made to influence public perception of Your hospital's performance on patient safety following the publication of the Leapfrog Safety Grade.

Plaintiff objects to this Interrogatory as vague and ambiguous because it does not specify which Leapfrog Safety Grade is at issue. Plaintiff will construe this Interrogatory to reference TLG's deceptive Safety Grades beginning in Fall 2024. Plaintiff objects to this Interrogatory as overly broad, unduly burdensome, and not proportional to the needs of this Action to the extent it seeks "any effort" Plaintiff "has made to influence public perception" after the release of TLG's deceptive and unfair Safety Grades because there have been many such "efforts" and those "efforts" are ongoing given the significant harm caused by TLG's deceptive and unfair business practices.

Answer: Subject to the foregoing objections, Plaintiff continues to influence public perception by, among other things, delivering the highest quality care to the community it serves, which, as discussed in response to Interrogatory 12, has led to numerous awards, accreditations, and accolades. In addition, several public statements disputing the misleading nature of the Safety Grade have been made on Plaintiff's behalf.

Supplemental Answer: In addition to the above, members of hospital leadership have communicated with patients, doctors, or community members on a regular basis to dispel the misleading nature of the Leapfrog Safety Grades. For instance, Plaintiff communicated its governing board, its medical executive committee, department directors, physicians and nurses, and patients when asked about the Safety Grades or Hospital Survey. These communications occurred in and after Fall 2024, after TLG released its deceptive and unfair Safety Grades for Plaintiff's hospital. The Palm Beach Health Network also issued a press release and has engaged in marketing efforts, including through social media, to counteract TLG's deceptive scores on behalf of Plaintiff and other affected members of the network. Plaintiff also engaged in email discussions about TLG's misleading grades, either as sender or recipient, which TLG has through Plaintiff's production of documents.

Interrogatory No. 16: Describe the due diligence Your hospital undertakes to ensure the accuracy of its own publicly reported safety data (including but not limited to data submitted to CMS, the CDC, and third party organizations).

Plaintiff objects to this Interrogatory as vague and ambiguous due to its use of the undefined term "due diligence." Plaintiff further objects to this Interrogatory because it seeks discovery of information that is irrelevant to the claims and defenses in this Action and is overly broad, unduly burdensome, and not proportional to the needs of this Action. Any "due diligence"

Plaintiff performs when reporting to *third parties* has nothing to do with the claims and defenses in this case related to TLG's decision to use deceptive business practices, especially when TLG does nothing to ensure the accuracy of information that hospitals that participate in its survey self-report.

Answer: Plaintiff declines to respond to this Interrogatory.

Amended Answer: Subject to the foregoing objections, Plaintiff makes reasonable efforts to ensure the accuracy of the data it reports to third-party organizations. For instance, Plaintiff employs data abstractors, quality coordinators and a Quality Director, who are all responsible for abstracting, validating, and submitting safety data.

Interrogatory No. 17: Describe in detail how You communicate to the shareholders, board members, collective bargaining representatives and investors of Tenet Healthcare System the outcome of any and all healthcare safety ratings, evaluative publications, studies, or performance analyses that Your Hospital receives.

Plaintiff objects to this Interrogatory because it seeks discovery of information that is irrelevant to the claims and defenses in this Action and is overly broad, unduly burdensome, and not proportional to the needs of this Action. Plaintiff's communication, if any, with the shareholders, board members, collective bargaining representatives and investors of Tenet Healthcare System, all non-parties to this litigation, has nothing to do with the claims and defenses in this case related to TLG's decision to use deceptive business practices.

Answer: Plaintiff declines to respond to this Interrogatory.

Amended Answer: Subject to the foregoing objection, Plaintiff communicates with Tenet stakeholders, including employees who work to support the Palm Beach Health Network, on a range of matters, including issues related to patient safety and outcomes and in particular related

to TLG and the Safety Grades by email and oral communication. Those communications included discussions about the reasons for particular grades, the method used to calculate Safety Grades, the value of Safety Grades, and responses to the Safety Grades. In addition, identified below are documents Plaintiff produced evidencing communications between the Plaintiff Hospitals and Tenet related to TLG, the Leapfrog survey, and Safety Grades.

Start Page	End Page
PBHN000006509	PBHN000006513
PBHN000006548	PBHN000006550
PBHN000005092	PBHN000005093
PBHN000005094	PBHN000005096
PBHN000006397	PBHN000006401
PBHN000002090	PBHN000002094
PBHN000002071	PBHN000002071

PBHN000004562	PBHN000004563
PBHN000004564	PBHN000004564
PBHN000004574	PBHN000004581
PBHN000004565	PBHN000004569
PBHN000004704	PBHN000004704
PBHN000004715	PBHN000004719
PBHN000006465	PBHN000006466

Discovery is ongoing, and Plaintiff reserves the right to amend, modify or supplement the response to this Interrogatory.

Interrogatory No. 18: State whether the compensation of Your Chief Executive Officer or any other executive-level leadership officers is tied to or related in any way to Your hospital's performance on patient safety, union worker contracts or Your hospital's ratings by third party ratings organizations' ratings publications (including but not limited to the Leapfrog Hospital Safety Grade).

Plaintiff objects to this Interrogatory because it seeks discovery of information that is irrelevant to the claims and defenses in this Action and is overly broad, unduly burdensome, and not proportional to the needs of this Action. Plaintiff's method of compensating its Chief

Executive Officer and other executive-level leadership **has nothing to do with the** claims and defenses in this case related to TLG's decision to use deceptive business practices.

Answer: TLG has, therefore, only propounded this Interrogatory for purposes of harassment. Plaintiff declines to respond to this Interrogatory.

Amended Answer: Subject to the foregoing objection, Plaintiff's performance on patient safety, union worker contracts, or ratings by third party ratings organizations' ratings publications is related in some way to the compensation of Plaintiff's Chief Executive Officer or other executive-level leadership officer(s).

Interrogatory No. 19: Identify all hospitals, medical centers, or healthcare systems that you consider to be your direct competitors within the relevant geographic market during the time period covered by the Complaint and describe in detail the criteria you use to determine whether another hospital or healthcare provider is a competitor.

Plaintiff objects to this Interrogatory because it seeks discovery of information that is irrelevant to the claims and defenses in this Action and is not reasonably calculated to lead to the discovery of admissible evidence. The identity of Plaintiff's competitors and "the criteria" used to determine whether a hospital or provide is a competitor has nothing to do with the claims and defenses in this case related to TLG's decision to use deceptive business practices. Plaintiff also objects to this Interrogatory to the extent it seeks confidential, proprietary information, and commercially sensitive information related to Plaintiff's scoring system and "criteria" used to determine whether a hospital or provide is a competitor.

Answer: Subject to the foregoing objections and on condition that this response is considered "Confidential" under the forthcoming agreed confidentiality order, Jupiter Medical Center is Plaintiff's competitor. Plaintiff considers this hospital a competitor because of its

proximity to Plaintiff, its competing services lines, and that patients within Plaintiff's service area go to this hospital for medical care.

Interrogatory No. 20: State and describe the results of any market analysis, competitive analysis, or consumer perception surveys you have conducted or commissioned regarding your competitors from 2020 to present, and identify the individuals or entities that prepared or participated in such analyses.

Plaintiff objects to this Interrogatory because it seeks discovery of information that is irrelevant to the claims and defenses in this Action and is not is not proportional to the needs of this Action. The results of any market analysis, competitive analysis, or consumer perception surveys and the identity of those who prepared or participated in such analyses has nothing to do with the claims and defenses in this case related to TLG's decision to use deceptive business practices.

Answer: Plaintiff declines to respond to this Interrogatory.

Amended Answer: Plaintiff further objects to this Interrogatory to the extent it requests information from outside of the relevant time period of January 1, 2023, to present. Plaintiff also objects to this Interrogatory as unduly burdensome to the extent it asks Plaintiff to "state and describe" various market analysis.

As agreed during the parties' meet and confer on September 3, 2025, Plaintiff will produce documents showing the results of studies or surveys Plaintiff has conducted or commissioned related to internal market analysis, competitive analysis, or consumer perception. Plaintiff will identify the documents responsive to this Interrogatory by Bates number in Plaintiffs' production cover letter.

Interrogatory No. 21: Identify with specificity any comments or concerns raised by any third party payor, bank or lender, or investor related to Your hospital's reputation and/or public perception on issues in any way involving patient safety or satisfaction.

Plaintiff objects to this Interrogatory because it seeks discovery of information that is overly broad, unduly burdensome and irrelevant to the claims and defenses in this Action and is not proportional to the needs of this case to the extent it seeks "comments and concerns" from third parties related generally to Plaintiff's reputation that has nothing to do with the specific and significant reputational harm caused by TLG's misleading grades.

Answer: Subject to the foregoing objections, Plaintiff will produce and identify documents related to the significant reputational harm caused by TLG's deceptive and unfair Safety Grades that provide sufficient detail to respond to this Interrogatory.

Amended Answer: Subject to the foregoing objections, Plaintiff is unaware of any documents related to this Interrogatory.

Interrogatory No. 22: Identify and describe any complaints, concerns, or comments from patients, community members, or referring physicians that relate to the hospital's reputation or comparisons to other hospitals in the region.

Plaintiff objects to this Interrogatory because it seeks discovery of information that is overly broad, unduly burdensome and irrelevant to the claims and defenses in this Action and is not proportional to the needs of this Action to the extent it seeks "comments and concerns" from patients, community members, or referring physicians that have nothing to do with the significant reputational harm caused by TLG's misleading grades. Plaintiff also objects to this interrogatory as seeking protected health information that is protected from disclosure by HIPAA, among other

statutes and regulations. Plaintiff will only produce this information as needed and subject to the agreed protective order entered by this Court.

Answer: Subject to the foregoing objections, Plaintiff has received reports that patients and physicians considered or decided not to use Plaintiff's facility because of TLG's misleading grades.

Amended Answer: Subject to the foregoing objections, Plaintiff has received reports that patients and physicians considered or decided not to use Plaintiff's facility because of TLG's misleading grades. In addition, concerns have been raised by patients, doctors, staff, and community members, and Plaintiff is aware of false and misleading statements based on TLG's false and misleading methodology and Safety Grades made in newspapers, viral social-media videos, television programs, and blogs.

Our Board of Directors has informed me that they have been barraged by community constituents and leaders about the Medical Center's poor TLG Hospital Safety Grade. Further, our medical leadership has received direct inquiries from patients regarding their concerns about TLG's grades and related public reports. The harm caused by TLG's false and misleading Safety Grade is ongoing.

In addition, the following produced documents evidence such harm.

Start Page	End Page
PBHN000002082	PBHN000002085
PBHN000002066	PBHN000002070
PBHN000002615	PBHN000002617
PBHN000006397	PBHN000006401
PBHN000002090	PBHN000002094
PBHN000004484	PBHN000004484

PBHN000004564	PBHN000004564
PBHN000004574	PBHN000004580
PBHN000004557	PBHN000004557
PBHN000008718	PBHN000008718
PBHN000006461	PBHN000006462
PBHN000008914	PBHN000008914
PBHN000008915	PBHN000008915

Discovery is ongoing, and Plaintiff reserves the right to amend, modify or supplement the response to this Interrogatory.

Interrogatory No. 23: List with specific detail each and every concern, complaint or comment made by any union, collective bargaining unit or employee association in any way related to patient safety at Your hospital.

Answer: Plaintiff objects to this Interrogatory because it seeks discovery of information that is overly broad, unduly burdensome and irrelevant to the claims and defenses in this Action and is overly broad, unduly burdensome, and not proportional to the needs of this Action to the extent it seeks “each and every concern, complaint or comment ” from third parties that have nothing to do with the significant reputational harm caused by TLG’s misleading grades. Plaintiff also objects to this Interrogatory to the extent it seeks health information that is protected from disclosure by HIPAA, among other statutes and regulations. Plaintiff will only produce this information as needed and subject to the agreed protective order entered by this Court.

Answer: Subject to the foregoing objections, Plaintiff is unaware of any concern, complaint or comment regarding TLG deceptive scores made by the union at Plaintiff’s hospital.

Interrogatory No. 24: Identify any and all criticism You have received since 2020 from Tenet Healthcare Corporation and/or from any individual executive of Tenet Healthcare Corporation regarding Your hospital’s performance in any way.

Answer: Plaintiff objects to this Interrogatory because it seeks discovery of information that is overly broad, unduly burdensome and irrelevant to the claims and defenses in this Action and is not reasonably calculated to lead to the discovery of admissible evidence. Any so-called

“criticism” has nothing to do with the claims and defenses related to TLG’s decision to use deceptive business practices. TLG has, therefore, only propounded this Interrogatory for purposes of harassment. Plaintiff declines to respond to this Interrogatory.

Amended Answer: As discussed during the parties’ meet and confer on September 3, 2025, TLG agreed to narrow this Interrogatory to concern only “criticism...regarding Your hospital’s patient safety.” After a reasonable and diligent search, Plaintiff is unaware of having received “criticism” from Tenet Health Corporation regarding patient safety. Plaintiff is always working to improve its performance, quality, and safety in a constructive way and engages with Tenet Health Corporation as needed to ensure Plaintiff provides the best patient care possible.

Dated: September 8, 2025

Respectfully submitted,

By: /s/ Lee R. Crain

MARCUS NEIMAN RASHBAUM & PINEIRO
LLP

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Attorneys for St. Mary's Medical Center, Inc.

CERTIFICATE OF SERVICE

This is to certify that true and correct copies of Plaintiff's Amended and Supplemented Responses and Objections to Defendant The Leapfrog Group's First Sets of Interrogatories to Plaintiff have been served on counsel for The Leapfrog Group by electronic transmission.

/s/ Lee R. Crain
Lee R. Crain

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

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

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

Plaintiffs,

v.

THE LEAPFROG GROUP,

Defendant.

**AFFIDAVIT OF CYNTHIA MCCAULEY IN SUPPORT OF
PLAINTIFF ST. MARY'S MEDICAL CENTER, INC.'S
AMENDED AND SUPPLEMENTED RESPONSES AND OBJECTIONS TO
DEFENDANT THE LEAPFROG GROUP'S FIRST SET OF
INTERROGATORIES TO ST. MARY'S MEDICAL CENTER**

I, Cynthia McCauley, declare as follows:

1. I am over 21 years of age and competent to give this testimony.
2. I am the Chief Executive Officer of St. Mary's Medical Center, Inc. ("Plaintiff"). I am the corporate representative of Plaintiff for the purpose of answering Defendant The Leapfrog Group's First Set of Interrogatories to St. Mary's Medical Center. I have read the foregoing interrogatories and the answers to those interrogatories, which are true according to the best of my knowledge, information, and belief.
3. I declare under penalty of perjury that the foregoing is true and correct.

Executed on September 8, 2025.

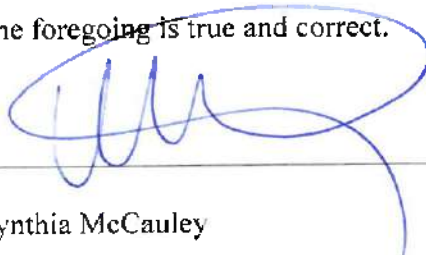

Cynthia McCauley

EXHIBIT 33

Message

From: West, Regina [Regina.West@tenethealth.com]
Sent: 11/4/2024 6:17:50 PM
To: Johnson, Stephany [Stephany.Johnson@tenethealth.com]
Subject: HO response regarding Leapfrog

Keeping you in the loop.

Gina West
St. Mary's Medical Center & PBHN Market Quality Director
901 45th Street
West Palm Beach, FL 33407
O: (561) 882-6435
F: (561) 882-9117
Email: Regina.West@tenethealth.com
Delray | Good Samaritan | Palm Beach Gardens | St. Mary's | West Boca

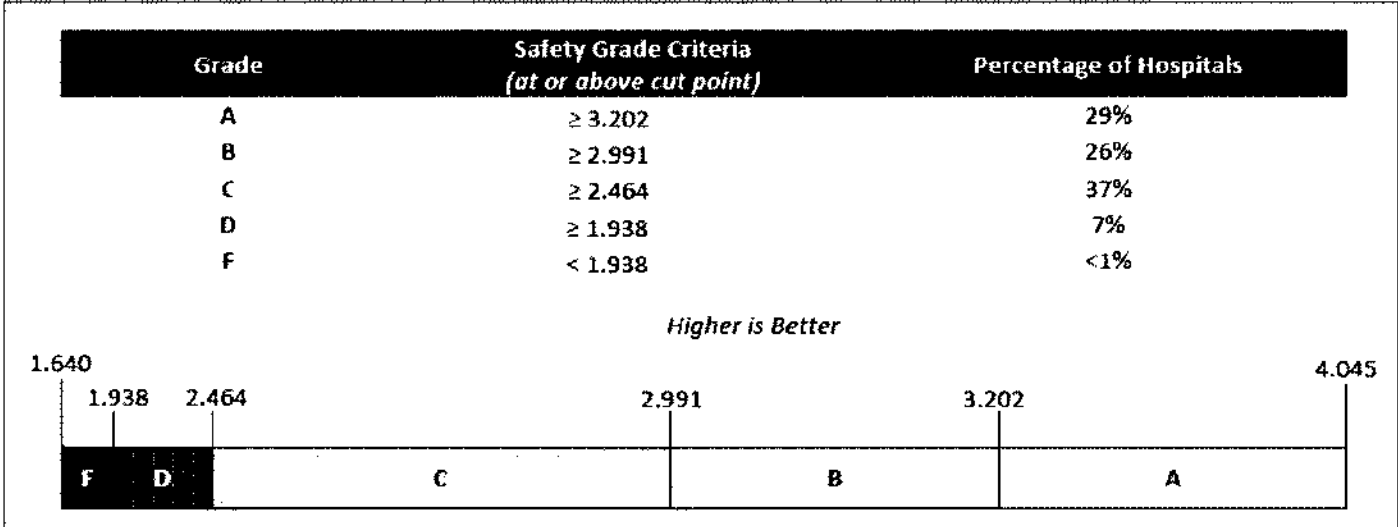
Notice: The information in this communication is confidential and is directed only to the intended recipient. Please do not forward this communication without my permission. If you have received this communication in error, please notify me immediately and delete/destroy this communication.

From: West, Regina
Sent: Monday, September 30, 2024 3:05 PM
To: Ramirez, Ricardo <Ricardo.Ramirez@tenethealth.com>
Subject: Leapfrog

Ricky – here are our Leapfrog Scores and anticipated grades based on imputed scoring:

- Delray: 1.5968 (F)
- Good Sam: 1.7652 (F)
- PB Gardens: 1.7770 (F)
- St. Mary's: 2.2450 (D)
- West Boca:

Spring's scoring spread to help gauge where we may land in once the scores are published



Gina West

St. Mary's Medical Center & PBHN Market Quality Director
901 45th Street
West Palm Beach, FL 33407
O: (561) 882-6435
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Delray | Good Samaritan | Palm Beach Gardens | St. Mary's | West Boca

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From: West, Regina
Sent: Friday, September 27, 2024 9:33 AM
To: Ramirez, Ricardo <Ricardo.Ramirez@tenethealth.com>
Subject: FW: Leapfrog

Looping you in: HO is not allowing participation in Leapfrog but they continue to ask for our scores.

Gina West
St. Mary's Medical Center & PBHN Market Quality Director
901 45th Street
West Palm Beach, FL 33407
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Email: Regina.West@tenethealth.com
Delray | Good Samaritan | Palm Beach Gardens | St. Mary's | West Boca

Notice: The information in this communication is confidential and is directed only to the intended recipient. Please do not forward this communication without my permission. If you have received this communication in error, please notify me immediately and delete/destroy this communication.

From: Gunod, Anna <Anna.Gunod@tenethealth.com>
Sent: Friday, September 27, 2024 9:29 AM
To: West, Regina <Regina.West@tenethealth.com>
Cc: Nunes, Andrea <ANDREA.Nunes@tenethealth.com>; WEHMEYER, HEATHER <heather.wehmeyer@tenethealth.com>; McDonald, Kathleen <Kathleen.Mcdonald@tenethealth.com>; Pool, Taylor <Taylor.Pool@tenethealth.com>
Subject: RE: Leapfrog

It is a No from home office. Facilities who need an exception due to Leapfrog participation being tied to a local requirement, contract compliance, or reimbursement need to submit their case for review by Dr. Franklin.

Thanks,
Anna

Anna Gunod, MPH, CIC
National Director of Infection Prevention

C: (860) 309-6819
anna.gunod@tenethealth.com



A COMMUNITY BUILT ON CARE

Tenet Healthcare
14201 Dallas Parkway
Dallas, Texas 75254

From: West, Regina <Regina.West@tenethealth.com>
Sent: Friday, September 27, 2024 6:01 AM
To: Gunod, Anna <Anna.Gunod@tenethealth.com>
Cc: Nunes, Andrea <ANDREA.Nunes@tenethealth.com>; WEHMEYER, HEATHER <heather.wehmeyer@tenethealth.com>; McDonald, Kathleen <Kathleen.Mcdonald@tenethealth.com>; Pool, Taylor <Taylor.Pool@tenethealth.com>
Subject: RE: Leapfrog

Although not supported, is it left up to the local markets to decide or a strict "No" from HO?

Gina West
St. Mary's Medical Center & PBHN Market Quality Director
901 45th Street
West Palm Beach, FL 33407
O: (561) 882-6435
F: (561) 882-9117
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Delray | Good Samaritan | Palm Beach Gardens | St. Mary's | West Boca

Notice: The information in this communication is confidential and is directed only to the intended recipient. Please do not forward this communication without my permission. If you have received this communication in error, please notify me immediately and delete/destroy this communication.

From: Gunod, Anna <Anna.Gunod@tenethealth.com>
Sent: Thursday, September 26, 2024 5:36 PM
To: West, Regina <Regina.West@tenethealth.com>
Cc: Nunes, Andrea <ANDREA.Nunes@tenethealth.com>; WEHMEYER, HEATHER <heather.wehmeyer@tenethealth.com>; McDonald, Kathleen <Kathleen.Mcdonald@tenethealth.com>; Pool, Taylor <Taylor.Pool@tenethealth.com>
Subject: RE: Leapfrog

Hi Gina,

Leapfrog participation is not supported unless it is directly tied to a payment/contract or a local regulatory requirement.

Thanks,
Anna

Anna Gunod, MPH, CIC
National Director of Infection Prevention

C: (860) 309-6819
anna.gunod@tenethealth.com

A COMMUNITY BUILT ON **CARE**

Tenet Healthcare
14201 Dallas Parkway
Dallas, Texas 75254

From: West, Regina <Regina.West@tenethealth.com>
Sent: Wednesday, September 25, 2024 1:24 PM
To: Gunod, Anna <Anna.Gunod@tenethealth.com>
Cc: Nunes, Andrea <ANDREA.Nunes@tenethealth.com>; WEHMEYER, HEATHER <heather.wehmeyer@tenethealth.com>; McDonald, Kathleen <Kathleen.Mcdonald@tenethealth.com>; Pool, Taylor <Taylor.Pool@tenethealth.com>
Subject: Leapfrog

Anna,

If we would like to participate in the next survey, are we able? We have done this in the past, so it would not be new participation. Because we aren't participating, we default to imputed scoring. This takes SMMC from 100 points in each of the categories below to limited achievement scores. We will likely decrease an entire letter and score a "D" this time around.

STEP 2: USE IMPUTATION POINT ASSIGNMENT (APPLIES TO CPOE, BCMA, IPS AND HAND HYGIENE)

If the hospital does not have historical data from the last two rounds (i.e., spring 2024, fall 2023) of the Safety Grade, the hospital is assigned a point value that is equivalent to receiving "Limited Achievement" for this measure on the Leapfrog Hospital Survey.

Note about IPS: Only hospitals that operate an adult or pediatric medical and/or surgical ICU or neuro ICU are eligible for Step 2 imputation of the IPS measure. A hospital's ICU designation (i.e., operating a medical ICU, surgical ICU, or pediatric ICU) is determined from the number of medical, surgical and/or pediatric ICU beds reported in Worksheet S-3 Part 1 of the hospital's most recent CMS Cost Report. If your hospital does not operate an ICU, but shares a CMS Certification Number with a hospital that does, please [contact the Help Desk](#) immediately if an IPS score was imputed.

Step 2 Imputation Point Assignments

Measure	Leapfrog Hospital Survey Performance Category	Corresponding Safety Grade Measure Score
CPOE	Limited Achievement	15
BCMA	Limited Achievement	25
IPS	Limited Achievement	5
Hand Hygiene	Limited Achievement	15

Gina West
 St. Mary's Medical Center & PBHN Market Quality Director
 901 45th Street
 West Palm Beach, FL 33407
 O: (561) 882-6435
 F: (561) 882-9117

Email: Regina.West@tenethealth.com

Delray | Good Samaritan | Palm Beach Gardens | St. Mary's | West Boca

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From: Gunod, Anna <Anna.Gunod@tenethealth.com>

Sent: Friday, August 23, 2024 9:36 AM

To: West, Regina <Regina.West@tenethealth.com>

Cc: Nunes, Andrea <ANDREA.Nunes@tenethealth.com>; WEHMEYER, HEATHER

<heather.wehmeyer@tenethealth.com>; McDonald, Kathleen <Kathleen.Mcdonald@tenethealth.com>; Pool, Taylor <Taylor.Pool@tenethealth.com>

Subject: RE: Leapfrog

Thank you, Gina.

Anna

Anna Gunod, MPH, CIC

National Director of Infection Prevention

C: (860) 309-6819

anna.gunod@tenethealth.com



A COMMUNITY BUILT ON **CARE**

Tenet Healthcare

14201 Dallas Parkway

Dallas, Texas 75254

From: West, Regina <Regina.West@tenethealth.com>

Sent: Friday, August 23, 2024 8:35 AM

To: Gunod, Anna <Anna.Gunod@tenethealth.com>

Cc: Nunes, Andrea <ANDREA.Nunes@tenethealth.com>; WEHMEYER, HEATHER

<heather.wehmeyer@tenethealth.com>; McDonald, Kathleen <Kathleen.Mcdonald@tenethealth.com>; Pool, Taylor <Taylor.Pool@tenethealth.com>

Subject: RE: Leapfrog

The hospitals in PBHN are not participating.

Gina West

St. Mary's Medical Center & PBHN Market Quality Director

901 45th Street

West Palm Beach, FL 33407

O: (561) 882-6435

F: (561) 882-9117

Email: Regina.West@tenethealth.com

Delray | Good Samaritan | Palm Beach Gardens | St. Mary's | West Boca

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From: Gunod, Anna <Anna.Gunod@tenethealth.com>
Sent: Friday, August 23, 2024 9:15 AM
To: DL-DCQI only <DLDCQIonly@tenethealth.com>
Subject: Leapfrog

Good morning, Quality Leaders,

I am doing an annual check-in on Leapfrog participation.

Please respond to this email with answers to the following questions:

Name of facility:

Is your facility participating in Leapfrog?

If yes, is participation tied to a local requirement or payer/reimbursement? Please provide some detail.

As a reminder, new participation in Leapfrog must be approved by home office clinical operations leadership.

Thank you,
Anna

Anna Gunod, MPH, CIC
National Director of Infection Prevention

C: (860) 309-6819
anna.gunod@tenethealth.com



A COMMUNITY BUILT ON 

Tenet Healthcare
14201 Dallas Parkway
Dallas, Texas 75254

EXHIBIT 34

Message

From: Nunes, Andrea [/O=EXCHANGELABS/OU=EXCHANGE ADMINISTRATIVE GROUP (FYDIBOHF23SPDLT)/CN=RECIPIENTS/CN=74E5480103274FD1B0332021509C584A-NUNES, ANDR]
Sent: 11/4/2024 7:35:40 PM
To: West, Regina [Regina.West@tenethealth.com]
CC: Ramirez, Ricardo [Ricardo.Ramirez@tenethealth.com]
Subject: RE: Fall 2024 Leapfrog Hospital Safety Grade Embargo Period
Attachments: Calculator_Fall2024_EmbargoPeriod West Boca Medical Center.xlsx; WBMC Safety Grade 11.4.2024.docx

Good Afternoon,
The Letter Grade is a D.

It is important to state that the following scores were imputed since West Boca did not complete a survey:

CPOE: Received 15 (100 is Achieved Standard)
BCMA: Received 25 (100 is Achieved Standard)
ICU Physician Staffing: Received 5 (100 is Achieved Standard)
Hand Hygiene: Received 15 (100 is Achieved Standard)

Also, since a survey was not completed, the following appear as declined to report

Safe Practice 1: Leadership: Declined to Report
Safe Practice 2: Culture: Declined to Report
Total Nursing Care Hours: Declined to Report

How to achieve a higher grade:

I utilized the Excel report as a guide and changed the imputed scores and N/A Scores to 100 as if we did the survey, the grade moves to a C with a score of 2.7065 (The score for a B is 2.991)

In order to move to a B, in addition to achieving 100 on the imputed scores and the declined to report scores, the Patient Experience Scores need to move to the 80s from the 60s or the HAIs need to be 0.00.

Thanks,
Andrea

Andrea Nunes, RN, BSN, MHM, CPHQ, CPHRM
Director Clinical Quality Improvement
21644 State Road 7
Boca Raton, Florida 33428
Fax: 561.883.7268
Telephone: 561.488.8287
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From: West, Regina <Regina.West@tenethealth.com>

Sent: Monday, November 4, 2024 1:30 PM

To: Nunes, Andrea <ANDREA.Nunes@tenethealth.com>; Johnson, Stephany <Stephany.Johnson@tenethealth.com>;

Pool, Taylor <Taylor.Pool@tenethealth.com>; Mcdonald, Kathleen <Kathleen.Mcdonald@tenethealth.com>

Subject: Fall 2024 Leapfrog Hospital Safety Grade Embargo Period

Please copy me when you respond to Vani. Thank you ☺

Gina West

St. Mary's Medical Center & PBHN Market Quality Director

901 45th Street

West Palm Beach, FL 33407

O: (561) 882-6435

F: (561) 882-9117

Email: Regina.West@tenethealth.com

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Sent: Monday, November 4, 2024 12:59 PM

To: Esleck, Sue <Sue.Esleck@tenethealth.com>; Higgins, Thea <Thea.Higgins@bhsala.com>; Hayes, Kim <Kimberly.Hayes@bhsala.com>; Simmons, Greta <Greta.Simmons@BHSALA.com>; Parker, Shirley <Shirley.Parker@BHSALA.com>; Nelson, Carolyn <CAROLYN.NELSON@abrazohealth.com>; Jakubowski, Jennifer1 <jjakubowski@abrazohealth.com>; Mckelvey, Mary <MARY.MCKELVEY@abrazohealth.com>; Scruton, John <John.Scruton@carondelet.org>; Romo, Claudia <CLAUDIA.ROMO@carondelet.org>; Speights, Rosetta <Rosetta.Speights@carondelet.org>; Menzel, Sharon <SMenzel@dmc.org>; Goll, Kathleen <KGOLL@DMC.ORG>; brazauskas, christine <christine.brazauskas@mwmc.com>; DeHaven, Josi <Josi.DeHaven@stvincenthospital.com>; CHILDERS, Ashley <ASHLEY.CHILDERS@tenethealth.com>; Williams, Deborah2 <Deborah2.Williams@tenethealth.com>; Bevel, Thelma <Thelma.Bevel@tenethealth.com>; WEHMEYER, HEATHER <heather.wehmeyer@tenethealth.com>; Pool, Taylor <Taylor.Pool@tenethealth.com>; Mcdonald, Kathleen <Kathleen.Mcdonald@tenethealth.com>; West, Regina <Regina.West@tenethealth.com>; Nunes, Andrea <ANDREA.Nunes@tenethealth.com>; Trujillo, Rainbeaux <Rainbeaux.Trujillo@tenethealth.com>; Venegas, Anthony <anthony.venegas@tenethealth.com>; Robles, Darlene <Darlene.Robles@tenethealth.com>; Gayre, Marlisa <LGAYRE@baptisthealthsystem.com>; Laughlin, Melody <Melody.Laughlin@baptisthealthsystem.com>; Greenville, Rita <Rita.Greenville@tenethealth.com>; Pizano, Yolanda <Yolanda.Pizano@valleybaptist.net>; Pierce, Linda <Linda.Pierce@valleybaptist.net>; Garcia, Mauro <Mauro.Garcia@tenethealth.com>; Ciani, Carissa <Carissa.Ciani@tenethealth.com>; CelayaHester, Natalie <Natalie.Celayahester@tenethealth.com>; Chang, ShiohHuey <ShiohHuey.Chang@tenethealth.com>; Niedbala, Deborah <DNiedbal@dmc.org>; Wylie, Cindy <cindy.wylie@tenethealth.com>; Burnette, Darlene <Darlene1.Burnette@tenethealth.com>; Havens, Alison <AHavens@dmc.org>; Pena, Angie <angie.pena@tenethealth.com>; Kiser, Kimmons <kimmons.kiser@tenethealth.com>; Martin, Sandra <sandra.martin@tenethealth.com>; ConleyWhite, Terri <Terri.Conleywhite@tenethealth.com>; Burch, Tina <TINA.BURCH@TENETHEALTH.COM>

Subject: Fall 2024 Leapfrog Hospital Safety Grade Embargo Period

Hello Everyone,

Good afternoon. Fall 2024 Safety Grade embargo period started today. Please review your score and the letter grade, and share it with me.

Thank you,

Satyavani Nukala
Biostatistician, Clinical Operations

Tenet Healthcare
14201 Dallas Pkwy,
Dallas, 75254
Office: 469.893.6615
Mobile: 469.766.5319
Fax: 469.893.7583
Satyavani.nukala@tenethealth.com

EXHIBIT 35



How Safe is Your Hospital?

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City

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This Hospital's Grade



SPRING 2025

West Boca Medical Center

21644 State Road 7
Boca Raton, FL 33426-1899

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EXHIBIT 37



West Boca Medical Center

21644 State Road 7
Boca Raton, FL 33428-1899

[View this hospital's Leapfrog Hospital Survey Results](#)

This Hospital's Grade

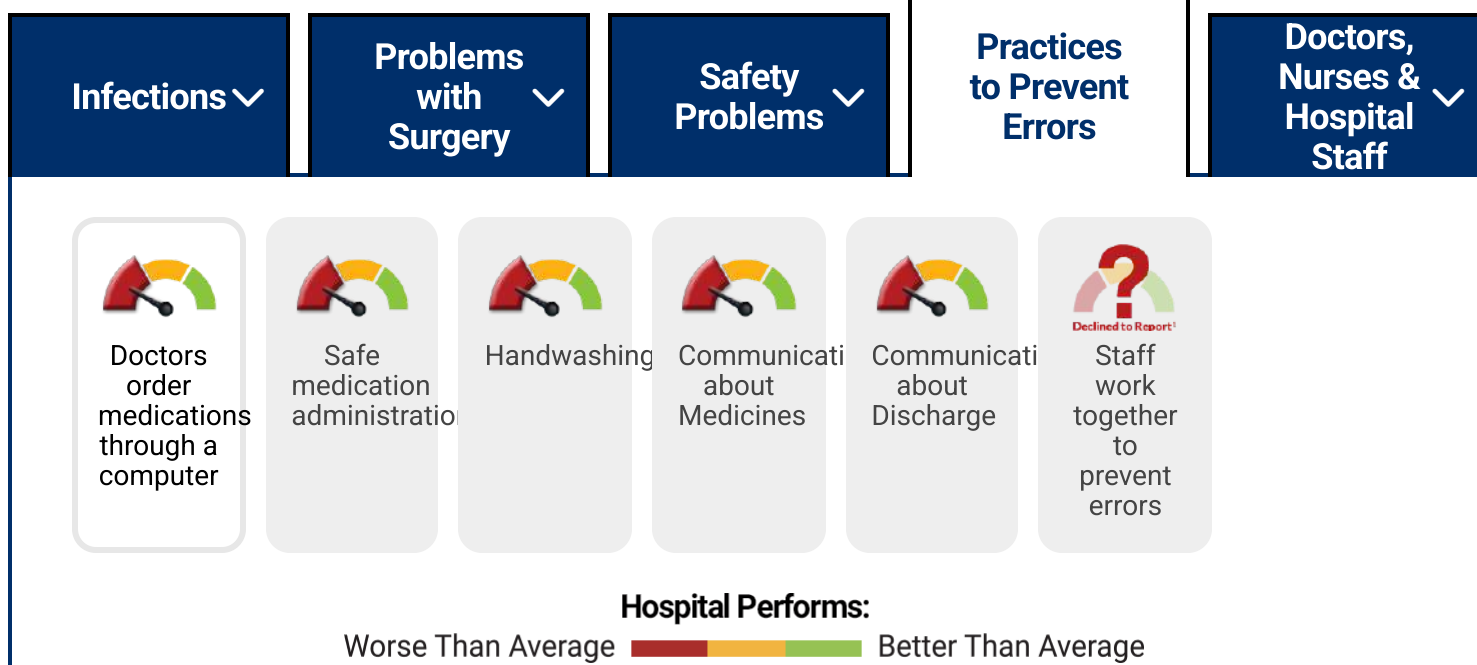


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Learn how to use the Leapfrog Hospital Safety Grade



This Hospital's Score:

15 *

Best Hospital's Score:

100

Average Hospital's Score:

80.23

Worst Hospital's Score:

15

Doctors order medications through a computer

Hospitals can use Computerized Physician Order Entry (CPOE) systems to order medications for patients in the hospital, instead of writing out prescriptions by hand. Good CPOE systems alert the doctor if they try to order a medication that could cause harm, such as prescribing an adult dosage for a child. CPOE systems help to reduce medication errors in the hospital.

Hospitals can earn up to 100 points for using a well-functioning CPOE system in most areas of the hospital. [For details on sources, click here.](#)

What safer hospitals do:

Hospitals use CPOE systems in all areas of the hospital and regularly test those systems to ensure they are alerting doctors to potential ordering errors.

Notes and Definitions

1. Declined to Report: The hospital was asked to provide this information to the public, but did not.

2. Not Available: "Not Available" means that the hospital does not have data for this measure. This could be because the measure is related to a service the hospital does not provide. For example, a hospital that does not have an ICU would not be able to report data about ICUs. It could also be because the hospital had too few patients or cases to report data for a particular condition or procedure. A "Not Available" result does not mean that the hospital withheld information from the public.

3. Straight A: The hospital has earned an 'A' Grade for five consecutive grading rounds or more, qualifying it for recognition as a "Straight A" hospital.

4. * The hospital declined to report their performance on this measure, so a score was assigned to reflect the lack of information available.

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This Hospital's Grade

West Boca Medical Center

21644 State Road 7
Boca Raton, FL 33428-1899
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Outcomes measures include errors, accidents, and injuries that this hospital has publicly reported.

Measure	The Hospital's Score	Worst Performing Hospital	Avg. Performing Hospital	Best Performing Hospital	Data Source	Time Period Covered
Dangerous object left in patient's body What's This?	0.000	0.327	0.014	0.000	CMS	07/01/2021 - 06/30/2023
Air or gas bubble in the blood What's This?	0.000	2.890	0.002	0.000	CMS	07/01/2021 - 06/30/2023
Patient falls and injuries What's This?	0.552	1.926	0.384	0.000	CMS	07/01/2021 - 06/30/2023
Infection in the blood What's This?	1.144	2.762	0.551	0.000	CMS	01/01/2023 - 12/31/2023
Infection in the urinary tract What's This?	0.522	2.512	0.540	0.000	CMS	01/01/2023 - 12/31/2023
Surgical site infection after colon surgery What's This?	2.922	3.094	0.831	0.000	CMS	01/01/2023 - 12/31/2023
MRSA Infection What's This?	1.318	2.850	0.719	0.000	CMS	01/01/2023 - 12/31/2023
C. diff. Infection What's This?	0.198	1.607	0.401	0.000	CMS	01/01/2023 - 12/31/2023
Death from treatable serious complications What's This?	Not Available	235.51	177.45	84.66	CMS	07/01/2021 - 06/30/2023
Harmful Events What's This?	0.92	3.10	1.00	0.53	CMS	07/01/2021 - 06/30/2023
Dangerous bed sores What's This? *	0.32	7.50	0.64	0.05	CMS	07/01/2021 - 06/30/2023
Collapsed lung What's This? *	0.23	0.65	0.25	0.10	CMS	07/01/2021 - 06/30/2023
Falls causing broken hips What's This? *	0.34	0.56	0.29	0.15	CMS	07/01/2021 - 06/30/2023
Blood Leakage What's This? *	2.24	5.53	2.42	1.01	CMS	07/01/2021 - 06/30/2023
Kidney injury after surgery What's This? *	Not Available	4.60	1.69	0.74	CMS	07/01/2021 - 06/30/2023
Serious breathing problem What's This? *	Not Available	57.80	10.53	1.94	CMS	07/01/2021 - 06/30/2023
Dangerous blood clot What's This? *	4.02	8.15	3.90	1.56	CMS	07/01/2021 - 06/30/2023
Sepsis infection after surgery What's This? *	Not Available	12.56	5.63	1.95	CMS	07/01/2021 - 06/30/2023
Surgical wound splits open What's This? *	1.82	4.00	1.87	1.13	CMS	07/01/2021 - 06/30/2023
Accidental cuts and tears What's This? *	0.81	2.41	0.89	0.28	CMS	07/01/2021 - 06/30/2023

* This measure is a part of the Harmful Events Composite and is not used for scoring.

Process measures include the management structures and procedures a hospital has in place to protect patients from errors, accidents, and injuries.

Measure	The Hospital's Score	Worst Performing Hospital	Avg. Performing Hospital	Best Performing Hospital	Data Source	Time Period Covered
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Measure	The Hospital's Score	Worst Performing Hospital	Avg. Performing Hospital	Best Performing Hospital	Data Source	Time Period Covered
Doctors order medications through a computer What's This?	15	15	80.23	100	Imputation Model Applied	Not Applicable
Safe medication administration What's This?	25	25	81.87	100	Imputation Model Applied	Not Applicable
Specially trained doctors care for ICU patients What's This?	5	5	65.15	100	Imputation Model Applied	Not Applicable
Effective leadership to prevent errors What's This?	Declined to Report	9.23	117.49	120.00	2024 Leapfrog Hospital Survey	2024
Staff work together to prevent errors What's This?	Declined to Report	0.00	116.85	120.00	2024 Leapfrog Hospital Survey	2024
Nursing and Bedside Care for Patients What's This?	Declined to Report	15	77.07	100	2024 Leapfrog Hospital Survey	01/01/2023 - 12/31/2023
Handwashing What's This?	15	15	74.40	100	Imputation Model Applied	Not Applicable
Communication with nurses What's This?	82	73	90.19	97	DMS	01/01/2023 - 12/31/2023
Communication with doctors What's This?	85	73	89.91	97	DMS	01/01/2023 - 12/31/2023
Responsiveness of hospital staff What's This?	66	55	81.63	95	DMS	01/01/2023 - 12/31/2023
Communication about medicines What's This?	64	55	74.42	93	DMS	01/01/2023 - 12/31/2023
Communication about discharge What's This?	78	67	85.25	97	DMS	01/01/2023 - 12/31/2023

For a full description of the methodology, [click here](#).



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Unless explicitly stated herein, nothing in this Agreement will be construed as conferring any license to Intellectual Property Rights of Leapfrog, whether by estoppel, implication, or otherwise. Please be aware that we actively and aggressively enforce our intellectual property rights to the fullest extent of the law. Please send an email to info@leapfroggroup.com to receive additional information.

d. "Intellectual Property Rights" means all intellectual property rights of any kind or nature however denominated throughout the world, including, without limitation all copyrights, patents, patent applications, trade secrets, inventions, proprietary know-how, registered and unregistered trademarks, registered and unregistered service marks, domain names, registered and unregistered trade names, rights of privacy and publicity, moral rights, and database rights.

e. In partial consideration of Leapfrog providing this

website, you agree that all Intellectual Property Rights and all ownership of any ideas, modifications, enhancements, improvements, inventions, works of authorship, or any other suggestions you or any of your personnel provides to Leapfrog relating to this website or the Safety Grade will be, and are hereby, assigned to Leapfrog and shall be the sole and exclusive property of Leapfrog.

4. Term and Access

This Agreement takes effect on the date you first access or use the Leapfrog Hospital Safety Grade. Leapfrog reserves the right at any time in its sole discretion to terminate this Agreement and your access to, and use of, the Safety Grade, with or without notice. Upon such termination for any reason, you will cease access to, or use of, the Safety Grade and all of your rights herein will cease and at the request of Leapfrog you will return or destroy all copies of any such content, including Confidential and Proprietary Information, in your possession

and certify in writing to Leapfrog that you have done so. Rights and obligations under this Agreement which by their nature are intended to survive the termination of your authorization to use the Safety Grade will remain in full effect after such termination, including without limitation those of Sections 1, 2, 3, 4, 5, 6, 7, 8, 9, and 10.

5. Linking

You are granted a limited, non-exclusive right to create a text hyperlink to this website for noncommercial purposes, provided such link does not portray Leapfrog, the website, the Leapfrog Hospital Safety Grade, or any of Leapfrog's other products and services, in any misleading, derogatory, or otherwise defamatory manner and provided further that the linking site does not contain any adult or illegal material or any material that is offensive, harassing, or otherwise objectionable. Leapfrog may revoke this limited right at any time. You may not use a Leapfrog logo or other proprietary graphic of Leapfrog to link to this site without the express written permission of Leapfrog. Further, you may not frame, in-line link, or

otherwise utilize framing techniques to enclose any Leapfrog trademark, logo, or other proprietary information, including the content found at this website, without Leapfrog's express written consent. Except as noted above, you are not granted any right or license by implication, estoppel, or otherwise in or under any patent, trademark, copyright, or proprietary right of Leapfrog or any third party.

6. Indemnity and Hold Harmless

You agree to indemnify and hold each of Leapfrog and any agent appointed by Leapfrog to pursue and enforce its rights and to undertake and fulfill its obligations under this Agreement ("Agent") and their respective affiliates and all of their respective past, present and future directors, officers, employees, successors and agents and all of their respective successors and assigns, both individually and in their official capacities (collectively "Indemnitees") harmless from and against any and all liabilities, damages, demands, claims, causes of action, fines or penalties (including, without

limitation, court costs and reasonable attorneys' fees) arising out of or related to the failure of you to fulfill any of your obligations under this Agreement or your use of or access to the Leapfrog Hospital Safety Grade. You hereby expressly forever release, and discharge Leapfrog, the Agents, and the Indemnitees from, and covenant not to assert against Leapfrog, the Agents, and the Indemnitees any and all causes of action, rights or claims of any type or description, known or unknown, which may arise in the future in any way resulting from, arising out of or in connection with your use of the Safety Grade. You agree that you are waiving any right that you may have to obtain or receive any monetary damages or other relief of any kind (including but not limited to settlement proceeds) as a result of any action or proceeding brought by you or by any other person or entity on your behalf regarding your use of the Safety Grade, and to the extent permitted by law, you agree that you will not seek or accept any monetary damages or other relief of any kind in any such action or proceeding.

7. Events Beyond Our Control

You absolve and release us and our affiliates from any claim of harm resulting from any cause(s) over which we or they do not have direct control, including, but not limited to, failure of electronic or mechanical equipment or communication lines, telephone or other interconnect problems, computer viruses or other damaging code or data, unauthorized access, theft, operator errors, severe weather, earthquakes, natural disasters, strikes or other labor problems, wars, or governmental restrictions, and disclosure of your private health information that you have provided to third parties through links on our Site.

8. Disclaimer of Warranties

THIS WEBSITE AND THE LEAPFROG HOSPITAL SAFETY GRADES ARE INTENDED FOR INFORMATIONAL PURPOSES ONLY. WHILE WE ENDEAVOR TO PROVIDE THE MOST ACCURATE, UP TO DATE INFORMATION AVAILABLE, THE SAFETY GRADES MAY CONTAIN TECHNICAL OR OTHER INACCURACIES OR TYPOGRAPHICAL ERRORS, AND MAY BE CHANGED OR UPDATED WITHOUT NOTICE. NEITHER

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TO THE FULL EXTENT PERMITTED BY LAW, NEITHER LEAPFROG NOR ITS AFFILIATES WILL BE LIABLE FOR ANY DAMAGES RESULTING FROM YOUR USE OF, OR RELIANCE UPON, THIS WEBSITE, ANY LEAPFROG HOSPITAL SAFETY

GRADES, OR ANY PRODUCTS OR SERVICES OBTAINED ON OR THROUGH THIS WEBSITE. IN THE EVENT OF ANY PROBLEM WITH THIS WEBSITE, ANY SAFETY GRADES, OR ANY PRODUCTS OR SERVICES OBTAINED ON OR THROUGH THIS WEBSITE, YOUR SOLE REMEDY IS TO CEASE USING SUCH ITEM(S). LEAPFROG IS NOT LIABLE FOR ANY INDIRECT, PUNITIVE, SPECIAL, INCIDENTAL, CONSEQUENTIAL, OR EXEMPLARY DAMAGES OR ANY DAMAGES FOR LOSS OF BUSINESS, REVENUE, OR PROFIT) ARISING OUT OF OR IN CONNECTION WITH YOUR USE OF THE SAFETY GRADE, EVEN IF LEAPFROG HAS PREVIOUSLY BEEN ADVISED OF, OR REASONABLY COULD HAVE FORESEEN, THE POSSIBILITY OF SUCH DAMAGES, HOWEVER THEY ARISE, WHETHER IN CONTRACT, TORT, WARRANTY OR ANY OTHER LEGAL THEORY. To the extent that any jurisdiction does not allow the exclusion or limitation of indirect, punitive, special, incidental, consequential or exemplary damages, portions of the above limitation or exclusion may not apply.

10. General Terms

a. Any express waiver or failure to exercise promptly any right under this Agreement in any particular circumstance does not constitute a waiver of its right to enforce this Agreement in any other circumstance, in any similar circumstance, or in any continuation or repetition of the circumstance in connection with which it has not previously enforced its right. If any part, term, or provision of this Agreement will be held void, illegal, unenforceable, or in conflict with any law of a federal, state, or local government having jurisdiction over this Agreement, the validity of the remaining portions or provisions will not be affected hereby.

b. This Agreement, the rights and obligations hereunder, and any claims or disputes relating thereto, will be governed by and construed in accordance with the laws of the District of Columbia without regard to the principles of conflicts of laws. Any claim, suit or action arising under or relating to this Agreement

must be brought and maintained exclusively in courts located within the District of Columbia. The parties hereby agree that such courts will have exclusive personal and subject matter jurisdiction over any such claim, suit, or action. YOU WAIVE ANY RIGHT TO A TRIAL BY JURY IN ANY ACTION TO ENFORCE OR DEFEND ANY RIGHT UNDER THIS AGREEMENT OR ANY AMENDMENT, INSTRUMENT, DOCUMENT OR AGREEMENT DELIVERED OR TO BE DELIVERED IN CONNECTION WITH THIS AGREEMENT OR ARISING FROM ANY RELATIONSHIP EXISTING IN CONNECTION WITH THIS AGREEMENT, AND AGREE THAT ANY ACTION WILL BE TRIED BEFORE A JUDGE SITTING WITHOUT A JURY.

c. This Agreement constitutes the entire agreement between you and Leapfrog relating to this subject matter, and cancels and supersedes any prior versions of this Agreement. No modification to this

Agreement will be binding against Leapfrog, unless in writing and signed by an authorized Leapfrog representative. You may not assign, sublicense, delegate or otherwise transfer this Agreement or any right granted hereunder.

You acknowledge that it will be impossible to measure the damages that would be suffered by Leapfrog if you fail to comply with this Agreement and that in the event of any such failure, Leapfrog will not have an adequate remedy at law. Leapfrog shall, therefore, be entitled in addition to any other rights and remedies to obtain specific performance of your obligations hereunder and to obtain immediate injunctive relief without having to post a bond. You shall not urge, as a defense to any proceeding for such specific performance or injunctive relief, that Leapfrog has an adequate remedy at law.



independent nonprofit organization committed to driving quality, safety, and transparency in the U.S. health system.

The Leapfrog Hospital Safety Grade

The Leapfrog Hospital Safety Grade is a public service provided by The Leapfrog Group, an

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EXHIBIT 40



Request for Public Comments: Planned Updates to the Leapfrog Hospital Safety Grade Methodology for Fall 2024

Leapfrog requests public comments for planned updates to the Leapfrog Hospital Safety Grade methodology that will be used to calculate the fall 2024 Hospital Safety Grades. Comments on these proposed changes may be submitted through **June 7, 2024**, using the directions below. Leapfrog will publish final methodology updates and responses to public comments by June 30, 2024.

Summary of Changes

Starting in fall 2024, Leapfrog will update the Imputation Methodology for CPOE, BCMA, IPS, and Hand Hygiene measures for hospitals that do not submit a 2024 Leapfrog Hospital Survey by August 31, 2024. The changes come under the guidance of Leapfrog's national expert panel, the research team at Johns Hopkins Medicine, and in response to stakeholder feedback. Table 2 on pages 4-5 includes the summary of data sources and anticipated reporting periods for the fall 2024 Hospital Safety Grades.

More information can be found on the Hospital Safety Grade website at <https://www.hospitalsafetygrade.org/for-hospitals/key-dates-and-information>.

Instructions to Submit a Public Comment (Deadline June 7, 2024)

1. Visit <https://leapfroghelpdesk.zendesk.com/>
2. Click on "Submit a Request" on the top right-hand corner of the webpage
3. Select "Hospital Safety Grade" as the name of the ratings program
4. Select "Submit a Public Comment" from the Safety Grade issue drop-down list
5. Include your public comments in the "Question" field
6. Click "Submit" after completing all required fields

PLANNED UPDATE TO IMPUTATION METHOD FOR CPOE, BCMA, IPS, AND HAND HYGIENE

BACKGROUND

The Leapfrog Group and other national organizations have ongoing concerns with the trajectory of patient safety in US hospitals. Leapfrog wants to ensure that the public has timely, transparent, and trustworthy information about a hospital's patient safety performance. Leapfrog's longstanding commitment is to use the best and most recent data publicly available to calculate Hospital Safety Grades.

To ensure the Hospital Safety Grade methodology continues to support these goals, Leapfrog's blue-ribbon Expert Panel and researchers at Johns Hopkins Medicine annually review the scoring methodology. The panel advised that Leapfrog modify the current imputation method, which is used to fill in missing data among hospitals that did not complete the most recent Leapfrog Survey.

Leapfrog is proposing the following changes to its imputation approaches effective with the fall 2024 Hospital Safety Grade.

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

Leapfrog is proposing the following changes effective with the fall 2024 Hospital Safety Grade.

1) New Step 1 Imputation (Does not apply to BCMA)

If the hospital had a score assigned by Leapfrog in the previous two rounds of grades (i.e., spring 2024, fall 2023), the hospital is assigned the most recent score on that measure in the current Hospital Safety Grade (i.e., fall 2024). This is a reduction from the previous methodology, which imputed scores from up to four previous rounds of grades. This will help ensure any historical data used in calculating the Safety Grade is reflective of hospital protocols within the past 2 years (e.g., the reporting periods for CPOE IPS, and Hand Hygiene on the 2023 Leapfrog Hospital Survey was 2023).

Note that Step 1 imputation will be temporarily paused for the BCMA measure. In 2024, Leapfrog expanded the BCMA Standard to include pre-operative and post-anesthesia care units in addition to med-surg units, critical care units, and labor and delivery units. Due to these changes, scores from the 2023 Leapfrog Hospital Survey are not an accurate representation of performance on the current measure and thus not suitable for Step 1 imputation.

2) New Step 2 Imputation

For hospitals that do not have historical data from the last two rounds of the Safety Grade (Step 2 imputation then applies), instead of imputing a score based on the cohort mean, hospitals will be assigned a point value that is equivalent to receiving "Limited Achievement" for that measure on the Leapfrog Hospital Survey (Table 1). This category assignment would reflect Leapfrog's lack of current information about a hospital's status in implementing these important patient safety structures.

Step 2 imputation for the IPS measure will only apply to hospitals that operate an adult or pediatric medical and/or surgical ICU or neuro ICU. A hospital's ICU designation will be determined using the most recently available CMS Cost Report. Hospitals that report operating one or more medical, surgical and/or pediatric ICU beds in Worksheet S-3 Part 1 will be eligible for Step 2 Imputation.

Table 1. Step 2 Imputation Point Assignments Beginning Fall 2024

	Leapfrog Hospital Survey Performance Category	Corresponding Safety Grade Measure Score
CPOE	Limited Achievement 	15
BCMA	Limited Achievement 	25
IPS	Limited Achievement 	5
Hand Hygiene	Limited Achievement 	15

Table 2. Planned Fall 2024 Leapfrog Safety Grade Measures, Data Sources, And Anticipated Reporting Periods

PROCESS/STRUCTURAL MEASURES (12)					
Measure Name	Primary Data Source	Reporting Period	Secondary Data Source	Reporting Period	
Computerized Physician Order Entry (CPOE)	2024 Leapfrog Hospital Survey	2024	Imputation Model Applied	N/A	
Bar Code Medication Administration (BCMA)	2024 Leapfrog Hospital Survey	2024	Imputation Model Applied	N/A	
ICU Physician Staffing (IPS)	2024 Leapfrog Hospital Survey	2024	Imputation Model Applied	N/A	
Safe Practice 1: Culture of Leadership Structures and Systems	2024 Leapfrog Hospital Survey	2024	N/A	N/A	
Safe Practice 2: Culture Measurement, Feedback & Intervention	2024 Leapfrog Hospital Survey	2024	N/A	N/A	
Total Nursing Care Hours per Patient Day	2024 Leapfrog Hospital Survey	2024	N/A	N/A	
Hand Hygiene	2024 Leapfrog Hospital Survey	2024	Imputation Model Applied	N/A	
H-COMP-1: Nurse Communication	CMS	10/01/2022 - 09/30/2023	N/A	N/A	
H-COMP-2: Doctor Communication	CMS	10/01/2022 - 09/30/2023	N/A	N/A	
H-COMP-3: Staff Responsiveness	CMS	10/01/2022 - 09/30/2023	N/A	N/A	
H-COMP-5: Communication about Medicines	CMS	10/01/2022 - 09/30/2023	N/A	N/A	
H-COMP-6: Discharge Information	CMS	10/01/2022 - 09/30/2023	N/A	N/A	

OUTCOME MEASURES (10)

Measure Name	Primary Data Source	Reporting Period	Secondary Data Source	Reporting Period
Foreign Object Retained	CMS	07/01/2021 - 06/30/2023	N/A	N/A
Air Embolism	CMS	07/01/2021 - 06/30/2023	N/A	N/A
Falls and Trauma	CMS	07/01/2021 - 06/30/2023	N/A	N/A
CLABSI	2024 Leapfrog Hospital Survey	01/01/2023 - 12/31/2023	CMS	10/01/2022 - 09/30/2023
CAUTI	2024 Leapfrog Hospital Survey	01/01/2023 - 12/31/2023	CMS	10/01/2022 - 09/30/2023
SSI: Colon	2024 Leapfrog Hospital Survey	01/01/2023 - 12/31/2023	CMS	10/01/2022 - 09/30/2023
MRSA	2024 Leapfrog Hospital Survey	01/01/2023 - 12/31/2023	CMS	10/01/2022 - 09/30/2023
C. Diff.	2024 Leapfrog Hospital Survey	01/01/2023 - 12/31/2023	CMS	10/01/2022 - 09/30/2023
PSI 4: Death rate among surgical inpatients with serious treatable conditions	CMS	07/01/2020 - 06/30/2022	N/A	N/A
CMS Medicare PSI 90: Patient safety and adverse events composite*	CMS	07/01/2020 - 06/30/2022	N/A	N/A

*Note: CMS calculates PSI 90 using the ten (10) component PSIs listed above. While scores for each of the 10 component PSIs will NOT be used to calculate fall 2024 Hospital Safety Grades, they will be publicly reported on the Hospital Safety Grade [website](#).

EXHIBIT 41



Final Updates to the Leapfrog Hospital Safety Grade Methodology for Fall 2024

On May 21, 2024, Leapfrog published planned updates to the Hospital Safety Grade methodology and held a public comment period through June 7, 2024. We thank commenters for their insightful feedback and suggestions that helped us finalize the methodology.

This document includes responses to the comments received and summarizes the final updates that will be made to the scoring methodology. Additionally, Table 2 on pages 5-6 includes a summary of data sources and anticipated reporting periods for the fall 2024 Hospital Safety Grades.

Summary of Changes

Starting in fall 2024, Leapfrog will update the Imputation Methodology for CPOE, BCMA, IPS, and Hand Hygiene measures for hospitals that do not submit a 2024 Leapfrog Hospital Survey by August 31, 2024. The changes come under the guidance of Leapfrog's national expert panel, the research team at Johns Hopkins Medicine, and in response to stakeholder feedback.

More information can be found on the Hospital Safety Grade website at <https://www.hospitalsafetygrade.org/for-hospitals/key-dates-and-information>.

RESPONSES TO PUBLIC COMMENTS

Four commenters supported the change to the imputation methodology.

We appreciate the feedback and agree that participating hospitals committed to transparency should be acknowledged for the resources and time they devote to completing the Leapfrog Hospital Survey. Hospitals that choose not to complete the Survey should not inadvertently benefit from hospitals that continuously strive to make improvements and maintain Leapfrog standards.

Two commentors expressed concerns about Step 2 Imputation misrepresenting the current procedures or infrastructure of the hospital to the public.

We recognize that hospitals eligible for Step 2 Imputation may score higher if they complete a Leapfrog Hospital Survey. However, we cannot ensure this is the case if we do not have the data, and our analyses have shown that performance among hospitals that intermittently complete the annual Survey is lower than those hospitals that completed the most recent Survey. The expert panel recognized that hospitals with a drop in performance may be incentivized to not report via the Leapfrog Hospital Survey and scores calculated using participating hospitals would misrepresent their true performance. We encourage hospitals to complete the Leapfrog Hospital Survey so they can receive credit for implementing processes that protect patients and save lives.

We do acknowledge the commenter's point that the public may misinterpret the assigned measure scores. In response, we will add a new denotation to the Hospital Safety Grade website (<https://www.hospitalsafetygrade.org/>) for scores that have been imputed.

Two commentors requested that the proposed changes be delayed until spring 2025 to allow hospitals time to complete the Leapfrog Hospital Survey.

While we do strongly encourage hospitals to submit their Survey by the Submission Deadline of June 30, 2024, hospitals that wish to have 2024 Leapfrog Hospital Survey data used in their fall 2024 Safety Grade will have until August 31 to submit or resubmit their Survey. Hospitals that completed a 2023 Leapfrog Hospital Survey will be eligible for Step 1 Imputation. Hospitals eligible for Step 2 Imputation have opted not to complete 2 consecutive years of the Leapfrog Hospital Survey and will be scored accordingly.

Four commenters opposed penalizing hospitals that choose not to devote resources to completing a voluntary Survey each year and be allowed to opt out of the Hospital Safety Grade.

The Leapfrog Hospital Survey is designed to help hospitals benchmark their progress in quality and safety. To ensure that these standards are consistently met, hospitals must continuously measure. While our Survey, is not required or linked to federal funding, we think it is just as important. Patients, employers, and purchasers benefit from having access to current and accurate information.

Our expert panel recognized that awareness and participation in the Leapfrog Hospital Survey has grown exponentially in recent years. As such, the choice of hospitals to not complete the Leapfrog Hospital Survey is one that could not be ignored as patient safety must remain a priority. A key element of the Hospital Safety Grade is that all eligible hospitals are compared to hospitals nationwide. The choice to not participate should not excuse a hospital from being graded, nor should they be given a score that unfairly awards them points.

FINAL UPDATE TO IMPUTATION METHOD FOR CPOE, BCMA, IPS, AND HAND HYGIENE

BACKGROUND

The Leapfrog Group and other national organizations have ongoing concerns with the trajectory of patient safety in US hospitals. Leapfrog wants to ensure that the public has timely, transparent, and trustworthy information about a hospital's patient safety performance. Leapfrog's longstanding commitment is to use the best and most recent data publicly available to calculate Hospital Safety Grades.

To ensure the Hospital Safety Grade methodology continues to support these goals, Leapfrog's blue-ribbon Expert Panel and researchers at Johns Hopkins Medicine annually review the scoring methodology. The panel advised that Leapfrog modify the current imputation method, which is used to fill in missing data among hospitals that did not complete the most recent Leapfrog Survey.

Leapfrog is proposing the following changes to its imputation approaches effective with the fall 2024 Hospital Safety Grade.

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

Leapfrog is proposing the following changes effective with the fall 2024 Hospital Safety Grade.

1) New Step 1 Imputation (Does not apply to BCMA)

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Note that Step 1 imputation will be temporarily paused for the BCMA measure. In 2024, Leapfrog expanded the BCMA Standard to include pre-operative and post-anesthesia care units in addition to med-surg units, critical care units, and labor and delivery units. Due to these changes, scores from the 2023 Leapfrog Hospital Survey are not an accurate representation of performance on the current measure and thus not suitable for Step 1 imputation.

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H-COMP-5: Communication about Medicines	CMS	10/01/2022 - 09/30/2023	N/A	N/A
H-COMP-6: Discharge Information	CMS	10/01/2022 - 09/30/2023	N/A	N/A

OUTCOME MEASURES (10)				
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Falls and Trauma	CMS	07/01/2021 - 06/30/2023	N/A	N/A
CLABSI	2024 Leapfrog Hospital Survey	01/01/2023 - 12/31/2023	CMS	10/01/2022 - 09/30/2023
CAUTI	2024 Leapfrog Hospital Survey	01/01/2023 - 12/31/2023	CMS	10/01/2022 - 09/30/2023
SSI: Colon	2024 Leapfrog Hospital Survey	01/01/2023 - 12/31/2023	CMS	10/01/2022 - 09/30/2023
MRSA	2024 Leapfrog Hospital Survey	01/01/2023 - 12/31/2023	CMS	10/01/2022 - 09/30/2023
C. Diff.	2024 Leapfrog Hospital Survey	01/01/2023 - 12/31/2023	CMS	10/01/2022 - 09/30/2023
PSI 4: Death rate among surgical inpatients with serious treatable conditions	CMS	07/01/2020 - 06/30/2022	N/A	N/A
CMS Medicare PSI 90: Patient safety and adverse events composite*	CMS	07/01/2020 - 06/30/2022	N/A	N/A

*Note: CMS calculates PSI 90 using the ten (10) component PSIs listed above. While scores for each of the 10 component PSIs will NOT be used to calculate fall 2024 Hospital Safety Grades, they will be publicly reported on the Hospital Safety Grade [website](#).

EXHIBIT 42

The Palm Beach Post

HEALTHCARE

Competition drives Tenet's renewed focus, community ties as health care rivals multiply



Alexandra Clough
Palm Beach Post

April 22, 2022, 5:01 a.m. ET

Five Tenet Healthcare-owned [hospitals in Palm Beach County](#) are retooling their image to emphasize ties to local physicians and communities.

The move comes as more residents pour into the region, and [rival medical providers](#) vie for new and often wealthy patients.

The Palm Beach Health Network [includes the following hospitals](#): Good Samaritan and St. Mary's medical centers in West Palm Beach; Palm Beach Gardens Medical Center in Palm Beach Gardens; Delray Medical Center in Delray Beach; and West Boca Medical Center in suburban Boca Raton.

UM arrives: [University of Miami opens medical offices in downtown West Palm Beach and Palm Beach](#)

Contending with COVID: [Health providers navigate pandemic as they continue Palm Beach County expansion](#)

West Palm site: [Nation's top orthopedic hospital opens in West Palm Beach](#)

The hospitals are owed by Tenet Health, a for-profit company based in Dallas.

Maggie Gill, chief executive of the Palm Beach Health Network, said the hospital company wants to showcase that it is a local provider, especially to new residents who may not be familiar with the Tenet brand.

"We want to share what we are doing," Gill said. "This is our home base."

Tenet spending \$150 million to upgrade facilities, services

The move comes as the company, the largest health care network in Palm Beach County, recently revealed it is spending \$150 million to upgrade cardiac, neurology, orthopedic and maternity services across its hospitals. The upgrades will be completed by the end of 2022.

Tenet hospitals account for more than 1,900 beds in the county.

Physicians also are working to expand the company's reach. Among them is Dr. Nicholas Sama, medical director of orthopedic surgery at Good Samaritan Medical Center, the waterfront hospital along North Flagler Drive in West Palm Beach, across the Flagler Memorial Bridge from Palm Beach.

Good Sam is upgrading its emergency services and facilities for robotic and orthopedic surgeries. Tenet also has an alliance with the Hospital for Special Surgery, a New York-based orthopedic specialty hospital with a West Palm Beach clinic downtown.

"We want people to know what we have to offer and reach out to the community," Sama said.

Sheri Montgomery, chief executive of Good Samaritan Medical Center, said the hospital has been ramping up its outreach to patients about screening services for cancer, as well as treatment of conditions such as congestive heart failure. Good Sam also recently partnered with fashion brand Lilly Pulitzer [to create the Lilly Pulitzer Birthing Suites](#).

There's more. West Boca Raton Medical Center recently opened the Boca Raton Center for Orthopedics and Spine Care to allow patients to transition from surgery to recovery and rehabilitation. At Palm Beach Gardens Medical Center, upgrades were made to its cardiac catheterization facilities and operating room handling cardiac and vascular surgery.

And at Delray Medical Center, there's a new cardiac catheterization lab as well as an Advanced Center for Heart Failure, among other improvements.

The Tenet hospital improvement program comes as rival health care companies [are opening clinics and hospitals](#) in Palm Beach County.

Some are zeroing in on West Palm Beach, where a number of financial firms and residents, relocated during the coronavirus pandemic. Some people moved to the area because they accelerated their retirements. Others moved here with companies that either expanded or relocated offices to the county.

"The shift to more fulltime residents has clearly provided a new focus for health care providers," said Michael Feldman, a Cushman & Wakefield brokerage director who specializes in the leasing and sales of health care, life science and professional office properties.

Last year, Tenet sold five hospitals in Miami-Dade and Broward counties. Feldman said the sale allows Tenet to focus more heavily on its outpatient surgery centers, as well as grow services in the lucrative Palm Beach County market.

Feldman said surgeries are a key profit source for hospitals.

Tenet reaches out to community leaders, organizations

In addition to spending money to boost technology and facilities, Tenet hospitals also are trying to forge closer ties with key community leaders.

Nancy Brinker, who created Susan G. Komen, the world's largest nonprofit in the fight against breast cancer, recently met with Gill and Montgomery to talk about [The Promise Fund](#), a nonprofit Brinker recently co-founded.

The Promise Fund provides grants to community-based entities that can help women in Florida needing screening or treatment of breast and cervical cancers.

These entities can't do biopsies or surgeries, so treatment has to be farmed out to other providers. The Promise Fund employs "navigators" who help patients create a treatment plan that includes finding doctors and treatment centers.

In the past, Brinker has expressed frustration with the absence of a Palm Beach County-based public or nonprofit hospital that can treat women who do not have health insurance and can't afford to pay for medical care.

Despite Palm Beach County's riches, including the millionaires and the billionaires crowding the coast, resources for poor women remain slim.

Brinker said she recently met with officials from Palm Beach Health and Good Sam to explore ways the hospital, and the doctors and other professionals who practice there, can provide low-cost services to women needing cancer treatment.

Montgomery said Good Sam also is working with pharmaceutical companies to supply medication to cancer patients identified by the Promise Fund.

Hospitals facing increased competition from locals, out-of-state care providers

In 2019, Gov. Ron DeSantis and Florida lawmakers did away with Florida's certificate of need program, which required that hospitals seek state approval before they could open a new facility. Hospitals wanting to operate in particular region needed to demonstrate there was an unmet need for their facility or for expanded services.

For years, the program allowed Tenet to grow throughout Palm Beach County without competition from rival hospitals, Feldman said. Those hospitals, in turn, used the program to beat back growth from Tenet, which failed in a 2013 bid to build an 80-bed hospital next to Scripps Florida.

But with the certificate of need program gone, the sky's the limit on health care companies seeking to establish a presence in the county.

Universal Health Services, which also owns Wellington Regional Medical Center, wants to build a 150-bed hospital and "shell" space for 150 more beds in Palm Beach Gardens.

In addition, Birmingham, Ala.-based Encompass Health wants to build a 50-bed rehabilitation hospital planned, also in Palm Beach Gardens.

Farther south, west of Delray Beach, a 24-bed specialty hospital for orthopedic medicine is under construction and set to open in 2024.

And that's not all. At least two nonprofit, university-affiliated hospital systems are looking to establish a presence in downtown West Palm Beach, real estate sources said.

Feldman said nonprofits are drawn to wealthy communities such as Palm Beach, where patients may express their gratitude by financing new projects.

Palm Beach Health officials said they are prepared for the challenges to their longtime dominant presence in the county.

"Competition raises our game," Gill said.

UHealth is latest health care provider to expand to West Palm Beach

Any new company planning to come to West Palm Beach will have to compete not only with Tenet but with other nonprofit hospital companies that already have established clinics in the city.

Cleveland Clinic was first in 2007, when it leased a small West Palm Beach office. The health care provider now operates a large clinic in the CityPlace Tower office building.

Three New York-based health systems also operate medical offices in the city: NYU Langone, Mount Sinai New York and the Hospital for Special Surgery.

The latest player is the University of Miami Health System, which last year [opened a major medical clinic](#) on the waterfront. Services available include cardiology, urology, neurology and dermatology.

The clinic's goal is to treat existing patients, attract new ones and establish a base for an expanded medical presence in the county. In addition to the West Palm Beach office, UHealth also opened a concierge family medicine practice on Palm Beach.

UHealth officials said many new Palm Beach County residents who relocated from the Northeast, Midwest and even California are used to top-notch teaching hospitals with an academic focus and a heavy emphasis on research.

"South Florida is in high demand from the residents moving from the Northeast, and these patients are very accustomed to accessing care from an academic medical center," said Rafic Warwar, UHealth's chief ambulatory officer.

Some Palm Beach residents privately say they would like to have a nonprofit academic medical center near the island, and a few have even voiced a desire to see Good Sam purchased by such an entity.

But that's not going to happen, Gill said.

"Nobody is buying Good Sam," Gill said. "It's a very important hospital. We want to make it the best it can be ... and grow with the community."

aclough@pbpost.com

EXHIBIT 43



Call Now **866-654-2362**

Videos

PBHNPG is Rebranding to Palm Beach Health Network Physician Group

Exciting changes are happening as Palm Beach Health Network Physician Groups (PBHNPG) is rebranding to the Palm Beach Health Network Physician Group (PBHNPG). This new name, logo design and brand aligns with our Palm Beach Health Network hospitals – Palm Beach Gardens Medical Center, St. Mary's Medical Center, Good Samaritan Medical Center, Delray Medical Center and West Boca Medical Center. Our focus remains the same – continue to deliver high quality care to the community we serve.

Since 2007, our multi-specialty physician group has provided care to communities across Palm Beach County. Our new Palm Beach Health Network Physician Group brand will facilitate development of a strong brand awareness as well as drive operational and strategic growth in Palm Beach County and beyond.



Call Now **866-654-2362**

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EXHIBIT 44

Message

From: West, Regina [/O=EXCHANGELABS/OU=EXCHANGE ADMINISTRATIVE GROUP (FYDIBOHF23SPDLT)/CN=RECIPIENTS/CN=1EAF650676C4F8795C1448499EF660E-WEST, REGIN]
Sent: 4/24/2024 7:09:10 PM
To: McCauley, Cynthia [Cynthia.McCauley@tenethealth.com]; Miller, Jessica1 [Jessica1.Miller@tenethealth.com]; DeStefano, Gerri1 [Gerri1.DeStefano@tenethealth.com]
CC: Morales menendez, Maria [m.moralesmenendez@tenethealth.com]; Jennings, Keith [Keith.Jennings@tenethealth.com]; HUEMPFNER, MICHAEL [MICHAEL.HUEMPFNER@tenethealth.com]; Gayles, Ashley [Ashley.Gayles@tenethealth.com]
Subject: Leapfrog Spring 2024

Good afternoon,

We remain a “C” for the Spring 2024 Leapfrog update. Our largest area of opportunity remains in the patient experience category. Moving our performance to the average score in each H-COMP area would move us to an “A.”

Current

Measure Domain	Measure	Enter Your Hospital's Score Here (Do NOT Leave Blank)	Mean
Process Measures	Computerized Physician Order Entry (CPOE)	100	81.81
	Bar Code Medication Administration (BCMA)	100	83.42
	ICU Physician Staffing (IPS)	100	83.29
	Safe Practice 1: Culture of Leadership Structures and Systems	N/A	117.59
	Safe Practice 2: Culture Measurements Feedback & Intervention	N/A	117.08
	Total Nursing Care Hours per Patient Day	N/A	74.69
	Hand Hygiene	100	78.85
	H-COMP 1: Nurse Communication	81	89.67
	H-COMP 2: Doctor Communication	84	89.22
	H-COMP 3: Staff Responsiveness	73	81.14
	H-COMP 5: Communication about Medicines	86	74.09
	H-COMP 6: Discharge Information	77	84.90
Outcome Measures	Foreign Object Retained	0.000	0.014
	Air Embolism	0.000	0.001
	Falls and Trauma	0.940	0.428
	CLABSI	0.874	0.753
	CAUTI	0.857	0.627
	SSI: Colon	0.382	0.844
	MRSA	0.548	0.791
	C.D. #	0.866	0.453
	PSA: Death rate among surgical inpatients with serious SSBLE	133.07	168.78
	CMS Medicare PSI 90 Patient safety and adverse events composite	0.92	1.21
Process Measure Domain Score:		2,283	
Outcome Measure Domain Score:		0.0572	
Process/Outcome Domains - Combined Score:		2,183	
Normalized Numerical Score:		2,839	
Hospital Safety Grade (Letter Grade):		C	

Patient Experience Scenario

Measure Domain	Measure	Enter Your Hospital's Score Here (Do NOT Leave Blank)	Mean
Process/Structural Measures	Computerized Physician Order Entry (CPOE)	100	91.81
	Bleeding Medication Administration (BMA)	100	93.45
	ICU Physician Staffing (IPS)	100	93.29
	Safe Practice 3: Culture of Leadership Structures and Systems	N/A	117.59
	Safe Practice 3: Culture Measurement, Feedback, & Intervention	N/A	117.08
	Total Nursing Care Hours per Patient Day	N/A	74.63
	Hand Hygiene	100	78.63
	m-COMP 1: Nurse Communication	88	89.67
	m-COMP 2: Doctor Communication	89	89.52
	m-COMP 3: Staff Responsiveness	83	81.14
	m-COMP 5: Communication about Medicines	74	74.29
	m-COMP 6: Discharge Information	84	84.90
Outcome Measures	Foreign Object Retained	0.000	0.014
	Air Embolism	0.000	0.001
	Falls and Trauma	0.940	0.478
	CLABSI	0.874	0.755
	CAUTI	0.857	0.627
	SSI: Colon	0.582	0.846
	MRSA	0.583	0.793
	C-ORT	0.666	0.455
	PSI-4: Death rate among surgical inpatients with sepsis/treatable	183.87	168.34
	CRS Medicare PSI-90 Patient safety and adverse events composite	0.92	1.07
Process Measure Domain Score:		0.1815	
Outcome Measure Domain Score:		0.0572	
Process/Outcome Domains - Combined Score:		0.2397	
Normalized Numerical Score:		3.2397	
Hospital Safety Grade (Letter Grade):		A	

Gina West

St. Mary's Medical Center & PBHN Market Quality Director

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Delray | Good Samaritan | Palm Beach Gardens | St. Mary's | West Boca

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EXHIBIT 45

Medicare.gov

Menu

Hospital

Good Samaritan Medical Center

Overall star rating:



Patient survey rating:



LOCATION

1309 N Flagler Dr
West Palm Beach, FL 33401

PHONE NUMBER

(561) 655-5511

 Save to Favorites

Feedback

Ratings

Quality

Details

Affiliated Doctors & Clinicians

Loc

RATINGS

Overall star rating



The overall star rating is based on how well a hospital performs across different areas of quality, such as treating heart attacks and pneumonia, readmission rates, and safety of care.

[Learn how Medicare calculates this rating](#)

[View Rating Details](#)

Patient survey rating



The patient survey rating measures patients' experiences of their hospital care. Recently discharged patients were asked about important topics like how well nurses and doctors communicated, how responsive hospital staff were to their needs, and the cleanliness and quietness of the hospital environment.

[Learn how the patient survey rating is measured](#)

[View Survey Details](#)

QUALITY

Choose a category to see how this hospital scores on quality topics:

Timely & effective care >

Complications & deaths >

Unplanned hospital visits >

Maternal health >

Patient-reported outcomes >

Psychiatric unit services >

Payment >

DETAILS

Hospital type

Acute Care Hospitals

Provides emergency services?

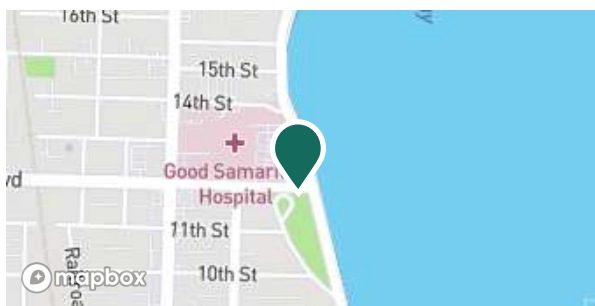
Yes

AFFILIATED DOCTORS & CLINICIANS

427 clinicians affiliated with Good Samaritan Medical Center near Palm Beach Gardens, FL.

SEARCH BY NAME OR SPECIALTY

LOCATION



Good Samaritan Medical Center

1309 N Flagler Dr
West Palm Beach, FL 33401

(561) 655-5511

[Get Directions](#)

Data last updated: August 6, 2025

To explore and download hospital data, [visit the data catalog on Data.cms.gov](#)

To explore data on ambulatory surgical centers (ASC), [visit the ASC data on Data.cms.gov](#)



Consider this when choosing a hospital

[Guide to choosing a hospital \(PDF\)](#)

[How Medicare covers inpatient hospital care](#)

[How Medicare covers outpatient hospital services](#)

Good Samaritan Medical Center

Overall star rating details

This shows how individual hospitals perform compared to all hospitals across the country for the 5 groups or categories of quality measures that make up for the overall star rating.

Overall star rating



The overall star rating is based on how well a hospital performs across different areas of quality, such as treating heart attacks and pneumonia, readmission rates, and safety of care.

Mortality

6 of 7

measures reported within
the group



Safety of Care

8 of 8

measures reported within
the group



Readmission

8 of 11

measures reported within
the group



Patient Experience

8 of 8

measures reported within
the group



Timely and Effective Care

11 of 12

measures reported within
the group



Good Samaritan Medical Center

Patient survey rating

The HCAHPS star ratings summarize patient experience, which is one aspect of hospital quality. Use the star ratings along with other quality information when making decisions about choosing a hospital.

Learn how the patient survey rating is measured

Get current data collection period

Patient survey rating



The patient survey rating is typically based on a one year response period.

Number of completed surveys

822

Survey response rate

15%

Patients who reported that their nurses "Always" communicated well.

69%

National average: 80%

Florida average: 76%

Patients who reported that their doctors "Always" communicated well.

71%

National average: 80%

Florida average: 75%

Patients who reported that they "Always" received help as soon as they wanted.

52%

National average: 66%

Florida average: 60%

Patients who reported that the staff "Always" explained about medicines before giving it to them.

51%

National average: 62%

Florida average: 58%

Patients who reported that their room and bathroom were "Always" clean.

58%

National average: 74%

Florida average: 71%

Patients who reported that the area around their room was "Always" quiet at night.

58%

National average: 62%

Florida average: 58%

Patients who reported that YES, they were given information about what to do during their recovery at home.

78%

National average: 86%

Florida average: 83%

Patients who "Strongly Agree" they understood their care when they left the hospital.

43%

National average: 52%

Florida average: 49%

Patients who gave their hospital a rating of 9 or 10 on a scale from 0 (lowest) to 10 (highest).

58%

National average: 72%

Florida average: 68%

Patients who reported YES, they would definitely recommend the hospital.

60%

National average: 70%

Florida average: 67%

Good Samaritan Medical Center

Timely & effective care

These measures show how often or how quickly hospitals provide care that research shows gets the best results for patients with certain conditions, and how hospitals use outpatient medical imaging tests (like CT scans and MRIs). This information can help you compare which hospitals give recommended care most often as part of the overall care they provide to patients.

[Find out why these measures are important](#)

[Get more information about the data](#)

[Get current data collection period](#)

Sepsis care

Sepsis is a complication that occurs when your body has an extreme response to an infection. It causes damage to...

[Read more](#)

Percentage of patients who received appropriate care for severe sepsis and/or septic shock

↑ Higher percentages are better

53% [2](#)

of 140 patients

National average: 63% [25,26](#)

Florida average: 70% [25,26](#)

Cataract surgery outcome

Cataracts affect your vision and are very common in older people. Cataracts can make your vision blurry and can...

Percentage of patients who had cataract surgery and had improvement in visual function within 90 days following the surgery

↑ Higher percentages are better

Not available [5](#)

National average: 98%

Florida average: Not available [5](#)

Colonoscopy follow-up

A colonoscopy is one test doctors can use to find precancerous polyps (abnormal growths) or colorectal...

Percentage of patients receiving appropriate recommendation for follow-up screening colonoscopy

↑ Higher percentages are better

97%

of 39 patients

National average: 92% [25,26](#)

Florida average: 89% [25,26](#)

Emergency department care

Timely and effective care in hospital emergency departments is essential for good patient outcomes. Delay...

[Read more](#)

Percentage of patients who left the emergency department before being seen

↓ Lower percentages are better

0%

of 53408 patients

National average: 2% [25,26](#)

Florida average: 1% [25,26](#)

Percentage of patients who came to the emergency department with stroke symptoms who received brain scan results within 45 minutes of arrival

↑ Higher percentages are better

Not available ¹

National average: 70% [25](#)

Florida average: 70% [25](#)

Emergency department volume

High

40,000 - 59,999 patients annually

Average (median) time patients spent in the emergency department before leaving from the visit

↓ A lower number of minutes is better

118 minutes

Other High volume hospitals:

Nation: 214 minutes [25,26](#)

Florida: 155 minutes [25,26](#)

Number of included patients: 444

Volume legend (patients annually):

Low: 0 - 19,999

Medium: 20,000 - 39,999

High: 40,000 - 59,999

Very High: 60,000+

Healthcare personnel vaccination

Hospital staff and healthcare personnel can transmit viruses to coworkers and patients, including those at high...

[Read more](#)

Percentage of healthcare workers given influenza vaccination

↑ *Higher percentages are better*

27%

of 1975 healthcare workers

National average: 80%

Florida average: 60%

Safe use of Opioids

When prescription opioids, or opioids and benzodiazepines are given at the same time, patients are at a higher risk of...

[Read more](#)

Proportion of inpatient hospitalizations for patients 18 years of age and older prescribed, or continued on, two or more opioids or an opioid and benzodiazepine concurrently at discharge.

↓ *Lower percentages are better*

19%

National average: 15%

Florida average: 16%

Use of medical imaging

These outpatient imaging efficiency measures give you information about hospitals' use of medical imaging tests...

Percentage of outpatients with low-back pain who had an MRI without trying recommended treatments

(like physical therapy) first

↓ Lower percentages are better

Not available

National average: 35.5%

Florida average: 35.7%

Percentage of outpatient CT scans of the abdomen that were "combination" (double) scans

↓ Lower percentages are better

6.1%

National average: 5.9%

Florida average: 4.9%

Percentage of outpatients who got cardiac imaging stress tests before low-risk outpatient surgery

↓ Lower percentages are better

3.9%

National average: 3.7%

Florida average: 4.4%

Percentage of patients who had an advanced breast screening on the same day or within 45 days of their initial mammogram or digital breast tomosynthesis (DBT) study

Percentages between 5 - 12% are best



28.3%

National average: 9%

Florida average: 15.2%

Good Samaritan Medical Center

Complications & deaths

Patients who are admitted to the hospital for treatment of medical problems sometimes get other serious injuries, complications, or conditions, and may even die. Some patients may experience problems soon after they are discharged and need to be admitted to the hospital again. These events can often be prevented if hospitals follow best practices for treating patients.

[Find out why these measures are important](#)

[Get more information about the data](#)

[Get current data collection period](#)

Complications

This section shows serious complications that patients experienced during a hospital stay or after having certain...

Rate of complications for hip/knee replacement patients

4%
No different than the national rate
National result: 3.6%
Number of included patients: 102

Serious complications

1.00
No different than the national value
National result: 1.00

Deaths among patients with serious treatable complications after surgery

156.08
No different than the national rate
National result: 176.55

Infections

Healthcare-associated infections, or HAIs, are infections that people get while they're getting treatment for another...

[Read more](#)

Central line-associated bloodstream infections (CLABSI) in ICUs and select wards

↓ Lower numbers are better

0.000

No different than national benchmark

National benchmark: 1.000

Catheter-associated urinary tract infections (CAUTI) in ICUs and select wards

↓ Lower numbers are better

0.987

No different than national benchmark

National benchmark: 1.000

Surgical site infections (SSI) from colon surgery

↓ Lower numbers are better

1.408

No different than national benchmark

National benchmark: 1.000

Surgical site infections (SSI) from abdominal hysterectomy

↓ Lower numbers are better

1.745

No different than national benchmark

National benchmark: 1.000

Methicillin-resistant Staphylococcus Aureus (MRSA) blood infections

↓ Lower numbers are better

0.348

No different than national benchmark

National benchmark: 1.000

Clostridium difficile (C.diff.) intestinal infections

↓ Lower numbers are better

0.423

Better than the national benchmark

National benchmark: 1.000

Death rates

Death rates show how often patients die, for any reason, within 30 days of admission to a hospital.

Overall

Death rate for patients (hospital-wide)

4%

No different than the national rate

National result: 4.2%

Number of included patients: 1050

By medical condition

Chronic obstructive pulmonary disease (COPD)

Death rate for COPD patients

8.1%

No different than the national rate

National result: 8.8%

Number of included patients: 64

Heart attack

Death rate for heart attack patients

12%

No different than the national rate

National result: 12.2%

Number of included patients: 107

Heart failure

Death rate for heart failure patients

9.8%

No different than the national rate

National result: 11.6%

Number of included patients: 204

Pneumonia

Death rate for pneumonia patients

16.8%

No different than the national rate

National result: 16.2%

Number of included patients: 349

Stroke

Death rate for stroke patients

13%

No different than the national rate

National result: 13.3%

Number of included patients: 51

By procedure

Coronary artery bypass graft (CABG)

Death rate for CABG surgery patients

Not available ⁵

National result: 2.6%

Good Samaritan Medical Center

Unplanned hospital visits

Returning to the hospital for unplanned care disrupts patients' lives, increases their risk of harmful events like healthcare-associated infections, and costs more money. Hospitals that give high quality care can keep patients from returning to the hospital and reduce their stay if they have to come back.

[Find out why these measures are important](#)

[Get more information about the data](#)

[Get current data collection period](#)

[Watch a video to learn more about hospital return days](#)

Overall

**Rate of readmission after discharge from hospital
(hospital-wide)**

15.8%

No different than the national rate

National result: 15%

Number of included patients: 1697

By medical condition

Chronic obstructive pulmonary disease (COPD)

**Rate of readmission for chronic obstructive
pulmonary disease (COPD) patients**

20.9%

No different than the national rate

National result: 18.2%
Number of included patients: 77

Heart attack

Rate of readmission for heart attack patients

13.6%

No different than the national rate

National result: 13.6%

Number of included patients: 92

Hospital return days for heart attack patients

15.8 days

Average days per 100 discharges

National result: Not applicable

Number of included patients: 90

Heart failure

Rate of readmission for heart failure patients

20.3%

No different than the national rate

National result: 19.7%

Number of included patients: 229

Hospital return days for heart failure patients

28.7 days

More days than average per 100 discharges

National result: Not applicable

Number of included patients: 197

Pneumonia

Rate of readmission for pneumonia patients

17.4%

No different than the national rate

National result: 16%

Number of included patients: 360

Hospital return days for pneumonia patients

40.5 days

More days than average per 100 discharges

National result: Not applicable

Number of included patients: 331

By procedure

Coronary artery bypass graft (CABG) surgery

Rate of readmission for coronary artery bypass graft (CABG) surgery patients

Not available [5](#)

National result: 10.6%

Hip/knee replacement

Rate of readmission after hip/knee replacement

7.1%

No different than the national rate

National result: 4.8%

Number of included patients: 101

Colonoscopy

Rate of unplanned hospital visits after an outpatient colonoscopy

12.9 per 1,000 colonoscopies

No different than the national rate

National result: 13 per 1,000 colonoscopies

Chemotherapy

Rate of inpatient admissions for patients receiving outpatient chemotherapy (per 100 chemotherapy patients)

Not available

Number of cases too small

National result: 10.6%

Rate of emergency department (ED) visits for patients receiving outpatient chemotherapy (per 100 chemotherapy patients)

Not available

Number of cases too small

National result: 5.5%

Outpatient surgery

Ratio of unplanned hospital visits after hospital outpatient surgery

0.9

No different than expected

National result: Not applicable

Number of included procedures: 753

Good Samaritan Medical Center



Maternal health

These measures aim to improve maternal health. By providing care during pregnancy that follows best practice...

[Read more](#)

[Find out why these measures are important](#)

[Get more information about the data](#)

[Get current data collection period](#)

Whether a hospital participated in a state or national program aimed at improving maternal and child health



Yes

Good Samaritan Medical Center

Patient-reported outcomes

Patient-reported outcomes are reports from patients about aspects of care that matter most to them, like pain...

[Read more](#)

[Find out why these measures are important](#)

[Get more information about the data](#)

[Get current data collection period](#)

Hip/knee replacement

This section shows how patients' pain and physical functions improved after surgery.

This hospital has chosen to voluntarily report patient-reported outcome data for their hip/knee replacement patients.

No

Good Samaritan Medical Center

Psychiatric unit services

These quality measures show how often or how quickly inpatient psychiatric facilities give recommended treatments and services known to get the best results for people with mental health conditions, substance abuse, and other health conditions. Some measures also describe whether these facilities have certain processes and...

[Read more](#)

[Find out why these measures are important](#)

[Get more information about the data](#)

[Get current data collection period](#)

Preventive care & screening

Patients discharged on one or more antipsychotic medications who had body mass index, blood pressure, blood sugar, and cholesterol level screenings in the past year

↑ Higher percentages are better

Not available

National average: 80%

Florida average: 80%

Patients assessed and given influenza vaccination

↑ Higher percentages are better

Not available

National average: 76%

Florida average: 70%

Substance use treatment

There is evidence that screening and counselling can reduce alcohol, drug, and tobacco use for adults (including...

Patients with alcohol abuse who received or refused a brief intervention during their inpatient stay

↑ Higher percentages are better

Not available

National average: 58%

Florida average: 59%

Patients with alcohol abuse who received a brief intervention during their inpatient stay

↑ Higher percentages are better

Not available

National average: 76%

Florida average: 78%

Patients who screened positive for an alcohol or drug use disorder during their inpatient stay who, at discharge, either: (1) received or refused a prescription for medications to treat their alcohol or drug use disorder OR (2) received or refused a referral for addiction treatment

↑ Higher percentages are better

Not available ⁵

National average: 71%

Florida average: 72%

Patients who screened positive for an alcohol or drug use disorder during their inpatient stay who, at discharge, either: (1) received a prescription for medications to treat their alcohol or drug use disorder OR (2) received a referral for addiction treatment

↑ *Higher percentages are better*

Not available ⁵

National average: 59%

Florida average: 64%

Patients who use tobacco and at discharge (1) received or refused a referral for outpatient counseling AND (2) received or refused a prescription for medications to help them quit or had a reason for not receiving medication

↑ *Higher percentages are better*

Not available ⁵

National average: 57%

Florida average: 62%

Patients who use tobacco and at discharge (1) received a referral for outpatient counseling AND (2) received a prescription for medications to help them quit or had a reason for not receiving medication

↑ *Higher percentages are better*

Not available ⁵

National average: 16%

Florida average: 27%

Patient safety

Hours that patients spent in physical restraints for every 1,000 hours of patient care

↓ Lower rates are better

Not available ⁵

National average: 0.30

Florida average: 0.09

Hours that patients spent in seclusion for every 1,000 hours of patient care

↓ Lower rates are better

Not available ⁵

National average: 0.36

Florida average: 0.07

Follow up care

Patients can experience gaps in their health care and in communication between their providers after leaving an...

[Read more](#)

Patients discharged from an inpatient psychiatric facility who received (or whose caregiver received) a complete record of inpatient psychiatric care and plans for follow-up

↑ Higher percentages are better

Not available ⁵

National average: 63%

Florida average: 44%

Patients admitted to an inpatient psychiatric facility with a principal diagnosis of select mental illness or substance use disorders (SUD) followed by an outpatient visit for mental illness or SUD treatment within 30 days

↑ Higher percentages are better

Not available ⁵

National average: 59.5%

Florida average: 52.8%

Patients admitted to an inpatient psychiatric facility with a principal diagnosis of select mental illness or substance use disorders (SUD) followed by an outpatient visit for mental illness or SUD treatment within 7 days

↑ *Higher percentages are better*

Not available

National average: 35.7%

Florida average: 31.2%

Patients admitted to an inpatient psychiatric facility for major depressive disorder (MDD), schizophrenia, or bipolar disorder who filled at least one prescription between the 2 days before they were discharged and 30 days after they were discharged from the facility

↑ *Higher percentages are better*

Not available

National average: 77.8%

Florida average: 67.9%

Unplanned readmission

Returning to the hospital for unplanned care can increase the risk of infections, and cost more money. Providing high...

[Read more](#)

Patients readmitted to any hospital within 30 days of discharge from the inpatient psychiatric facility

↓ *Lower percentages are better*

Not available

National average: 19.4%

Good Samaritan Medical Center

Payment

Looking at how payments vary is one way to see differences in how hospitals and other healthcare providers care for patients.

[Find out why these measures are important](#)

[Get more information about the data](#)

[Get current data collection period](#)

Medicare Spending per Beneficiary

The Medicare Spending Per Beneficiary (MSPB or “Medicare hospital spending per patient”) measure shows whether...

[Read more](#)

Medicare spending per beneficiary

• *(displayed in ratio)*

0.99

National average: 0.99

Florida average: 1.02

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Medicare.gov

Menu

Hospital

Delray Medical Center

Overall star rating:



Patient survey rating:



LOCATION

5352 Linton Blvd
Delray Beach, FL 33484

PHONE NUMBER

(561) 498-4440

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Ratings

Quality

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Affiliated Doctors & Clinicians

Loc

RATINGS

Overall star rating



The overall star rating is based on how well a hospital performs across different areas of quality, such as treating heart attacks and pneumonia, readmission rates, and safety of care.

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The patient survey rating measures patients' experiences of their hospital care. Recently discharged patients were asked about important topics like how well nurses and doctors communicated, how responsive hospital staff were to their needs, and the cleanliness and quietness of the hospital environment.

[Learn how the patient survey rating is measured](#)

[View Survey Details](#)

QUALITY

Choose a category to see how this hospital scores on quality topics:

- [Timely & effective care](#) >
- [Complications & deaths](#) >
- [Unplanned hospital visits](#) >
- [Maternal health](#) >
- [Patient-reported outcomes](#) >
- [Psychiatric unit services](#) >
- [Payment](#) >

DETAILS

Hospital type

Acute Care Hospitals

Provides emergency services?

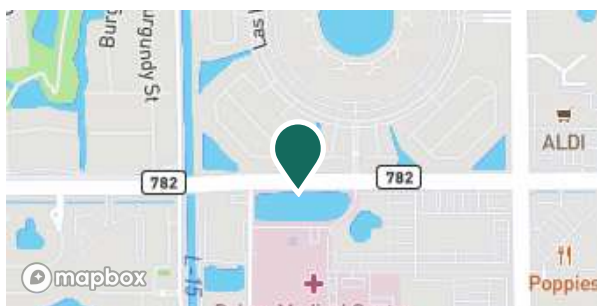
Yes

AFFILIATED DOCTORS & CLINICIANS

557 clinicians affiliated with Delray Medical Center near Delray Beach, FL.

SEARCH BY NAME OR SPECIALTY

LOCATION



Delray Medical Center

5352 Linton Blvd
Delray Beach, FL 33484

(561) 498-4440

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Delray Medical Center

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Mortality

7 of 7

measures reported within
the group



Safety of Care

7 of 8

measures reported within
the group



Readmission

9 of 11

measures reported within
the group



Patient Experience

8 of 8

measures reported within
the group



Timely and Effective Care

8 of 12

measures reported within
the group



Delray Medical Center

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The HCAHPS star ratings summarize patient experience, which is one aspect of hospital quality. Use the star ratings along with other quality information when making decisions about choosing a hospital.

Learn how the patient survey rating is measured

Get current data collection period

Patient survey rating



The patient survey rating is typically based on a one year response period.

Number of completed surveys

1,564

Survey response rate

24%

Patients who reported that their nurses "Always" communicated well.

59%

National average: 80%

Florida average: 76%

Patients who reported that their doctors "Always" communicated well.

64%

National average: 80%

Florida average: 75%

Patients who reported that they "Always" received help as soon as they wanted.

41%

National average: 66%

Florida average: 60%

Patients who reported that the staff "Always" explained about medicines before giving it to them.

44%

National average: 62%

Florida average: 58%

Patients who reported that their room and bathroom were "Always" clean.

54%

National average: 74%

Florida average: 71%

Patients who reported that the area around their room was "Always" quiet at night.

42%

National average: 62%

Florida average: 58%

Patients who reported that YES, they were given information about what to do during their recovery at home.

74%

National average: 86%

Florida average: 83%

Patients who "Strongly Agree" they understood their care when they left the hospital.

37%

National average: 52%

Florida average: 49%

Patients who gave their hospital a rating of 9 or 10 on a scale from 0 (lowest) to 10 (highest).

46%

National average: 72%

Florida average: 68%

Patients who reported YES, they would definitely recommend the hospital.

44%

National average: 70%

Florida average: 67%

Delray Medical Center

Timely & effective care

These measures show how often or how quickly hospitals provide care that research shows gets the best results for patients with certain conditions, and how hospitals use outpatient medical imaging tests (like CT scans and MRIs). This information can help you compare which hospitals give recommended care most often as part of the overall care they provide to patients.

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[Get current data collection period](#)

Sepsis care

Sepsis is a complication that occurs when your body has an extreme response to an infection. It causes damage to...

[Read more](#)

Percentage of patients who received appropriate care for severe sepsis and/or septic shock

↑ Higher percentages are better

44% ²

of 153 patients

National average: 63% ^{25,26}

Florida average: 70% ^{25,26}

Cataract surgery outcome

Cataracts affect your vision and are very common in older people. Cataracts can make your vision blurry and can...

Percentage of patients who had cataract surgery and had improvement in visual function within 90 days following the surgery

↑ Higher percentages are better

Not available ⁵

National average: 98%

Florida average: Not available ⁵

Colonoscopy follow-up

A colonoscopy is one test doctors can use to find precancerous polyps (abnormal growths) or colorectal...

Percentage of patients receiving appropriate recommendation for follow-up screening colonoscopy

↑ Higher percentages are better

Not available ¹

National average: 92% ^{25,26}

Florida average: 89% ^{25,26}

Emergency department care

Timely and effective care in hospital emergency departments is essential for good patient outcomes. Delay...

[Read more](#)

Percentage of patients who left the emergency department before being seen

↓ Lower percentages are better

2%

of 56588 patients

National average: 2% [25,26](#)

Florida average: 1% [25,26](#)

Percentage of patients who came to the emergency department with stroke symptoms who received brain scan results within 45 minutes of arrival

↑ Higher percentages are better

Not available ¹

National average: 70% [25](#)

Florida average: 70% [25](#)

Emergency department volume

High

40,000 - 59,999 patients annually

Average (median) time patients spent in the emergency department before leaving from the visit

↓ A lower number of minutes is better

169 minutes

Other High volume hospitals:

Nation: 214 minutes [25,26](#)

Florida: 155 minutes [25,26](#)

Number of included patients: 400

Volume legend (patients annually):

Low: 0 - 19,999

Medium: 20,000 - 39,999

High: 40,000 - 59,999

Very High: 60,000+

Healthcare personnel vaccination

Hospital staff and healthcare personnel can transmit viruses to coworkers and patients, including those at high...

[Read more](#)

Percentage of healthcare workers given influenza vaccination

↑ *Higher percentages are better*

37%

of 3507 healthcare workers

National average: 80%

Florida average: 60%

Safe use of Opioids

When prescription opioids, or opioids and benzodiazepines are given at the same time, patients are at a higher risk of...

[Read more](#)

Proportion of inpatient hospitalizations for patients 18 years of age and older prescribed, or continued on, two or more opioids or an opioid and benzodiazepine concurrently at discharge.

↓ *Lower percentages are better*

18%

National average: 15%

Florida average: 16%

Use of medical imaging

These outpatient imaging efficiency measures give you information about hospitals' use of medical imaging tests...

Percentage of outpatients with low-back pain who had an MRI without trying recommended treatments

(like physical therapy) first

↓ Lower percentages are better

Not available

National average: 35.5%

Florida average: 35.7%

Percentage of outpatient CT scans of the abdomen that were "combination" (double) scans

↓ Lower percentages are better

3%

National average: 5.9%

Florida average: 4.9%

Percentage of outpatients who got cardiac imaging stress tests before low-risk outpatient surgery

↓ Lower percentages are better

7%

National average: 3.7%

Florida average: 4.4%

Percentage of patients who had an advanced breast screening on the same day or within 45 days of their initial mammogram or digital breast tomosynthesis (DBT) study

Percentages between 5 - 12% are best



Not available

National average: 9%

Florida average: 15.2%

Delray Medical Center

Complications & deaths

Patients who are admitted to the hospital for treatment of medical problems sometimes get other serious injuries, complications, or conditions, and may even die. Some patients may experience problems soon after they are discharged and need to be admitted to the hospital again. These events can often be prevented if hospitals follow best practices for treating patients.

[Find out why these measures are important](#)

[Get more information about the data](#)

[Get current data collection period](#)

Complications

This section shows serious complications that patients experienced during a hospital stay or after having certain...

Rate of complications for hip/knee replacement patients

4.9%

No different than the national rate

National result: 3.6%

Number of included patients: 60

Serious complications

1.03

No different than the national value

National result: 1.00

Deaths among patients with serious treatable complications after surgery

108.94

Better than the national rate

National result: 176.55

Infections

Healthcare-associated infections, or HAIs, are infections that people get while they're getting treatment for another...

[Read more](#)

Central line-associated bloodstream infections (CLABSI) in ICUs and select wards

↓ Lower numbers are better

1.075

No different than national benchmark

National benchmark: 1.000

Catheter-associated urinary tract infections (CAUTI) in ICUs and select wards

↓ Lower numbers are better

0.576

No different than national benchmark

National benchmark: 1.000

Surgical site infections (SSI) from colon surgery

↓ Lower numbers are better

3.098

Worse than the national benchmark

National benchmark: 1.000

Surgical site infections (SSI) from abdominal hysterectomy

↓ Lower numbers are better

Not available ¹³

National benchmark: 1.000

Methicillin-resistant Staphylococcus Aureus (MRSA) blood infections

↓ Lower numbers are better

0.271

Better than the national benchmark

National benchmark: 1.000

Clostridium difficile (C.diff.) intestinal infections

↓ Lower numbers are better

0.276

Better than the national benchmark

National benchmark: 1.000

Death rates

Death rates show how often patients die, for any reason, within 30 days of admission to a hospital.

Overall

Death rate for patients (hospital-wide)

3.8%

No different than the national rate

National result: 4.2%

Number of included patients: 3235

By medical condition

Chronic obstructive pulmonary disease (COPD)

Death rate for COPD patients

6.2%

No different than the national rate

National result: 8.8%

Number of included patients: 144

Heart attack

Death rate for heart attack patients

11.3%

No different than the national rate

National result: 12.2%

Number of included patients: 317

Heart failure

Death rate for heart failure patients

8.3%

Better than the national rate

National result: 11.6%

Number of included patients: 747

Pneumonia

Death rate for pneumonia patients

13.7%

Better than the national rate

National result: 16.2%

Number of included patients: 1018

Stroke

Death rate for stroke patients

12.4%

No different than the national rate

National result: 13.3%

Number of included patients: 455

By procedure

Coronary artery bypass graft (CABG)

Death rate for CABG surgery patients

2.9%

No different than the national rate

National result: 2.6%

Number of included patients: 114

Delray Medical Center

Unplanned hospital visits

Returning to the hospital for unplanned care disrupts patients' lives, increases their risk of harmful events like healthcare-associated infections, and costs more money. Hospitals that give high quality care can keep patients from returning to the hospital and reduce their stay if they have to come back.

[Find out why these measures are important](#)

[Get more information about the data](#)

[Get current data collection period](#)

[Watch a video to learn more about hospital return days](#)

Overall

**Rate of readmission after discharge from hospital
(hospital-wide)**

16%

Worse than the national rate

National result: 15%

Number of included patients: 5929

By medical condition

Chronic obstructive pulmonary disease (COPD)

Rate of readmission for chronic obstructive pulmonary disease (COPD) patients

18.8%

No different than the national rate

National result: 18.2%

Number of included patients: 156

Heart attack

Rate of readmission for heart attack patients

13.7%

No different than the national rate

National result: 13.6%

Number of included patients: 316

Hospital return days for heart attack patients

14.7 days

More days than average per 100 discharges

National result: Not applicable

Number of included patients: 314

Heart failure

Rate of readmission for heart failure patients

19.6%

No different than the national rate

National result: 19.7%

Number of included patients: 881

Hospital return days for heart failure patients

-5.7 days

Average days per 100 discharges

National result: Not applicable

Number of included patients: 733

Pneumonia

Rate of readmission for pneumonia patients

15.9%

No different than the national rate

National result: 16%

Number of included patients: 1094

Hospital return days for pneumonia patients

10.8 days

More days than average per 100 discharges

National result: Not applicable

Number of included patients: 993

By procedure

Coronary artery bypass graft (CABG) surgery

Rate of readmission for coronary artery bypass graft (CABG) surgery patients

11.4%

No different than the national rate

National result: 10.6%

Number of included patients: 110

Hip/knee replacement

Rate of readmission after hip/knee replacement

6.2%

No different than the national rate

National result: 4.8%

Number of included patients: 58

Colonoscopy

Rate of unplanned hospital visits after an outpatient colonoscopy

13.9 per 1,000 colonoscopies

No different than the national rate

National result: 13 per 1,000 colonoscopies

Chemotherapy

Rate of inpatient admissions for patients receiving outpatient chemotherapy (per 100 chemotherapy patients)

Not available ¹

Number of cases too small

National result: 10.6%

Rate of emergency department (ED) visits for patients receiving outpatient chemotherapy (per 100 chemotherapy patients)

Not available ¹

Number of cases too small

National result: 5.5%

Outpatient surgery

Ratio of unplanned hospital visits after hospital outpatient surgery

0.9

No different than expected

National result: Not applicable

Number of included procedures: 632

Delray Medical Center

Maternal health

These measures aim to improve maternal health. By providing care during pregnancy that follows best practice...

[Read more](#)

[Find out why these measures are important](#)

[Get more information about the data](#)

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Whether a hospital participated in a state or national program aimed at improving maternal and child health



Not Applicable

Not eligible for a "Birthing-Friendly" designation because this hospital doesn't provide inpatient labor and delivery care

Delray Medical Center

Patient-reported outcomes

Patient-reported outcomes are reports from patients about aspects of care that matter most to them, like pain...

[Read more](#)

[Find out why these measures are important](#)

[Get more information about the data](#)

[Get current data collection period](#)

Hip/knee replacement

This section shows how patients' pain and physical functions improved after surgery.

This hospital has chosen to voluntarily report patient-reported outcome data for their hip/knee replacement patients.

No

Delray Medical Center

Psychiatric unit services

These quality measures show how often or how quickly inpatient psychiatric facilities give recommended treatments and services known to get the best results for people with mental health conditions, substance abuse, and other health conditions. Some measures also describe whether these facilities have certain processes and...

[Read more](#)

[Find out why these measures are important](#)

[Get more information about the data](#)

[Get current data collection period](#)

Preventive care & screening

Patients discharged on one or more antipsychotic medications who had body mass index, blood pressure, blood sugar, and cholesterol level screenings in the past year

↑ *Higher percentages are better*

76%

of 399 patients

National average: 80%

Florida average: 80%

Patients assessed and given influenza vaccination

↑ *Higher percentages are better*

81%

of 333 patients

National average: 76%

Florida average: 70%

Substance use treatment

There is evidence that screening and counselling can reduce alcohol, drug, and tobacco use for adults (including...

Patients with alcohol abuse who received or refused a brief intervention during their inpatient stay

↑ *Higher percentages are better*

22%

of 96 patients

National average: 58%

Florida average: 59%

Patients with alcohol abuse who received a brief intervention during their inpatient stay

↑ Higher percentages are better

51%

of 39 patients

National average: 76%

Florida average: 78%

Patients who screened positive for an alcohol or drug use disorder during their inpatient stay who, at discharge, either: (1) received or refused a prescription for medications to treat their alcohol or drug use disorder OR (2) received or refused a referral for addiction treatment

↑ Higher percentages are better

34%

of 92 patients

National average: 71%

Florida average: 72%

Patients who screened positive for an alcohol or drug use disorder during their inpatient stay who, at discharge, either: (1) received a prescription for medications to treat their alcohol or drug use disorder OR (2) received a referral for addiction treatment

↑ Higher percentages are better

34%

of 92 patients

National average: 59%

Florida average: 64%

Patients who use tobacco and at discharge (1) received or refused a referral for outpatient counseling AND (2) received or refused a prescription for medications to help them quit or had a reason for not receiving medication

↑ Higher percentages are better

24%

of 34 patients

National average: 57%

Florida average: 62%

Patients who use tobacco and at discharge (1) received a referral for outpatient counseling AND (2) received a prescription for medications to help them quit or had a reason for not receiving medication

↑ *Higher percentages are better*

24%

of 34 patients

National average: 16%

Florida average: 27%

Patient safety

Hours that patients spent in physical restraints for every 1,000 hours of patient care

↓ *Lower rates are better*

0.36

of 2232 days

National average: 0.30

Florida average: 0.09

Hours that patients spent in seclusion for every 1,000 hours of patient care

↓ *Lower rates are better*

0.64

of 2232 days

National average: 0.36

Florida average: 0.07

Follow up care

Patients can experience gaps in their health care and in communication between their providers after leaving an...

[Read more](#)

Patients discharged from an inpatient psychiatric facility who received (or whose caregiver received) a complete record of inpatient psychiatric care and plans for follow-up

↑ *Higher percentages are better*

20%

of 687 patients

National average: 63%

Florida average: 44%

Patients admitted to an inpatient psychiatric facility with a principal diagnosis of select mental illness or substance use disorders (SUD) followed by an outpatient visit for mental illness or SUD treatment within 30 days

↑ *Higher percentages are better*

57.9%

of 107 patients

National average: 59.5%

Florida average: 52.8%

Patients admitted to an inpatient psychiatric facility with a principal diagnosis of select mental illness or substance use disorders (SUD) followed by an outpatient visit for mental illness or SUD treatment within 7 days

↑ *Higher percentages are better*

44.9%

of 107 patients

National average: 35.7%

Florida average: 31.2%

Patients admitted to an inpatient psychiatric facility for major depressive disorder (MDD), schizophrenia, or bipolar disorder who filled at least one prescription between the 2 days before they were

discharged and 30 days after they were discharged from the facility

↑ *Higher percentages are better*

70.9%

of 175 patients

National average: 77.8%

Florida average: 67.9%

Unplanned readmission

Returning to the hospital for unplanned care can increase the risk of infections, and cost more money. Providing high...

[Read more](#)

Patients readmitted to any hospital within 30 days of discharge from the inpatient psychiatric facility

↓ *Lower percentages are better*

17.9%

No different than the national rate

National average: 19.4%

Number of included patients: 273

Delray Medical Center

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● *(displayed in ratio)*

1.03

National average: 0.99

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Hospital

St Mary's Medical Center

Overall star rating:



Patient survey rating:



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901 45th St
West Palm Beach, FL 33407

PHONE NUMBER

(561) 840-6202

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- [Psychiatric unit services](#) >
- [Payment](#) >

DETAILS

Hospital type

Acute Care Hospitals

Provides emergency services?

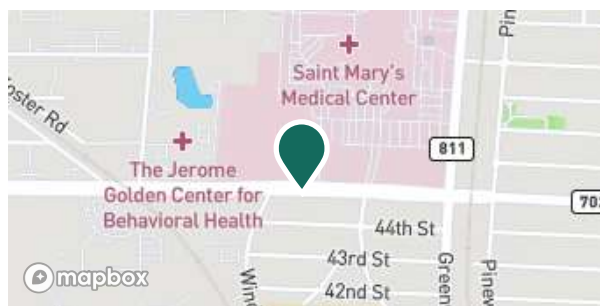
Yes

AFFILIATED DOCTORS & CLINICIANS

216 clinicians affiliated with St Mary's Medical Center near West Palm Beach, FL.

SEARCH BY NAME OR SPECIALTY

LOCATION



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901 45th St

West Palm Beach, FL 33407

(561) 840-6202

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measures reported within
the group



Safety of Care

7 of 8

measures reported within
the group



Readmission

5 of 11

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Timely and Effective Care

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Get current data collection period

Patient survey rating



The patient survey rating is typically based on a one year response period.

Number of completed surveys

549

Survey response rate

9%

Patients who reported that their nurses "Always" communicated well.

66%

National average: 80%

Florida average: 76%

Patients who reported that their doctors "Always" communicated well.

69%

National average: 80%

Florida average: 75%

Patients who reported that they "Always" received help as soon as they wanted.

48%

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Florida average: 60%

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Patients who reported that their room and bathroom were "Always" clean.

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Patients who reported that the area around their room was "Always" quiet at night.

48%

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Florida average: 58%

Patients who reported that YES, they were given information about what to do during their recovery at home.

81%

National average: 86%

Florida average: 83%

Patients who "Strongly Agree" they understood their care when they left the hospital.

42%

National average: 52%

Florida average: 49%

Patients who gave their hospital a rating of 9 or 10 on a scale from 0 (lowest) to 10 (highest).

57%

National average: 72%

Florida average: 68%

Patients who reported YES, they would definitely recommend the hospital.

55%

National average: 70%

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St Mary's Medical Center

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Sepsis care

Sepsis is a complication that occurs when your body has an extreme response to an infection. It causes damage to...

[Read more](#)

Percentage of patients who received appropriate care for severe sepsis and/or septic shock

↑ Higher percentages are better

43% ²

of 124 patients

National average: 63% ^{25,26}

Florida average: 70% ^{25,26}

Cataract surgery outcome

Cataracts affect your vision and are very common in older people. Cataracts can make your vision blurry and can...

Percentage of patients who had cataract surgery and had improvement in visual function within 90 days following the surgery

↑ Higher percentages are better

Not available ⁵

National average: 98%

Florida average: Not available ⁵

Colonoscopy follow-up

A colonoscopy is one test doctors can use to find precancerous polyps (abnormal growths) or colorectal...

Percentage of patients receiving appropriate recommendation for follow-up screening colonoscopy

↑ Higher percentages are better

Not available ¹

National average: 92% ^{25,26}

Florida average: 89% ^{25,26}

Emergency department care

Timely and effective care in hospital emergency departments is essential for good patient outcomes. Delay...

[Read more](#)

Percentage of patients who left the emergency department before being seen

↓ Lower percentages are better

3%

of 65179 patients

National average: 2% [25,26](#)

Florida average: 1% [25,26](#)

Percentage of patients who came to the emergency department with stroke symptoms who received brain scan results within 45 minutes of arrival

↑ Higher percentages are better

Not available ¹

National average: 70% [25](#)

Florida average: 70% [25](#)

Emergency department volume

Very High

60,000+ patients annually

Average (median) time patients spent in the emergency department before leaving from the visit

↓ A lower number of minutes is better

166 minutes

Other Very High volume hospitals:

Nation: 194 minutes [25,26](#)

Florida: 168 minutes [25,26](#)

Number of included patients: 426

Volume legend (patients annually):

Low: 0 - 19,999

Medium: 20,000 - 39,999

High: 40,000 - 59,999
Very High: 60,000+

Healthcare personnel vaccination

Hospital staff and healthcare personnel can transmit viruses to coworkers and patients, including those at high...
[Read more](#)

Percentage of healthcare workers given influenza vaccination

↑ Higher percentages are better

50%
of 2805 healthcare workers

National average: 80%
Florida average: 60%

Safe use of Opioids

When prescription opioids, or opioids and benzodiazepines are given at the same time, patients are at a higher risk of...
[Read more](#)

Proportion of inpatient hospitalizations for patients 18 years of age and older prescribed, or continued on, two or more opioids or an opioid and benzodiazepine concurrently at discharge.

↓ Lower percentages are better

10%
National average: 15%
Florida average: 16%

Use of medical imaging

These outpatient imaging efficiency measures give you information about hospitals' use of medical imaging tests...

Percentage of outpatients with low-back pain who had an MRI without trying recommended treatments

(like physical therapy) first

↓ Lower percentages are better

Not available ¹

National average: 35.5%

Florida average: 35.7%

Percentage of outpatient CT scans of the abdomen that were "combination" (double) scans

↓ Lower percentages are better

0%

National average: 5.9%

Florida average: 4.9%

Percentage of outpatients who got cardiac imaging stress tests before low-risk outpatient surgery

↓ Lower percentages are better

Not available ¹

National average: 3.7%

Florida average: 4.4%

Percentage of patients who had an advanced breast screening on the same day or within 45 days of their initial mammogram or digital breast tomosynthesis (DBT) study

Percentages between 5 - 12% are best



Not available ¹

National average: 9%

Florida average: 15.2%

St Mary's Medical Center

Complications & deaths

Patients who are admitted to the hospital for treatment of medical problems sometimes get other serious injuries, complications, or conditions, and may even die. Some patients may experience problems soon after they are discharged and need to be admitted to the hospital again. These events can often be prevented if hospitals follow best practices for treating patients.

[Find out why these measures are important](#)

[Get more information about the data](#)

[Get current data collection period](#)

Complications

This section shows serious complications that patients experienced during a hospital stay or after having certain...

Rate of complications for hip/knee replacement patients

Not available ¹

Number of cases too small

National result: 3.6%

Serious complications

0.91

No different than the national value

National result: 1.00

Deaths among patients with serious treatable complications after surgery

152.54

No different than the national rate

National result: 176.55

Infections

Healthcare-associated infections, or HAIs, are infections that people get while they're getting treatment for another...

[Read more](#)

Central line-associated bloodstream infections (CLABSI) in ICUs and select wards

↓ Lower numbers are better

0.548

No different than national benchmark

National benchmark: 1.000

Catheter-associated urinary tract infections (CAUTI) in ICUs and select wards

↓ Lower numbers are better

0.786

No different than national benchmark

National benchmark: 1.000

Surgical site infections (SSI) from colon surgery

↓ Lower numbers are better

1.034

No different than national benchmark

National benchmark: 1.000

Surgical site infections (SSI) from abdominal hysterectomy

↓ Lower numbers are better

Not available [13](#)

National benchmark: 1.000

Methicillin-resistant Staphylococcus Aureus (MRSA) blood infections

↓ Lower numbers are better

0.624

No different than national benchmark

National benchmark: 1.000

Clostridium difficile (C.diff.) intestinal infections

↓ Lower numbers are better

0.409

Better than the national benchmark

National benchmark: 1.000

Death rates

Death rates show how often patients die, for any reason, within 30 days of admission to a hospital.

Overall

Death rate for patients (hospital-wide)

4.3%

No different than the national rate

National result: 4.2%

Number of included patients: 603

By medical condition

Chronic obstructive pulmonary disease (COPD)

Death rate for COPD patients

Not available ¹

Number of cases too small

National result: 8.8%

Heart attack

Death rate for heart attack patients

Not available ¹

Number of cases too small

National result: 12.2%

Heart failure

Death rate for heart failure patients

12.2%

No different than the national rate

National result: 11.6%

Number of included patients: 45

Pneumonia

Death rate for pneumonia patients

15.7%

No different than the national rate

National result: 16.2%

Number of included patients: 94

Stroke

Death rate for stroke patients

13%

No different than the national rate

National result: 13.3%

Number of included patients: 225

By procedure

Coronary artery bypass graft (CABG)

Death rate for CABG surgery patients

Not available ⁵

National result: 2.6%

St Mary's Medical Center

Unplanned hospital visits

Returning to the hospital for unplanned care disrupts patients' lives, increases their risk of harmful events like healthcare-associated infections, and costs more money. Hospitals that give high quality care can keep patients from returning to the hospital and reduce their stay if they have to come back.

[Find out why these measures are important](#)

[Get more information about the data](#)

[Get current data collection period](#)

[Watch a video to learn more about hospital return days](#)

Overall

**Rate of readmission after discharge from hospital
(hospital-wide)**

15.2%

No different than the national rate

National result: 15%

Number of included patients: 1143

By medical condition

Chronic obstructive pulmonary disease (COPD)

**Rate of readmission for chronic obstructive
pulmonary disease (COPD) patients**

Not available ¹

Number of cases too small

National result: 18.2%

Heart attack

Rate of readmission for heart attack patients

Not available ¹

Number of cases too small

National result: 13.6%

Hospital return days for heart attack patients

Not applicable ¹

Number of cases too small

National result: Not applicable

Heart failure

Rate of readmission for heart failure patients

19.8%

No different than the national rate

National result: 19.7%

Number of included patients: 46

Hospital return days for heart failure patients

33.4 days

More days than average per 100 discharges

National result: Not applicable

Number of included patients: 43

Pneumonia

Rate of readmission for pneumonia patients

15.7%

No different than the national rate

National result: 16%
Number of included patients: 95

Hospital return days for pneumonia patients

11.2 days

Average days per 100 discharges

National result: Not applicable

Number of included patients: 94

By procedure

Coronary artery bypass graft (CABG) surgery

Rate of readmission for coronary artery bypass graft (CABG) surgery patients

Not available ⁵

National result: 10.6%

Hip/knee replacement

Rate of readmission after hip/knee replacement

Not available ¹

Number of cases too small

National result: 4.8%

Colonoscopy

Rate of unplanned hospital visits after an outpatient colonoscopy

Not available ¹

Number of cases too small

National result: 13 per 1,000 colonoscopies

Chemotherapy

Rate of inpatient admissions for patients receiving outpatient chemotherapy (per 100 chemotherapy patients)

Not available [5](#)

National result: 10.6%

Rate of emergency department (ED) visits for patients receiving outpatient chemotherapy (per 100 chemotherapy patients)

Not available [5](#)

National result: 5.5%

Outpatient surgery

Ratio of unplanned hospital visits after hospital outpatient surgery

1.8

Worse than expected

National result: Not applicable

Number of included procedures: 89

St Mary's Medical Center 

Maternal health

These measures aim to improve maternal health. By providing care during pregnancy that follows best practice...

[Read more](#)

[Find out why these measures are important](#)

[Get more information about the data](#)

[Get current data collection period](#)

Whether a hospital participated in a state or national program aimed at improving maternal and child health



Yes

St Mary's Medical Center

Patient-reported outcomes

Patient-reported outcomes are reports from patients about aspects of care that matter most to them, like pain...

[Read more](#)

[Find out why these measures are important](#)

[Get more information about the data](#)

[Get current data collection period](#)

Hip/knee replacement

This section shows how patients' pain and physical functions improved after surgery.

This hospital has chosen to voluntarily report patient-reported outcome data for their hip/knee replacement patients.

No

St Mary's Medical Center

Psychiatric unit services

These quality measures show how often or how quickly inpatient psychiatric facilities give recommended treatments and services known to get the best results for people with mental health conditions, substance abuse, and other health conditions. Some measures also describe whether these facilities have certain processes and...

[Read more](#)

[Find out why these measures are important](#)

[Get more information about the data](#)

[Get current data collection period](#)

Preventive care & screening

Patients discharged on one or more antipsychotic medications who had body mass index, blood pressure, blood sugar, and cholesterol level screenings in the past year

↑ *Higher percentages are better*

Not available ⁵

National average: 80%

Florida average: 80%

Patients assessed and given influenza vaccination

↑ Higher percentages are better

Not available [5](#)

National average: 76%

Florida average: 70%

Substance use treatment

There is evidence that screening and counselling can reduce alcohol, drug, and tobacco use for adults (including...

Patients with alcohol abuse who received or refused a brief intervention during their inpatient stay

↑ Higher percentages are better

Not available [5](#)

National average: 58%

Florida average: 59%

Patients with alcohol abuse who received a brief intervention during their inpatient stay

↑ Higher percentages are better

Not available [5](#)

National average: 76%

Florida average: 78%

Patients who screened positive for an alcohol or drug use disorder during their inpatient stay who, at discharge, either: (1) received or refused a prescription for medications to treat their alcohol or drug use disorder OR (2) received or refused a referral for addiction treatment

↑ Higher percentages are better

Not available [5](#)

National average: 71%

Florida average: 72%

Patients who screened positive for an alcohol or drug use disorder during their inpatient stay who, at discharge, either: (1) received a prescription for medications to treat their alcohol or drug use disorder OR (2) received a referral for addiction treatment

↑ *Higher percentages are better*

Not available ⁵

National average: 59%

Florida average: 64%

Patients who use tobacco and at discharge (1) received or refused a referral for outpatient counseling AND (2) received or refused a prescription for medications to help them quit or had a reason for not receiving medication

↑ *Higher percentages are better*

Not available ⁵

National average: 57%

Florida average: 62%

Patients who use tobacco and at discharge (1) received a referral for outpatient counseling AND (2) received a prescription for medications to help them quit or had a reason for not receiving medication

↑ *Higher percentages are better*

Not available ⁵

National average: 16%

Florida average: 27%

Patient safety

Hours that patients spent in physical restraints for every 1,000 hours of patient care

↓ *Lower rates are better*

Not available ⁵

National average: 0.30

Florida average: 0.09

Hours that patients spent in seclusion for every 1,000 hours of patient care

↓ Lower rates are better

Not available

National average: 0.36

Florida average: 0.07

Follow up care

Patients can experience gaps in their health care and in communication between their providers after leaving an...

[Read more](#)

Patients discharged from an inpatient psychiatric facility who received (or whose caregiver received) a complete record of inpatient psychiatric care and plans for follow-up

↑ Higher percentages are better

Not available

National average: 63%

Florida average: 44%

Patients admitted to an inpatient psychiatric facility with a principal diagnosis of select mental illness or substance use disorders (SUD) followed by an outpatient visit for mental illness or SUD treatment within 30 days

↑ Higher percentages are better

Not available

National average: 59.5%

Florida average: 52.8%

Patients admitted to an inpatient psychiatric facility with a principal diagnosis of select mental illness or substance use disorders (SUD) followed by an

outpatient visit for mental illness or SUD treatment within 7 days

↑ Higher percentages are better

Not available ⁵

National average: 35.7%

Florida average: 31.2%

Patients admitted to an inpatient psychiatric facility for major depressive disorder (MDD), schizophrenia, or bipolar disorder who filled at least one prescription between the 2 days before they were discharged and 30 days after they were discharged from the facility

↑ Higher percentages are better

Not available ⁵

National average: 77.8%

Florida average: 67.9%

Unplanned readmission

Returning to the hospital for unplanned care can increase the risk of infections, and cost more money. Providing high...

[Read more](#)

Patients readmitted to any hospital within 30 days of discharge from the inpatient psychiatric facility

↓ Lower percentages are better

Not available ⁵

National average: 19.4%

St Mary's Medical Center

Payment

Looking at how payments vary is one way to see differences in how hospitals and other healthcare providers care for patients.

[Find out why these measures are important](#)

[Get more information about the data](#)

[Get current data collection period](#)

Medicare Spending per Beneficiary

The Medicare Spending Per Beneficiary (MSPB or “Medicare hospital spending per patient”) measure shows whether...
[Read more](#)

Medicare spending per beneficiary

• *(displayed in ratio)*

1.03

National average: 0.99

Florida average: 1.02

Collapse available information and return to the default view of this page.

[Collapse page](#)



A federal government website managed and paid for by the U.S. Centers for Medicare and Medicaid Services. 7500 Security Boulevard, Baltimore, MD 21244
7500 Security Boulevard, Baltimore, MD 21244

Hospital

West Boca Medical Center

Overall star rating:



Patient survey rating:



LOCATION

21644 State Rd 7
Boca Raton, FL 33428

PHONE NUMBER

(561) 488-8100

 Save to Favorites

Feedback

Ratings

Quality

Details

Affiliated Doctors & Clinicians

Loc

RATINGS

Overall star rating



The overall star rating is based on how well a hospital performs across different areas of quality, such as treating heart attacks and pneumonia, readmission rates, and safety of care.

[Learn how Medicare calculates this rating](#)

[View Rating Details](#)

Patient survey rating



The patient survey rating measures patients' experiences of their hospital care. Recently discharged patients were asked about important topics like how well nurses and doctors communicated, how responsive hospital staff were to their needs, and the cleanliness and quietness of the hospital environment.

[Learn how the patient survey rating is measured](#)

[View Survey Details](#)

QUALITY

Choose a category to see how this hospital scores on quality topics:

- [Timely & effective care](#) >
- [Complications & deaths](#) >
- [Unplanned hospital visits](#) >
- [Maternal health](#) >
- [Patient-reported outcomes](#) >
- [Psychiatric unit services](#) >
- [Payment](#) >

DETAILS

Hospital type

Acute Care Hospitals

Provides emergency services?

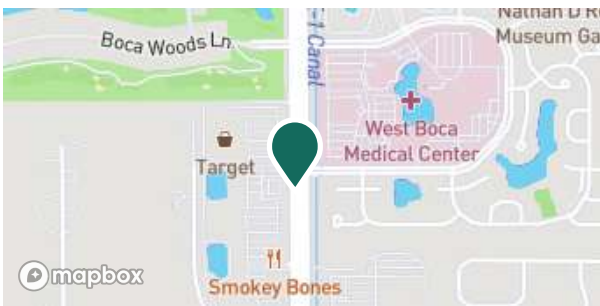
Yes

AFFILIATED DOCTORS & CLINICIANS

216 clinicians affiliated with West Boca Medical Center near Boca Raton, FL.

SEARCH BY NAME OR SPECIALTY

LOCATION



West Boca Medical Center

21644 State Rd 7
Boca Raton, FL 33428

(561) 488-8100

Get Directions

Data last updated: August 6, 2025

To explore and download hospital data, [visit the data catalog on Data.cms.gov](#)

To explore data on ambulatory surgical centers (ASC), [visit the ASC data on Data.cms.gov](#)



Consider this when choosing a hospital

[Guide to choosing a hospital \(PDF\)](#)

[How Medicare covers inpatient hospital care](#)

[How Medicare covers outpatient hospital services](#)

West Boca Medical Center

Overall star rating details

This shows how individual hospitals perform compared to all hospitals across the country for the 5 groups or categories of quality measures that make up for the overall star rating.

Overall star rating



The overall star rating is based on how well a hospital performs across different areas of quality, such as treating heart attacks and pneumonia, readmission rates, and safety of care.

Mortality

4 of 7

measures reported within
the group



Safety of Care

6 of 8

measures reported within
the group



Readmission

7 of 11

measures reported within
the group



Patient Experience

8 of 8

measures reported within
the group



Timely and Effective Care

9 of 12

measures reported within
the group



West Boca Medical Center

Patient survey rating

The HCAHPS star ratings summarize patient experience, which is one aspect of hospital quality. Use the star ratings along with other quality information when making decisions about choosing a hospital.

Learn how the patient survey rating is measured

Get current data collection period

Patient survey rating



The patient survey rating is typically based on a one year response period.

Number of completed surveys

711

Survey response rate

15%

Patients who reported that their nurses "Always" communicated well.

62%

National average: 80%

Florida average: 76%

Patients who reported that their doctors "Always" communicated well.

63%

National average: 80%

Florida average: 75%

Patients who reported that they "Always" received help as soon as they wanted.

40%

National average: 66%

Florida average: 60%

Patients who reported that the staff "Always" explained about medicines before giving it to them.

45%

National average: 62%

Florida average: 58%

Patients who reported that their room and bathroom were "Always" clean.

55%

National average: 74%

Florida average: 71%

Patients who reported that the area around their room was "Always" quiet at night.

39%

National average: 62%

Florida average: 58%

Patients who reported that YES, they were given information about what to do during their recovery at home.

78%

National average: 86%

Florida average: 83%

Patients who "Strongly Agree" they understood their care when they left the hospital.

36%

National average: 52%

Florida average: 49%

Patients who gave their hospital a rating of 9 or 10 on a scale from 0 (lowest) to 10 (highest).

49%

National average: 72%

Florida average: 68%

Patients who reported YES, they would definitely recommend the hospital.

49%

National average: 70%

Florida average: 67%

West Boca Medical Center

Timely & effective care

These measures show how often or how quickly hospitals provide care that research shows gets the best results for patients with certain conditions, and how hospitals use outpatient medical imaging tests (like CT scans and MRIs). This information can help you compare which hospitals give recommended care most often as part of the overall care they provide to patients.

[Find out why these measures are important](#)

[Get more information about the data](#)

[Get current data collection period](#)

Sepsis care

Sepsis is a complication that occurs when your body has an extreme response to an infection. It causes damage to...

[Read more](#)

Percentage of patients who received appropriate care for severe sepsis and/or septic shock

↑ Higher percentages are better

59% ²

of 115 patients

National average: 63% ^{25,26}

Florida average: 70% ^{25,26}

Cataract surgery outcome

Cataracts affect your vision and are very common in older people. Cataracts can make your vision blurry and can...

Percentage of patients who had cataract surgery and had improvement in visual function within 90 days following the surgery

↑ Higher percentages are better

Not available ⁵

National average: 98%

Florida average: Not available ⁵

Colonoscopy follow-up

A colonoscopy is one test doctors can use to find precancerous polyps (abnormal growths) or colorectal...

Percentage of patients receiving appropriate recommendation for follow-up screening colonoscopy

↑ Higher percentages are better

94%

of 102 patients

National average: 92% ^{25,26}

Florida average: 89% ^{25,26}

Emergency department care

Timely and effective care in hospital emergency departments is essential for good patient outcomes. Delay...

[Read more](#)

Percentage of patients who left the emergency department before being seen

↓ Lower percentages are better

1%

of 46190 patients

National average: 2% [25,26](#)

Florida average: 1% [25,26](#)

Percentage of patients who came to the emergency department with stroke symptoms who received brain scan results within 45 minutes of arrival

↑ Higher percentages are better

Not available ¹

National average: 70% [25](#)

Florida average: 70% [25](#)

Emergency department volume

High

40,000 - 59,999 patients annually

Average (median) time patients spent in the emergency department before leaving from the visit

↓ A lower number of minutes is better

151 minutes

Other High volume hospitals:

Nation: 214 minutes [25,26](#)

Florida: 155 minutes [25,26](#)

Number of included patients: 450

Volume legend (patients annually):

Low: 0 - 19,999

Medium: 20,000 - 39,999

High: 40,000 - 59,999
Very High: 60,000+

Healthcare personnel vaccination

Hospital staff and healthcare personnel can transmit viruses to coworkers and patients, including those at high...
[Read more](#)

Percentage of healthcare workers given influenza vaccination

↑ Higher percentages are better

59%
of 1699 healthcare workers

National average: 80%
Florida average: 60%

Safe use of Opioids

When prescription opioids, or opioids and benzodiazepines are given at the same time, patients are at a higher risk of...
[Read more](#)

Proportion of inpatient hospitalizations for patients 18 years of age and older prescribed, or continued on, two or more opioids or an opioid and benzodiazepine concurrently at discharge.

↓ Lower percentages are better

14%
National average: 15%
Florida average: 16%

Use of medical imaging

These outpatient imaging efficiency measures give you information about hospitals' use of medical imaging tests...

Percentage of outpatients with low-back pain who had an MRI without trying recommended treatments

(like physical therapy) first

↓ Lower percentages are better

Not available

National average: 35.5%

Florida average: 35.7%

Percentage of outpatient CT scans of the abdomen that were "combination" (double) scans

↓ Lower percentages are better

1.9%

National average: 5.9%

Florida average: 4.9%

Percentage of outpatients who got cardiac imaging stress tests before low-risk outpatient surgery

↓ Lower percentages are better

Not available

National average: 3.7%

Florida average: 4.4%

Percentage of patients who had an advanced breast screening on the same day or within 45 days of their initial mammogram or digital breast tomosynthesis (DBT) study

Percentages between 5 - 12% are best



28.8%

National average: 9%

Florida average: 15.2%

West Boca Medical Center

Complications & deaths

Patients who are admitted to the hospital for treatment of medical problems sometimes get other serious injuries, complications, or conditions, and may even die. Some patients may experience problems soon after they are discharged and need to be admitted to the hospital again. These events can often be prevented if hospitals follow best practices for treating patients.

[Find out why these measures are important](#)

[Get more information about the data](#)

[Get current data collection period](#)

Complications

This section shows serious complications that patients experienced during a hospital stay or after having certain...

Rate of complications for hip/knee replacement patients

Not available ¹

Number of cases too small

National result: 3.6%

Serious complications

0.92

No different than the national value

National result: 1.00

Deaths among patients with serious treatable complications after surgery

Not available ¹

Number of cases too small

National result: 176.55

Infections

Healthcare-associated infections, or HAIs, are infections that people get while they're getting treatment for another...

[Read more](#)

Central line-associated bloodstream infections (CLABSI) in ICUs and select wards

↓ Lower numbers are better

0.000

No different than national benchmark

National benchmark: 1.000

Catheter-associated urinary tract infections (CAUTI) in ICUs and select wards

↓ Lower numbers are better

0.000

No different than national benchmark

National benchmark: 1.000

Surgical site infections (SSI) from colon surgery

↓ Lower numbers are better

2.381

No different than national benchmark

National benchmark: 1.000

Surgical site infections (SSI) from abdominal hysterectomy

↓ Lower numbers are better

Not available [13](#)

National benchmark: 1.000

**Methicillin-resistant Staphylococcus Aureus (MRSA)
blood infections**

↓ Lower numbers are better

0.504

No different than national benchmark

National benchmark: 1.000

Clostridium difficile (C.diff.) intestinal infections

↓ Lower numbers are better

0.259

Better than the national benchmark

National benchmark: 1.000

Death rates

Death rates show how often patients die, for any reason, within 30 days of admission to a hospital.

Overall

Death rate for patients (hospital-wide)

3.8%

No different than the national rate

National result: 4.2%

Number of included patients: 694

By medical condition

Chronic obstructive pulmonary disease (COPD)

Death rate for COPD patients

8.2%

No different than the national rate

National result: 8.8%

Number of included patients: 37

Heart attack

Death rate for heart attack patients

Not available ¹

Number of cases too small

National result: 12.2%

Heart failure

Death rate for heart failure patients

10.7%

No different than the national rate

National result: 11.6%

Number of included patients: 178

Pneumonia

Death rate for pneumonia patients

13.4%

No different than the national rate

National result: 16.2%

Number of included patients: 283

Stroke

Death rate for stroke patients

12.8%

No different than the national rate

National result: 13.3%

Number of included patients: 42

By procedure

Coronary artery bypass graft (CABG)

Death rate for CABG surgery patients

Not available ⁵

National result: 2.6%

West Boca Medical Center

Unplanned hospital visits

Returning to the hospital for unplanned care disrupts patients' lives, increases their risk of harmful events like healthcare-associated infections, and costs more money. Hospitals that give high quality care can keep patients from returning to the hospital and reduce their stay if they have to come back.

[Find out why these measures are important](#)

[Get more information about the data](#)

[Get current data collection period](#)

[Watch a video to learn more about hospital return days](#)

Overall

**Rate of readmission after discharge from hospital
(hospital-wide)**

16%

No different than the national rate

National result: 15%

Number of included patients: 1157

By medical condition

Chronic obstructive pulmonary disease (COPD)

Rate of readmission for chronic obstructive pulmonary disease (COPD) patients

17.8%

No different than the national rate

National result: 18.2%

Number of included patients: 38

Heart attack

Rate of readmission for heart attack patients

Not available ¹

Number of cases too small

National result: 13.6%

Hospital return days for heart attack patients

Not applicable ¹

Number of cases too small

National result: Not applicable

Heart failure

Rate of readmission for heart failure patients

19.9%

No different than the national rate

National result: 19.7%

Number of included patients: 194

Hospital return days for heart failure patients

-13.8 days

Average days per 100 discharges

National result: Not applicable

Number of included patients: 164

Pneumonia

Rate of readmission for pneumonia patients

16.6%

No different than the national rate

National result: 16%

Number of included patients: 291

Hospital return days for pneumonia patients

-1.3 days

Average days per 100 discharges

National result: Not applicable

Number of included patients: 268

By procedure

Coronary artery bypass graft (CABG) surgery

Rate of readmission for coronary artery bypass graft (CABG) surgery patients

Not available ⁵

National result: 10.6%

Hip/knee replacement

Rate of readmission after hip/knee replacement

Not available ¹

Number of cases too small

National result: 4.8%

Colonoscopy

Rate of unplanned hospital visits after an outpatient colonoscopy

13 per 1,000 colonoscopies

No different than the national rate

National result: 13 per 1,000 colonoscopies

Chemotherapy

Rate of inpatient admissions for patients receiving outpatient chemotherapy (per 100 chemotherapy patients)

Not available ¹

Number of cases too small

National result: 10.6%

Rate of emergency department (ED) visits for patients receiving outpatient chemotherapy (per 100 chemotherapy patients)

Not available ¹

Number of cases too small

National result: 5.5%

Outpatient surgery

Ratio of unplanned hospital visits after hospital outpatient surgery

1

No different than expected

National result: Not applicable

Number of included procedures: 225

West Boca Medical Center 

Maternal health

These measures aim to improve maternal health. By providing care during pregnancy that follows best practice...
[Read more](#)

[Find out why these measures are important](#)

[Get more information about the data](#)

[Get current data collection period](#)

Whether a hospital participated in a state or national program aimed at improving maternal and child health



Yes

West Boca Medical Center

Patient-reported outcomes

Patient-reported outcomes are reports from patients about aspects of care that matter most to them, like pain...
[Read more](#)

[Find out why these measures are important](#)

[Get more information about the data](#)

[Get current data collection period](#)

Hip/knee replacement

This section shows how patients' pain and physical functions improved after surgery.

This hospital has chosen to voluntarily report patient-reported outcome data for their hip/knee replacement patients.

No

West Boca Medical Center

Psychiatric unit services

These quality measures show how often or how quickly inpatient psychiatric facilities give recommended treatments and services known to get the best results for people with mental health conditions, substance abuse, and other health conditions. Some measures also describe whether these facilities have certain processes and...

[Read more](#)

[Find out why these measures are important](#)

[Get more information about the data](#)

[Get current data collection period](#)

Preventive care & screening

Patients discharged on one or more antipsychotic medications who had body mass index, blood pressure, blood sugar, and cholesterol level screenings in the past year

↑ *Higher percentages are better*

Not available [5](#)

National average: 80%

Florida average: 80%

Patients assessed and given influenza vaccination

↑ *Higher percentages are better*

Not available [5](#)

National average: 76%

Florida average: 70%

Substance use treatment

There is evidence that screening and counselling can reduce alcohol, drug, and tobacco use for adults (including...

Patients with alcohol abuse who received or refused a brief intervention during their inpatient stay

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Patients who screened positive for an alcohol or drug use disorder during their inpatient stay who, at discharge, either: (1) received or refused a prescription for medications to treat their alcohol or drug use disorder OR (2) received or refused a referral for addiction treatment

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Not available [5](#)

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Not available

National average: 59%

Florida average: 64%

Patients who use tobacco and at discharge (1) received or refused a referral for outpatient counseling AND (2) received or refused a prescription for medications to help them quit or had a reason for not receiving medication

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Not available

National average: 57%

Florida average: 62%

Patients who use tobacco and at discharge (1) received a referral for outpatient counseling AND (2) received a prescription for medications to help them quit or had a reason for not receiving medication

↑ *Higher percentages are better*

Not available

National average: 16%

Florida average: 27%

Patient safety

Hours that patients spent in physical restraints for every 1,000 hours of patient care

↓ *Lower rates are better*

Not available [5](#)

National average: 0.30

Florida average: 0.09

Hours that patients spent in seclusion for every 1,000 hours of patient care

↓ *Lower rates are better*

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National average: 0.36

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Patients can experience gaps in their health care and in communication between their providers after leaving an...

[Read more](#)

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National average: 59.5%

Florida average: 52.8%

Patients admitted to an inpatient psychiatric facility with a principal diagnosis of select mental illness or substance use disorders (SUD) followed by an outpatient visit for mental illness or SUD treatment within 7 days

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Not available ⁵

National average: 35.7%

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Patients admitted to an inpatient psychiatric facility for major depressive disorder (MDD), schizophrenia, or bipolar disorder who filled at least one prescription between the 2 days before they were discharged and 30 days after they were discharged from the facility

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Not available ⁵

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Unplanned readmission

Returning to the hospital for unplanned care can increase the risk of infections, and cost more money. Providing high...

[Read more](#)

Patients readmitted to any hospital within 30 days of discharge from the inpatient psychiatric facility

↓ *Lower percentages are better*

Not available ⁵

National average: 19.4%

West Boca Medical Center

Payment

Looking at how payments vary is one way to see differences in how hospitals and other healthcare providers care for patients.

[Find out why these measures are important](#)

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[Get current data collection period](#)

Medicare Spending per Beneficiary

The Medicare Spending Per Beneficiary (MSPB or “Medicare hospital spending per patient”) measure shows whether...

[Read more](#)

Medicare spending per beneficiary

• *(displayed in ratio)*

1.03

National average: 0.99

Florida average: 1.02

Collapse available information and return to the default view of this page.

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7500 Security Boulevard, Baltimore, MD 21244

Medicare.gov

Menu

Hospital

Palm Beach Gardens Medical Center

Overall star rating:



Patient survey rating:



LOCATION

3360 Burns Rd
Palm Beach Gardens, FL 33410

PHONE NUMBER

(561) 622-1411

 Save to Favorites

Feedback

Ratings

Quality

Details

Affiliated Doctors & Clinicians

Loc

RATINGS

Overall star rating



The overall star rating is based on how well a hospital performs across different areas of quality, such as treating heart attacks

and pneumonia, readmission rates, and safety of care.

[Learn how Medicare calculates this rating](#)

View Rating Details

Patient survey rating



The patient survey rating measures patients' experiences of their hospital care. Recently discharged patients were asked about important topics like how well nurses and doctors communicated, how responsive hospital staff were to their needs, and the cleanliness and quietness of the hospital environment.

[Learn how the patient survey rating is measured](#)

View Survey Details

QUALITY

Choose a category to see how this hospital scores on quality topics:

- Timely & effective care >
- Complications & deaths >
- Unplanned hospital visits >
- Maternal health >
- Patient-reported outcomes >
- Psychiatric unit services >

Payment



DETAILS

Hospital type

Acute Care Hospitals

Provides emergency services?

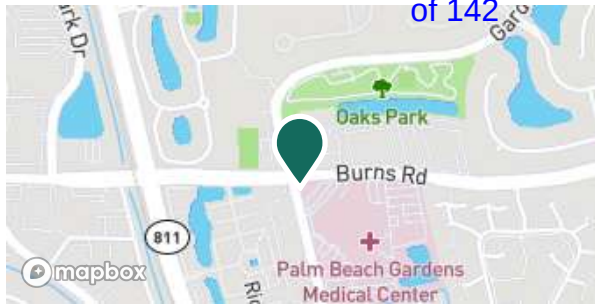
Yes

AFFILIATED DOCTORS & CLINICIANS

293 clinicians affiliated with Palm Beach Gardens Medical Center near Palm Beach Gardens, FL.

SEARCH BY NAME OR SPECIALTY

LOCATION



Palm Beach Gardens Medical Center

3360 Burns Rd
Palm Beach Gardens, FL 33410

(561) 622-1411

[Get Directions](#)

Data last updated: August 6, 2025

To explore and download hospital data, [visit the data catalog on Data.cms.gov](#)

To explore data on ambulatory surgical centers (ASC), [visit the ASC data on Data.cms.gov](#)



Consider this when choosing a hospital

[Guide to choosing a hospital \(PDF\)](#)

[How Medicare covers inpatient hospital care](#)

[How Medicare covers outpatient hospital services](#)

Palm Beach Gardens Medical Center

Overall star rating details

This shows how individual hospitals perform compared to all hospitals across the country for the 5 groups or categories of quality measures that make up for the overall star rating.

Overall star rating



The overall star rating is based on how well a hospital performs across different areas of quality, such as treating heart attacks and pneumonia, readmission rates, and safety of care.

Mortality 7 of 7 measures reported within the group
Safety of Care 7 of 8 measures reported within the group
Readmission 9 of 11 measures reported within the group
Patient Experience 8 of 8 measures reported within the group
Timely and Effective Care 8 of 12

measures reported within
the group

Palm Beach Gardens Medical Center

Patient survey rating

The HCAHPS star ratings summarize patient experience, which is one aspect of hospital quality. Use the star ratings along with other quality information when making decisions about choosing a hospital.

[Learn how the patient survey rating is measured](#)

[Get current data collection period](#)

Patient survey rating



The patient survey rating is typically based on a one year response period.

Number of completed surveys

1,118

Survey response rate

22%

**Patients who reported that their nurses "Always"
communicated well.**

67%

National average: 80%

Florida average: 76%

Patients who reported that their doctors "Always" communicated well.

70%

National average: 80%

Florida average: 75%

Patients who reported that they "Always" received help as soon as they wanted.

47%

National average: 66%

Florida average: 60%

Patients who reported that the staff "Always" explained about medicines before giving it to them.

49%

National average: 62%

Florida average: 58%

Patients who reported that their room and bathroom were "Always" clean.

57%

National average: 74%

Florida average: 71%

Patients who reported that the area around their room was "Always" quiet at night.

44%

National average: 62%

Florida average: 58%

Patients who reported that YES, they were given information about what to do during their recovery at home.

81%

National average: 86%

Florida average: 83%

Patients who "Strongly Agree" they understood their care when they left the hospital.

41%

National average: 52%

Florida average: 49%

Patients who gave their hospital a rating of 9 or 10 on a scale from 0 (lowest) to 10 (highest).

56%

National average: 72%

Florida average: 68%

Patients who reported YES, they would definitely recommend the hospital.

56%

National average: 70%

Florida average: 67%

**Palm Beach Gardens Medical
Center**

Timely & effective care

These measures show how often or how quickly hospitals provide care that research shows gets the best results for patients with certain conditions, and how hospitals use outpatient medical imaging tests (like CT scans and MRIs). This information can help you compare which hospitals give recommended care most often as part of the overall care they provide to patients.

[Find out why these measures are important](#)

[Get more information about the data](#)

[Get current data collection period](#)

Sepsis care

Sepsis is a complication that occurs when your body has an extreme response to an infection. It causes damage to...

[Read more](#)

Percentage of patients who received appropriate care for severe sepsis and/or septic shock

↑ Higher percentages are better

69% [2](#)

of 107 patients

National average: 63% [25,26](#)

Florida average: 70% [25,26](#)

Cataract surgery outcome

Cataracts affect your vision and are very common in older people. Cataracts can make your vision blurry and can...

Percentage of patients who had cataract surgery and had improvement in visual function within 90 days following the surgery

↑ Higher percentages are better

Not available [5](#)

National average: 98%

Florida average: Not available [5](#)

Colonoscopy follow-up

A colonoscopy is one test doctors can use to find precancerous polyps (abnormal growths) or colorectal...

Percentage of patients receiving appropriate recommendation for follow-up screening colonoscopy

↑ *Higher percentages are better*

88%

of 50 patients

National average: 92% [25,26](#)

Florida average: 89% [25,26](#)

Emergency department care

Timely and effective care in hospital emergency departments is essential for good patient outcomes. Delay...

[Read more](#)

Percentage of patients who left the emergency department before being seen

↓ *Lower percentages are better*

1%

of 30689 patients

National average: 2% [25,26](#)

Florida average: 1% [25,26](#)

Percentage of patients who came to the emergency department with stroke symptoms who received brain scan results within 45 minutes of arrival

↑ *Higher percentages are better*

Not available ¹

National average: 70% [25](#)

Florida average: 70% [25](#)

Emergency department volume

Medium

20,000 - 39,999 patients annually

Average (median) time patients spent in the emergency department before leaving from the visit

↓ *A lower number of minutes is better*

151 minutes

Other Medium volume hospitals:

Nation: 175 minutes [25,26](#)

Florida: 142 minutes [25,26](#)

Number of included patients: 470

Volume legend (patients annually):

Low: 0 - 19,999

Medium: 20,000 - 39,999

High: 40,000 - 59,999

Very High: 60,000+

Healthcare personnel vaccination

Hospital staff and healthcare personnel can transmit viruses to coworkers and patients, including those at high...

[Read more](#)

Percentage of healthcare workers given influenza vaccination

↑ *Higher percentages are better*

24%

of 1909 healthcare workers

National average: 80%

Florida average: 60%

Safe use of Opioids

When prescription opioids, or opioids and benzodiazepines are given at the same time, patients are at a higher risk of...

[Read more](#)

Proportion of inpatient hospitalizations for patients 18 years of age and older prescribed, or continued on, two or more opioids or an opioid and benzodiazepine concurrently at discharge.

↓ Lower percentages are better

20%

National average: 15%

Florida average: 16%

Use of medical imaging

These outpatient imaging efficiency measures give you information about hospitals' use of medical imaging tests...

Percentage of outpatients with low-back pain who had an MRI without trying recommended treatments (like physical therapy) first

↓ Lower percentages are better

Not available ¹

National average: 35.5%

Florida average: 35.7%

Percentage of outpatient CT scans of the abdomen that were "combination" (double) scans

↓ Lower percentages are better

3.6%

National average: 5.9%

Florida average: 4.9%

Percentage of outpatients who got cardiac imaging stress tests before low-risk outpatient surgery

↓ Lower percentages are better

Not available ¹

National average: 3.7%

Florida average: 4.4%

Percentage of patients who had an advanced breast screening on the same day or within 45 days of their initial mammogram or digital breast tomosynthesis (DBT) study

Percentages between 5 - 12% are best



25.6%

National average: 9%

Florida average: 15.2%

Palm Beach Gardens Medical Center

Complications & deaths

Patients who are admitted to the hospital for treatment of medical problems sometimes get other serious injuries, complications, or conditions, and may even die. Some patients may experience problems soon after they are discharged and need to be admitted to the hospital again. These events can often be prevented if hospitals follow best practices for treating patients.

[Find out why these measures are important](#)

[Get more information about the data](#)

[Get current data collection period](#)

Complications

This section shows serious complications that patients experienced during a hospital stay or after having certain...

Rate of complications for hip/knee replacement patients

3.7%

No different than the national rate

National result: 3.6%

Number of included patients: 65

Serious complications

1.34

No different than the national value

National result: 1.00

Deaths among patients with serious treatable complications after surgery

165.31

No different than the national rate

National result: 176.55

Infections

Healthcare-associated infections, or HAIs, are infections that people get while they're getting treatment for another...

[Read more](#)

Central line-associated bloodstream infections (CLABSI) in ICUs and select wards

↓ *Lower numbers are better*

0.000

No different than national benchmark

National benchmark: 1.000

Catheter-associated urinary tract infections (CAUTI) in ICUs and select wards

↓ *Lower numbers are better*

0.345

No different than national benchmark

National benchmark: 1.000

Surgical site infections (SSI) from colon surgery

↓ Lower numbers are better

1.180

No different than national benchmark

National benchmark: 1.000

Surgical site infections (SSI) from abdominal hysterectomy

↓ Lower numbers are better

Not available [13](#)

National benchmark: 1.000

Methicillin-resistant Staphylococcus Aureus (MRSA) blood infections

↓ Lower numbers are better

0.000

Better than the national benchmark

National benchmark: 1.000

Clostridium difficile (C.diff.) intestinal infections

↓ Lower numbers are better

0.416

Better than the national benchmark

National benchmark: 1.000

Death rates

Death rates show how often patients die, for any reason, within 30 days of admission to a hospital.

Overall

Death rate for patients (hospital-wide)

3.7%

No different than the national rate

National result: 4.2%

Number of included patients: 1630

By medical condition

Chronic obstructive pulmonary disease (COPD)

Death rate for COPD patients

6.7%

No different than the national rate

National result: 8.8%

Number of included patients: 94

Heart attack

Death rate for heart attack patients

11.1%

No different than the national rate

National result: 12.2%

Number of included patients: 170

Heart failure

Death rate for heart failure patients

10.5%

No different than the national rate

National result: 11.6%

Number of included patients: 370

Pneumonia

Death rate for pneumonia patients

14.8%

No different than the national rate

National result: 16.2%

Number of included patients: 615

Stroke

Death rate for stroke patients

10%

No different than the national rate

National result: 13.3%

Number of included patients: 100

By procedure

Coronary artery bypass graft (CABG)

Death rate for CABG surgery patients

2.9%

No different than the national rate

National result: 2.6%

Number of included patients: 97

Palm Beach Gardens Medical Center

Unplanned hospital visits

Returning to the hospital for unplanned care disrupts patients' lives, increases their risk of harmful events like healthcare-associated infections, and costs more money. Hospitals that give high quality care can keep patients from returning to the hospital and reduce their stay if they have to come back.

[Find out why these measures are important](#)

[Get more information about the data](#)

[Get current data collection period](#)

[Watch a video to learn more about hospital return days](#)

Overall

**Rate of readmission after discharge from hospital
(hospital-wide)**

15.9%

No different than the national rate

National result: 15%

Number of included patients: 2709

By medical condition

Chronic obstructive pulmonary disease (COPD)

**Rate of readmission for chronic obstructive
pulmonary disease (COPD) patients**

19.9%

No different than the national rate

National result: 18.2%

Number of included patients: 108

Heart attack

Rate of readmission for heart attack patients

13.4%

No different than the national rate

National result: 13.6%

Number of included patients: 183

Hospital return days for heart attack patients

-4.9 days

Average days per 100 discharges

National result: Not applicable

Number of included patients: 178

Heart failure

Rate of readmission for heart failure patients

20.7%

No different than the national rate

National result: 19.7%

Number of included patients: 418

Hospital return days for heart failure patients

18 days

More days than average per 100 discharges

National result: Not applicable

Number of included patients: 354

Pneumonia

Rate of readmission for pneumonia patients

16.8%

No different than the national rate

National result: 16%

Number of included patients: 658

Hospital return days for pneumonia patients

37.8 days

More days than average per 100 discharges

National result: Not applicable

Number of included patients: 586

By procedure

Coronary artery bypass graft (CABG) surgery

Rate of readmission for coronary artery bypass graft (CABG) surgery patients

9.8%

No different than the national rate

National result: 10.6%

Number of included patients: 94

Hip/knee replacement

Rate of readmission after hip/knee replacement

5.7%

No different than the national rate

National result: 4.8%

Number of included patients: 63

Colonoscopy

Rate of unplanned hospital visits after an outpatient colonoscopy

12.9 per 1,000 colonoscopies

No different than the national rate

National result: 13 per 1,000 colonoscopies

Chemotherapy

Rate of inpatient admissions for patients receiving outpatient chemotherapy (per 100 chemotherapy patients)

Not available

National result: 10.6%

Rate of emergency department (ED) visits for patients receiving outpatient chemotherapy (per 100 chemotherapy patients)

Not available ⁵

National result: 5.5%

Outpatient surgery

Ratio of unplanned hospital visits after hospital outpatient surgery

0.9

No different than expected

National result: Not applicable

Number of included procedures: 542

Palm Beach Gardens Medical Center

Maternal health

These measures aim to improve maternal health. By providing care during pregnancy that follows best practice...

[Read more](#)

[Find out why these measures are important](#)

[Get more information about the data](#)

[Get current data collection period](#)

Whether a hospital participated in a state or national program aimed at improving maternal and child

health

Not Applicable

Not eligible for a "Birthing-Friendly" designation because this hospital doesn't provide inpatient labor and delivery care



Palm Beach Gardens Medical Center

Patient-reported outcomes

Patient-reported outcomes are reports from patients about aspects of care that matter most to them, like pain...

[Read more](#)

[Find out why these measures are important](#)

[Get more information about the data](#)

[Get current data collection period](#)

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[Read more](#)

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Not available ⁵ of 142

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Florida average: 31.2%

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Palm Beach Gardens Medical Center

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[Read more](#)

Medicare spending per beneficiary

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Services. 7500 Security Boulevard, Baltimore, MD 21244
7500 Security Boulevard, Baltimore, MD 21244

EXHIBIT 46

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

GOOD SAMARITAN MEDICAL	)	
CENTER, INC., et al.,	)	
	)	
Plaintiffs,	)	
	)	
v.	)	
	)	No. 9:25-CV-80526-DMM
THE LEAPFROG GROUP,	)	
	)	
Defendant.	)	

**AMENDED NOTICE OF TAKING IN-PERSON VIDEOTAPED DEPOSITION OF
ERIK CAZARES, INDIVIDUALLY, AND PURSUANT TO RULE 30(b)(6) TO PALM
BEACH GARDENS MEDICAL CENTER**

PLEASE TAKE NOTICE that pursuant to Rules 30 and 30(b)(6), Federal Rules of Civil Procedure, the undersigned for the Defendants will take the deposition of Erik Cazares, individually, and as the Corporate Representative of Palm Beach Gardens Community Hospital, Inc. d/b/a Palm Beach Gardens Medical Center (“Palm Beach”) upon oral examination at the location and on the date indicated:

Deponent Name	Location	Date and Time
Erik Cazares, individually, and as the Corporate Representative of Palm Beach Gardens Medical Center (“Palm Beach”)	ASC Advisors LLC 550 S Andrews Ave, Suite 700 Fort Lauderdale, FL	September 24, 2025 10:30 AM (EST)

The deposition will be taken upon oral examination before Lexitas Legal, Official Court Reporters, or a Notary Public, in and for the State of Florida at Large, or some other officer fully authorized by law to take the deposition. The deposition testimony will be recorded by a stenographer and videotaped by a videographer. The deposition will continue from day to day until

completed. The deposition shall be taken for any and all purposes allowable under the Federal Rules of Civil Procedure.

Date: September 17, 2025

Respectfully submitted,

WILSON ELSEER MOSKOWITZ EDELMAN &
DICKER LLP.

By: /s Jura C. Zibas

Jura C. Zibas, Esq.

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Chicago, IL 60601

312.821.6139 (Direct)

Attorneys for Defendant, The Leapfrog Group

cc: Lexitas

CERTIFICATE OF SERVICE

I HEREBY CERTIFY that on September 17, 2025 a true and correct copy of the foregoing document has been served by mail to the following:

MARCUS NEIMAN RASHBAUM &
PINEIRO LLP

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shvidt@gibsondunn.com

Attorneys for the Plaintiff Hospitals

s/ Kimberly E. Blair

Kimberly E. Blair

EXHIBIT A

DEFINITIONS AND INSTRUCTIONS

The following definitions shall apply to each and every request contained herein:

1. “Complaint” means the Complaint filed by Plaintiffs in the above-captioned matter in the United States District Court for the Southern District of Florida, West Palm Beach Division on or about April 30, 2025. *See generally*, Doc. 1.

2. “You,” “Your,” or “Plaintiff” means Plaintiff, Palm Beach Gardens Community Hospital, Inc. d/b/a Palm Beach Gardens Medical Center, and any of its current or former business and/or creative partners, associates, employees, interns, draftsmen, managers, agents, vendors, servants, representatives, corporate alter egos and all other persons acting or purporting to act with, for, or on his behalf, including but not limited to collaborators, consultants, advisors, attorneys, or any person acting in an advisory or consulting capacity, unless specifically stated otherwise.

3. “Defendant” means defendants, The Leapfrog Group, a not-for-profit corporation incorporated in the District of Columbia.

4. “Parties” means Plaintiffs and Defendant.

5. The terms “and” and “or” shall each be construed broadly and shall each mean “and” or “or” or “and” and “or” wherever such meaning broadens the meaning of the sentence of phrase.

6. “Concerning” means relating to, referring to, reflecting, describing, evidencing, interpreting, consisting of, pertaining to, regarding, or constituting, in whole or in part, directly or indirectly, the matter identified.

7. The terms “relate to,” “relates to,” “relating to,” and “related to” shall mean and include: refer, reflect, discuss, show, constitute or be in any way logically or factually connected

with the matter discussed.

8. “Document” includes all written, graphic matter, handwriting, typewriting, audio or video tape recordings, however produced or reproduced, of every kind and description, including but not limited to, the original and each copy thereof which is non-identical by reason of any mark, change, or other cause or reason whatsoever, of all correspondence, records, reports, memoranda, notes, facsimiles, messages and message books, telephone logs, memoranda of telephone conversations, publications, books, brochures, booklets, manuals, flyers, leaflets, contracts, memoranda of agreement, books of account, ledgers, journals, working papers, records or summaries of personal interviews or conversations, appointment calendars, diaries, receipts, invoices, billing statements, files, tapes, discs, drives, data cards, films, data processing files and all other computer-readable records or programs, including any and all drafts or non-identical copies thereof. Documents in electronic or digital form stored in any format, discs, drives, data, cards, data processing files and other computer-readable records or programs must be produced in reasonably usable form (e.g., by printing or “downloading” such documents onto paper). In addition, all electronic documents must be produced in native electronic format on a DVD or CD or other common, easily- readable storage device. (The word “writing” may be used synonymously herein in place of “document.”)

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10. When used in reference to a person, the term “identify” shall mean to state the full

name and job title of such person and, in the event such person is currently not an employee of Plaintiff, such person's last known residence address and telephone number.

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12. "Safety Grade" or "Hospital Safety Grade" refers to the "letter grade Leapfrog bi-annually assigns to general hospitals in the United States," as described on the Frequently Asked Questions page of Leapfrog's website: <https://www.hospitalsafetygrade.org/frequently-asked-questions>.

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14. "Hospital Survey", "Leapfrog Survey" or "Survey" refers to the biannual survey administered by The Leapfrog Group to collect information on hospital performance as described on the "Leapfrog Hospital Survey" page of Leapfrog's website: <https://www.leapfroggroup.org/data-users/leapfrog-hospital-survey>.

MATTERS FOR EXAMINATION

1. All facts that support the claims raised against Defendant in the Complaint.
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requests for production.

4. Plaintiff's policies and procedures for compliance with Plaintiff's patient safety plans.

5. Plaintiff's policies and procedures for compliance with reporting mandated by the Centers for Medicare and Medicaid Services ("CMS").

6. Plaintiff's policies and procedures for practices to prevent errors, including but not limited to Computerized Physician Order Entry, Bar Code Medication Administration, ICU Physician Staffing, and Hygiene.

7. Facts related to Plaintiff's allegations that Leapfrog is a "Pay-to-Play Scheme."

8. Plaintiff's decisions regarding Your participation in the Leapfrog Survey.

9. Plaintiff's non-participation for measures included in the Methodology and Safety Grades.

10. Plaintiff's formal or informal grievance or complaint process You may have initiated in response to Leapfrog's Safety Grade.

11. Plaintiff's claim in the Complaint related to harm to Your reputation.

12. Plaintiff's claim in the Complaint related to harm to Your goodwill.

13. Facts related to reports Plaintiff received from patients that they decided not to use Palm Beach Gardens Medical Center due to Leapfrog's Safety Grade.

14. Facts related to direct inquiries Plaintiff received from patients regarding their concerns about Leapfrog Safety Grades.

15. Plaintiff's communications with Defendant regarding Leapfrog, the Hospital Survey, and Plaintiff's Safety Grades based on documents produced in response to Leapfrog's requests for production.

16. Facts related to the effects of the Safety Grades and Leapfrog Scoring Methodology on Plaintiff's patient volume and referrals.

17. Facts related to the effects of the Safety Grades and Leapfrog Scoring Methodology on Plaintiff's market growth.

18. Facts related to the effects of the Safety Grades and Leapfrog Scoring Methodology on Plaintiff's patient referrals based on documents produced in response to Leapfrog's requests for production.

19. Facts related to Plaintiff's market share and position relative to Plaintiff's competitors based on documents produced in response to Leapfrog's requests for production.

20. Plaintiff's participation in consumer perception surveys or market research reports concerning how the public views Plaintiff and how it compares to other competing hospitals based on documents produced in response to Leapfrog's requests for production.

21. Plaintiff's involvement or partnership with organizations that evaluate healthcare performance, including but not limited to Vizient, Inc., Premier, Inc., HealthTrust Purchasing Group, HealthGrades, etc based on documents produced in response to Leapfrog's requests for production.

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

GOOD SAMARITAN MEDICAL	)	
CENTER, INC., et al.,	)	
	)	
Plaintiffs,	)	
	)	
v.	)	
	)	No. 9:25-CV-80526-DMM
THE LEAPFROG GROUP,	)	
	)	
Defendant.	)	

**AMENDED NOTICE OF TAKING IN-PERSON VIDEOTAPED DEPOSITION OF
JERAD HANLON, INDIVIDUALLY, AND PURSUANT TO RULE 30(b)(6) TO WEST
BOCA MEDICAL CENTER, INC.**

PLEASE TAKE NOTICE that pursuant to Rules 30 and 30(b)(6), Federal Rules of Civil Procedure, the undersigned for the Defendants will take the deposition of Jerad Hanlon, individually, and as the Corporate Representative of West Boca Medical Center, Inc. (“West Boca”) upon oral examination at the location and on the date indicated:

Deponent Name	Location	Date and Time
Jerad Hanlon, individually, and as the Corporate Representative of West Boca Medical Center, Inc.	Neiman Mays Floch & Almeida PLLC One Financial Plaza 100 SE 3rd Ave #805 Fort Lauderdale, FL 33394	September 23, 2025 9:00 AM (EST)

The deposition will be taken upon oral examination before Lexitas Legal, Official Court Reporters, or a Notary Public, in and for the State of Florida at Large, or some other officer fully authorized by law to take the deposition. The deposition testimony will be recorded by a stenographer and videotaped by a videographer. The deposition will continue from day to day until

completed. The deposition shall be taken for any and all purposes allowable under the Federal Rules of Civil Procedure.

Date: September 17, 2025

Respectfully submitted,

WILSON ELSEER MOSKOWITZ EDELMAN &
DICKER LLP.

By: /s Jura C. Zibas

Jura C. Zibas, Esq.

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312.821.6139 (Direct)

Attorneys for Defendant, The Leapfrog Group

cc: Lexitas

CERTIFICATE OF SERVICE

I HEREBY CERTIFY that on September 17, 2025 a true and correct copy of the foregoing document has been served by mail to the following:

MARCUS NEIMAN RASHBAUM &
PINEIRO LLP

By: /s/ Brandon S. Floch

Jeffrey E. Marcus

Florida Bar No.: 310890

Michael Pineiro

Florida Bar No.: 41897

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Facsimile: 214.571.2900

Email: byang@gibsondunn.com

Email: shvidt@gibsondunn.com

Attorneys for the Plaintiff Hospitals

s/ Kimberly E. Blair

Kimberly E. Blair

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name and job title of such person and, in the event such person is currently not an employee of Plaintiff, such person's last known residence address and telephone number.

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MATTERS FOR EXAMINATION

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8. Plaintiff's decisions regarding Your participation in the Leapfrog Survey.

9. Plaintiff's non-participation for measures included in the Methodology and Safety Grades.

10. Plaintiff's formal or informal grievance or complaint process You may have initiated in response to Leapfrog's Safety Grade.

11. Plaintiff's claim in the Complaint related to harm to Your reputation.

12. Plaintiff's claim in the Complaint related to harm to Your goodwill.

13. Facts related to reports Plaintiff received from patients that they decided not to use West Boca Medical Center, Inc due to Leapfrog's Safety Grade.

14. Facts related to direct inquires Plaintiff received from patients regarding their concerns about Leapfrog Safety Grades.

15. Plaintiff's communications with Defendant regarding Leapfrog, the Hospital Survey, and Plaintiff's Safety Grades based on documents produced in response to Leapfrog's requests for production.

16. Facts related to the effects of the Safety Grades and Leapfrog Scoring Methodology on Plaintiff's patient volume and referrals.

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

GOOD SAMARITAN MEDICAL	)	
CENTER, INC., et al.,	)	
	)	
Plaintiffs,	)	
	)	
v.	)	
	)	No. 9:25-CV-80526-DMM
THE LEAPFROG GROUP,	)	
	)	
Defendant.	)	

**AMENDED NOTICE OF TAKING IN-PERSON VIDEOTAPED DEPOSITION OF
HEATHER HAVERICAK, INDIVIDUALLY, AND PURSUANT TO RULE 30(b)(6) TO
DELRAY MEDICAL CENTER, INC.**

PLEASE TAKE NOTICE that pursuant to Rules 30 and 30(b)(6), Federal Rules of Civil Procedure, the undersigned for the Defendants will take the deposition of Heather Havericak, individually, and as the Corporate Representative of Delray Medical Center, Inc. (“Delray”) upon oral examination at the location and on the date indicated:

Deponent Name	Location	Date and Time
Heather Havericak, individually, and as the Corporate Representative of Delray Medical Center, Inc.	Lexitas c/o Quest Workspace 515 North Flagler Drive Suite 350 West Palm Beach, FL 33401 561-370-7400	September 19, 2025 9:00 AM (EST)

The deposition will be taken upon oral examination before Lexitas Legal, Official Court Reporters, or a Notary Public, in and for the State of Florida at Large, or some other officer fully authorized by law to take the deposition. The deposition testimony will be recorded by a stenographer and videotaped by a videographer. The deposition will continue from day to day until completed. The deposition shall be taken for any and all purposes allowable under the Federal Rules of Civil Procedure.

September 17, 2025

Respectfully submitted,

WILSON ELSER MOSKOWITZ EDELMAN &
DICKER LLP.

By: /s Jura C. Zibas

Jura C. Zibas, Esq.

Florida Bar No.: 124571

2063 Main Street - Suite 100

Sarasota FL 34237

Telephone: 941-866-8561

Fax: 941-210-5979

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Cheryl.Kujawski@wilsonelser.com

Kimberly E. Blair

Kimberly E. Blair (pro hac vice)

kimberly.blair@wilsonelser.com

Illinois Bar ID # 6272934

161 N. Clark, Ste. 4500

Chicago, IL 60601

312.821.6139 (Direct)

Attorneys for Defendant, The Leapfrog Group

cc: Lexitas

CERTIFICATE OF SERVICE

I HEREBY CERTIFY that on September 17, 2025 a true and correct copy of the foregoing document has been served by mail to the following:

MARCUS NEIMAN RASHBAUM &
PINEIRO LLP

By: /s/ Brandon S. Floch

Jeffrey E. Marcus
Florida Bar No.: 310890
Michael Pineiro
Florida Bar No.: 41897
Daniel Rashbaum
Florida Bar No.: 75084
Brandon S. Floch
Florida Bar #
125218 2 South Biscayne Blvd., Ste 2530
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Telephone: 305-400-4268
Facsimile: 954-688-2492
mpineiro@mnrlawfirm.com
drashbaum@mnrlawfirm.com
bfloch@mnrlawfirm.com

GIBSON, DUNN & CRUTCHER LLP

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Attorneys for the Plaintiff Hospitals

s/ Kimberly E. Blair

Kimberly E. Blair

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

GOOD SAMARITAN MEDICAL	)	
CENTER, INC., et al.,	)	
	)	
Plaintiffs,	)	
	)	
v.	)	
	)	No. 9:25-CV-80526-DMM
THE LEAPFROG GROUP,	)	
	)	
Defendant.	)	

**AMENDED NOTICE OF TAKING IN-PERSON VIDEOTAPED DEPOSITION OF
CYNTHIA McCAULEY, INDIVIDUALLY, AND PURSUANT TO RULE 30(b)(6) TO
ST. MARY’S MEDICAL CENTER**

PLEASE TAKE NOTICE that pursuant to Rules 30 and 30(b)(6), Federal Rules of Civil Procedure, the undersigned for the Defendants will take the deposition of Cynthia McCauley, individually, and as the Corporate Representative of St. Mary’s Medical Center (“St. Mary’s”) upon oral examination at the location and on the date indicated:

Deponent Name	Location	Date and Time
Cynthia McCauley, individually, and as the Corporate Representative of St. Mary’s Medical Center	Lexitas c/o Quest Workspace 515 North Flagler Drive Suite 350 West Palm Beach, FL 33401 561-370-7400	September 24, 2025 9:00 AM (EST)

The deposition will be taken upon oral examination before Lexitas Legal, Official Court Reporters, or a Notary Public, in and for the State of Florida at Large, or some other officer fully authorized by law to take the deposition. The deposition testimony will be recorded by a stenographer and videotaped by a videographer. The deposition will continue from day to day until

completed. The deposition shall be taken for any and all purposes allowable under the Federal Rules of Civil Procedure.

Date: September 17, 2025

Respectfully submitted,

WILSON ELSEER MOSKOWITZ EDELMAN &
DICKER LLP.

By: /s Jura C. Zibas

Jura C. Zibas, Esq.

Florida Bar No.: 124571

2063 Main Street - Suite 100

Sarasota FL 34237

Telephone: 941-866-8561

Fax: 941-210-5979

Jura.Zibas@wilsonelser.com

Cheryl.Kujawski@wilsonelser.com

Kimberly E. Blair

Kimberly E. Blair (pro hac vice)

kimberly.blair@wilsonelser.com

Illinois Bar ID # 6272934

161 N. Clark, Ste. 4500

Chicago, IL 60601

312.821.6139 (Direct)

Attorneys for Defendant, The Leapfrog Group

cc:Lexitas

CERTIFICATE OF SERVICE

I HEREBY CERTIFY that on September 17, 2025 a true and correct copy of the foregoing document has been served by mail to the following:

MARCUS NEIMAN RASHBAUM &
PINEIRO LLP

By: /s/ Brandon S. Floch

Jeffrey E. Marcus
Florida Bar No.: 310890
Michael Pineiro
Florida Bar No.: 41897
Daniel Rashbaum
Florida Bar No.: 75084
Brandon S. Floch
Florida Bar #
125218 2 South Biscayne Blvd., Ste 2530
Miami, Florida 33131
Telephone: 305-400-4268
Facsimile: 954-688-2492
mpineiro@mnrlawfirm.com
drashbaum@mnrlawfirm.com
bfloch@mnrlawfirm.com

GIBSON, DUNN & CRUTCHER LLP

Mary Beth Maloney (pro hac vice)
Lee R. Crain (pro hac vice)
200 Park Avenue
New York, NY 10166
Telephone: 212.351.4000
Facsimile: 212.351.4035
Email: mmaloney@gibsondunn.com
Email: lcrain@gibsondunn.com

Betty X. Yang (pro hac vice)
Scott K. Hvidt (pro hac vice)
2001 Ross Avenue, Suite 2100
Dallas, TX 75201
Telephone: 214.698.3100
Facsimile: 214.571.2900
Email: byang@gibsondunn.com
Email: shvidt@gibsondunn.com

Attorneys for the Plaintiff Hospitals

s/ Kimberly E. Blair

Kimberly E. Blair

EXHIBIT A

DEFINITIONS AND INSTRUCTIONS

The following definitions shall apply to each and every request contained herein:

1. “Complaint” means the Complaint filed by Plaintiffs in the above-captioned matter in the United States District Court for the Southern District of Florida, West Palm Beach Division on or about April 30, 2025. *See generally*, Doc. 1.

2. “You,” “Your,” or “Plaintiff” means Plaintiff, St. Mary’s Medical Center, and any of its current or former business and/or creative partners, associates, employees, interns, draftsmen, managers, agents, vendors, servants, representatives, corporate alter egos and all other persons acting or purporting to act with, for, or on his behalf, including but not limited to collaborators, consultants, advisors, attorneys, or any person acting in an advisory or consulting capacity, unless specifically stated otherwise.

3. “Defendant” means defendants, The Leapfrog Group, a not-for-profit corporation incorporated in the District of Columbia.

4. “Parties” means Plaintiffs and Defendant.

5. The terms “and” and “or” shall each be construed broadly and shall each mean “and” or “or” or “and” and “or” wherever such meaning broadens the meaning of the sentence of phrase.

6. “Concerning” means relating to, referring to, reflecting, describing, evidencing, interpreting, consisting of, pertaining to, regarding, or constituting, in whole or in part, directly or indirectly, the matter identified.

7. The terms “relate to,” “relates to,” “relating to,” and “related to” shall mean and include: refer, reflect, discuss, show, constitute or be in any way logically or factually connected

with the matter discussed.

8. “Document” includes all written, graphic matter, handwriting, typewriting, audio or video tape recordings, however produced or reproduced, of every kind and description, including but not limited to, the original and each copy thereof which is non-identical by reason of any mark, change, or other cause or reason whatsoever, of all correspondence, records, reports, memoranda, notes, facsimiles, messages and message books, telephone logs, memoranda of telephone conversations, publications, books, brochures, booklets, manuals, flyers, leaflets, contracts, memoranda of agreement, books of account, ledgers, journals, working papers, records or summaries of personal interviews or conversations, appointment calendars, diaries, receipts, invoices, billing statements, files, tapes, discs, drives, data cards, films, data processing files and all other computer-readable records or programs, including any and all drafts or non-identical copies thereof. Documents in electronic or digital form stored in any format, discs, drives, data, cards, data processing files and other computer-readable records or programs must be produced in reasonably usable form (e.g., by printing or “downloading” such documents onto paper). In addition, all electronic documents must be produced in native electronic format on a DVD or CD or other common, easily- readable storage device. (The word “writing” may be used synonymously herein in place of “document.”)

9. “Communication” means any and all oral or written contact between two or more persons including, without limitation, any meetings, conferences, face-to-face conversations, telephone, teleconference, video conference, voice mail, audio recording, video recording, mails, electronic transmissions, electronic mail (email), text messaging, instant messaging (IM), facsimile or any other forms of oral or written communications by any other medium.

10. When used in reference to a person, the term “identify” shall mean to state the full

name and job title of such person and, in the event such person is currently not an employee of Plaintiff, such person's last known residence address and telephone number.

11. When used in reference to a Document, the term "identify" shall mean to state the date the Document bears, if any, its author(s), location, and a brief description of its form (e.g., memorandum, e-mail, letter, etc.) and contents, as well as the identity of the person(s) known to have possession, custody, or control over the Document.

12. "Safety Grade" or "Hospital Safety Grade" refers to the "letter grade Leapfrog bi-annually assigns to general hospitals in the United States," as described on the Frequently Asked Questions page of Leapfrog's website: <https://www.hospitalsafetygrade.org/frequently-asked-questions>.

13. "Scoring Methodology" or "Methodology" refers to the measures, data, and scoring Leapfrog uses to assign Hospital Safety Grades, as described on Leapfrog's website: <https://www.hospitalsafetygrade.org/media/file/Safety-Grade-Scoring-Methodology-Fall-2024.pdf>.

14. "Hospital Survey", "Leapfrog Survey" or "Survey" refers to the biannual survey administered by The Leapfrog Group to collect information on hospital performance as described on the "Leapfrog Hospital Survey" page of Leapfrog's website: <https://www.leapfroggroup.org/data-users/leapfrog-hospital-survey>.

MATTERS FOR EXAMINATION

1. All facts that support the claims raised against Defendant in the Complaint.
2. Plaintiff's initial disclosures served in the above-styled action.
3. Plaintiff's responses to Defendant's discovery requests, including responses to interrogatories and general document collection efforts for preparing responses to Leapfrog's

requests for production.

4. Plaintiff's policies and procedures for compliance with Plaintiff's patient safety plans.

5. Plaintiff's policies and procedures for compliance with reporting mandated by the Centers for Medicare and Medicaid Services ("CMS").

6. Plaintiff's policies and procedures for practices to prevent errors, including but not limited to Computerized Physician Order Entry, Bar Code Medication Administration, ICU Physician Staffing, and Hygiene.

7. Facts related to Plaintiff's allegations that Leapfrog is a "Pay-to-Play Scheme."

8. Plaintiff's decisions regarding Your participation in the Leapfrog Survey.

9. Plaintiff's non-participation for measures included in the Methodology and Safety Grades.

10. Plaintiff's formal or informal grievance or complaint process You may have initiated in response to Leapfrog's Safety Grade.

11. Plaintiff's claim in the Complaint related to harm to Your reputation.

12. Plaintiff's claim in the Complaint related to harm to Your goodwill.

13. Facts related to reports Plaintiff received from patients that they decided not to use St. Mary's Medical Center due to Leapfrog's Safety Grade.

14. Facts related to direct inquiries Plaintiff received from patients regarding their concerns about Leapfrog Safety Grades.

15. Plaintiff's communications with Defendant regarding Leapfrog, the Hospital Survey, and Plaintiff's Safety Grades based on documents produced in response to Leapfrog's requests for production.

16. Facts related to the effects of the Safety Grades and Leapfrog Scoring Methodology on Plaintiff's patient volume and referrals.

17. Facts related to the effects of the Safety Grades and Leapfrog Scoring Methodology on Plaintiff's market growth.

18. Facts related to the effects of the Safety Grades and Leapfrog Scoring Methodology on Plaintiff's patient referrals based on documents produced in response to Leapfrog's requests for production.

19. Facts related to Plaintiff's market share and position relative to Plaintiff's competitors based on documents produced in response to Leapfrog's requests for production.

20. Plaintiff's participation in consumer perception surveys or market research reports concerning how the public views Plaintiff and how it compares to other competing hospitals based on documents produced in response to Leapfrog's requests for production.

21. Plaintiff's involvement or partnership with organizations that evaluate healthcare performance, including but not limited to Vizient, Inc., Premier, Inc., HealthTrust Purchasing Group, HealthGrades, etc based on documents produced in response to Leapfrog's requests for production.

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

GOOD SAMARITAN MEDICAL	)	
CENTER, INC., et al.,	)	
	)	
Plaintiffs,	)	
	)	
v.	)	
	)	No. 9:25-CV-80526-DMM
THE LEAPFROG GROUP,	)	
	)	
Defendant.	)	

**AMENDED NOTICE OF TAKING IN-PERSON VIDEOTAPED DEPOSITION OF
SHERI MONTGOMERY, INDIVIDUALLY, AND PURSUANT TO RULE 30(b)(6) TO
GOOD SAMARITAN MEDICAL CENTER, INC.**

PLEASE TAKE NOTICE that pursuant to Rules 30 and 30(b)(6), Federal Rules of Civil Procedure, the undersigned for the Defendants will take the deposition of Sheri Montgomery, individually, and as the Corporate Representative of Good Samaritan Medical Center, Inc. (“Good Samaritan”) upon oral examination at the location and on the date indicated:

Deponent Name	Location	Date and Time
Sheri Montgomery, individually, and as the Corporate Representative of Good Samaritan Medical Center, Inc.	Wilson, Elser, Edelman & Dicker, LLP 515 North Flagler Drive, Suite 350 West Palm Beach, FL 33401 Tel: 312.821.6139 Fax: 312.704.1522	September 15, 2025 9:00 AM

The deposition will be taken upon oral examination before Lexitas Legal, Official Court Reporters, or a Notary Public, in and for the State of Florida at Large, or some other officer fully authorized by law to take the deposition. The deposition testimony will be recorded by a stenographer and videotaped by a videographer. The deposition will continue from day to day until

completed. The deposition shall be taken for any and all purposes allowable under the Federal Rules of Civil Procedure.

Date: September 14, 2025

Respectfully submitted,

WILSON ELSEER MOSKOWITZ EDELMAN &
DICKER LLP.

By: /s Jura C. Zibas

Jura C. Zibas, Esq.

Florida Bar No.: 124571

2063 Main Street - Suite 100

Sarasota FL 34237

Telephone: 941-866-8561

Fax: 941-210-5979

Jura.Zibas@wilsonelser.com

Cheryl.Kujawski@wilsonelser.com

Kimberly E. Blair

Kimberly E. Blair (pro hac vice)

kimberly.blair@wilsonelser.com

Illinois Bar ID # 6272934

161 N. Clark, Ste. 4500

Chicago, IL 60601

312.821.6139 (Direct)

Attorneys for Defendant, The Leapfrog Group

cc: Lexitas

CERTIFICATE OF SERVICE

I HEREBY CERTIFY that on September 14, 2025 a true and correct copy of the foregoing document has been served by mail to the following:

MARCUS NEIMAN RASHBAUM &
PINEIRO LLP

By: /s/ Brandon S. Floch

Jeffrey E. Marcus
Florida Bar No.: 310890
Michael Pineiro
Florida Bar No.: 41897
Daniel Rashbaum
Florida Bar No.: 75084
Brandon S. Floch
Florida Bar #
125218 2 South Biscayne Blvd., Ste 2530
Miami, Florida 33131
Telephone: 305-400-4268
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mpineiro@mnrlawfirm.com
drashbaum@mnrlawfirm.com
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GIBSON, DUNN & CRUTCHER LLP

Mary Beth Maloney (pro hac vice)
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200 Park Avenue
New York, NY 10166
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Email: lcrain@gibsondunn.com

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2001 Ross Avenue, Suite 2100
Dallas, TX 75201
Telephone: 214.698.3100
Facsimile: 214.571.2900
Email: byang@gibsondunn.com
Email: shvidt@gibsondunn.com

Attorneys for the Plaintiff Hospitals

s/ Kimberly E. Blair

Kimberly E. Blair

EXHIBIT A

DEFINITIONS AND INSTRUCTIONS

The following definitions shall apply to each and every request contained herein:

1. “Complaint” means the Complaint filed by Plaintiffs in the above-captioned matter in the United States District Court for the Southern District of Florida, West Palm Beach Division on or about April 30, 2025. *See generally*, Doc. 1.

2. “You,” “Your,” or “Plaintiff” means Plaintiff, Good Samaritan Medical Center, Inc., and any of its current or former business and/or creative partners, associates, employees, interns, draftsmen, managers, agents, vendors, servants, representatives, corporate alter egos and all other persons acting or purporting to act with, for, or on his behalf, including but not limited to collaborators, consultants, advisors, attorneys, or any person acting in an advisory or consulting capacity, unless specifically stated otherwise.

3. “Defendant” means defendants, The Leapfrog Group, a not-for-profit corporation incorporated in the District of Columbia.

4. “Parties” means Plaintiffs and Defendant.

5. The terms “and” and “or” shall each be construed broadly and shall each mean “and” or “or” or “and” and “or” wherever such meaning broadens the meaning of the sentence of phrase.

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9. “Communication” means any and all oral or written contact between two or more persons including, without limitation, any meetings, conferences, face-to-face conversations, telephone, teleconference, video conference, voice mail, audio recording, video recording, mails, electronic transmissions, electronic mail (email), text messaging, instant messaging (IM), facsimile or any other forms of oral or written communications by any other medium.

10. When used in reference to a person, the term “identify” shall mean to state the full

name and job title of such person and, in the event such person is currently not an employee of Plaintiff, such person's last known residence address and telephone number.

11. When used in reference to a Document, the term "identify" shall mean to state the date the Document bears, if any, its author(s), location, and a brief description of its form (e.g., memorandum, e-mail, letter, etc.) and contents, as well as the identity of the person(s) known to have possession, custody, or control over the Document.

12. "Safety Grade" or "Hospital Safety Grade" refers to the "letter grade Leapfrog bi-annually assigns to general hospitals in the United States," as described on the Frequently Asked Questions page of Leapfrog's website: <https://www.hospitalsafetygrade.org/frequently-asked-questions>.

13. "Scoring Methodology" or "Methodology" refers to the measures, data, and scoring Leapfrog uses to assign Hospital Safety Grades, as described on Leapfrog's website: <https://www.hospitalsafetygrade.org/media/file/Safety-Grade-Scoring-Methodology-Fall-2024.pdf>.

14. "Hospital Survey", "Leapfrog Survey" or "Survey" refers to the biannual survey administered by The Leapfrog Group to collect information on hospital performance as described on the "Leapfrog Hospital Survey" page of Leapfrog's website: <https://www.leapfroggroup.org/data-users/leapfrog-hospital-survey>.

MATTERS FOR EXAMINATION

1. All facts that support the claims raised against Defendant in the Complaint.
2. Plaintiff's initial disclosures served in the above-styled action.
3. Plaintiff's responses to Defendant's discovery requests, including responses to interrogatories and general document collection efforts for preparing responses to Leapfrog's

requests for production.

4. Plaintiff's policies and procedures for compliance with Plaintiff's patient safety plans.

5. Plaintiff's policies and procedures for compliance with reporting mandated by the Centers for Medicare and Medicaid Services ("CMS").

6. Plaintiff's policies and procedures for practices to prevent errors, including but not limited to Computerized Physician Order Entry, Bar Code Medication Administration, ICU Physician Staffing, and Hygiene.

7. Facts related to Plaintiff's allegations that Leapfrog is a "Pay-to-Play Scheme."

8. Plaintiff's decisions regarding Your participation in the Leapfrog Survey.

9. Plaintiff's non-participation for measures included in the Methodology and Safety Grades.

10. Plaintiff's non-participation in completing the Leapfrog survey which is used to generate Safety Grades for Plaintiff's Hospital.

11. Plaintiff's formal or informal grievance or complaint process You may have initiated in response to Leapfrog's Safety Grade.

12. Plaintiff's claim for damages in the Complaint related to harm to Your reputation.

13. Plaintiff's claim for damages in the Complaint related to harm to Your goodwill.

14. Facts related to reports Plaintiff received from patients that they decided not to use Palm Beach Gardens Medical Center due to Leapfrog's Safety Grade.

15. Facts related to direct inquiries Plaintiff received from patients regarding their concerns about Leapfrog Safety Grades.

16. Plaintiff's communications with Defendant regarding Leapfrog, the Hospital

Survey, and Plaintiff's Safety Grades based on documents produced in response to Leapfrog's requests for production.

17. Facts related to the effects of the Safety Grades and Leapfrog Scoring Methodology on Plaintiff's patient volume and referrals.

18. Facts related to the effects of the Safety Grades and Leapfrog Scoring Methodology on Plaintiff's market growth.

19. Facts related to the effects of the Safety Grades and Leapfrog Scoring Methodology on Plaintiff's patient referrals based on documents produced in response to Leapfrog's requests for production.

20. Facts related to Plaintiff's market share and position relative to Plaintiff's competitors based on documents produced in response to Leapfrog's requests for production.

21. Plaintiff's participation in consumer perception surveys or market research reports concerning how the public views Plaintiff and how it compares to other competing hospitals based on documents produced in response to Leapfrog's requests for production.

22. Plaintiff's involvement or partnership with organizations that evaluate healthcare performance, including but not limited to Vizient, Inc., Premier, Inc., HealthTrust Purchasing Group, HealthGrades, etc based on documents produced in response to Leapfrog's requests for production.

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

GOOD SAMARITAN MEDICAL	)	
CENTER, INC., et al.,	)	
	)	
Plaintiffs,	)	
	)	
v.	)	
	)	No. 9:25-CV-80526-DMM
THE LEAPFROG GROUP,	)	
	)	
Defendant.	)	

**AMENDED NOTICE OF TAKING IN-PERSON VIDEOTAPED DEPOSITION OF
REGINA WEST, INDIVIDUALLY, AND PURSUANT TO RULE 30(b)(6) TO PALM
BEACH HEALTH NETWORK**

PLEASE TAKE NOTICE that pursuant to Rules 30 and 30(b)(6), Federal Rules of Civil Procedure, the undersigned for the Defendants will take the deposition of Regina West, individually, and as the Market Quality Director of Palm Beach Health Network (“Palm Beach”), upon oral examination at the location and on the date indicated:

Deponent Name	Location	Date and Time
Regina West, individually, and as the Market Quality Director of Palm Beach Health Network	Lexitas c/o Quest Workspace 515 North Flagler Drive Suite 350 West Palm Beach, FL 33401 561-370-7400	September 25, 2025 9:00 A.M (EST)

The deposition will be taken upon oral examination before Lexitas Legal, Official Court Reporters, or a Notary Public, in and for the State of Florida at Large, or some other officer fully authorized by law to take the deposition. The deposition testimony will be recorded by a stenographer and videotaped by a videographer. The deposition will continue from day to day until

completed. The deposition shall be taken for any and all purposes allowable under the Federal Rules of Civil Procedure.

Date: September 17, 2025

Respectfully submitted,

WILSON ELSEER MOSKOWITZ EDELMAN &
DICKER LLP.

By: /s Jura C. Zibas

Jura C. Zibas, Esq.

Florida Bar No.: 124571

2063 Main Street - Suite 100

Sarasota FL 34237

Telephone: 941-866-8561

Fax: 941-210-5979

Jura.Zibas@wilsonelser.com

Cheryl.Kujawski@wilsonelser.com

Kimberly E. Blair

Kimberly E. Blair (pro hac vice)

kimberly.blair@wilsonelser.com

Illinois Bar ID # 6272934

161 N. Clark, Ste. 4500

Chicago, IL 60601

312.821.6139 (Direct)

Attorneys for Defendant, The Leapfrog Group

Cc: Lexitas

CERTIFICATE OF SERVICE

I HEREBY CERTIFY that on September 17, 2025 a true and correct copy of the foregoing document has been served by mail to the following:

MARCUS NEIMAN RASHBAUM &
PINEIRO LLP

By: /s/ Brandon S. Floch

Jeffrey E. Marcus
Florida Bar No.: 310890
Michael Pineiro
Florida Bar No.: 41897
Daniel Rashbaum
Florida Bar No.: 75084
Brandon S. Floch
Florida Bar #
125218 2 South Biscayne Blvd., Ste 2530
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GIBSON, DUNN & CRUTCHER LLP

Mary Beth Maloney (pro hac vice)
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200 Park Avenue
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Betty X. Yang (pro hac vice)
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Telephone: 214.698.3100
Facsimile: 214.571.2900
Email: byang@gibsondunn.com
Email: shvidt@gibsondunn.com

Attorneys for the Plaintiff Hospitals

s/ Kimberly E. Blair

Kimberly E. Blair

EXHIBIT A

DEFINITIONS AND INSTRUCTIONS

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1. “Complaint” means the Complaint filed by Plaintiffs in the above-captioned matter in the United States District Court for the Southern District of Florida, West Palm Beach Division on or about April 30, 2025. *See generally*, Doc. 1.

2. “You,” “Your,” or “Plaintiff” means Plaintiff, Palm Beach Health Network, and any of its current or former business and/or creative partners, associates, employees, interns, draftsmen, managers, agents, vendors, servants, representatives, corporate alter egos and all other persons acting or purporting to act with, for, or on his behalf, including but not limited to collaborators, consultants, advisors, attorneys, or any person acting in an advisory or consulting capacity, unless specifically stated otherwise.

3. “Defendant” means defendants, The Leapfrog Group, a not-for-profit corporation incorporated in the District of Columbia.

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9. “Communication” means any and all oral or written contact between two or more persons including, without limitation, any meetings, conferences, face-to-face conversations, telephone, teleconference, video conference, voice mail, audio recording, video recording, mails, electronic transmissions, electronic mail (email), text messaging, instant messaging (IM), facsimile or any other forms of oral or written communications by any other medium.

10. When used in reference to a person, the term “identify” shall mean to state the full

name and job title of such person and, in the event such person is currently not an employee of Plaintiff, such person's last known residence address and telephone number.

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MATTERS FOR EXAMINATION

1. All facts that support the claims raised against Defendant in the Complaint.
2. Plaintiff's initial disclosures served in the above-styled action.
3. Plaintiff's responses to Defendant's discovery requests, including responses to interrogatories and general document collection efforts for preparing responses to Leapfrog's

requests for production.

4. Plaintiff's policies and procedures for compliance with Plaintiff's patient safety plans.

5. Plaintiff's policies and procedures for compliance with reporting mandated by the Centers for Medicare and Medicaid Services ("CMS").

6. Plaintiff's policies and procedures for practices to prevent errors, including but not limited to Computerized Physician Order Entry, Bar Code Medication Administration, ICU Physician Staffing, and Hygiene.

7. Facts related to Plaintiff's allegations that Leapfrog is a "Pay-to-Play Scheme."

8. Plaintiff's decisions regarding Your participation in the Leapfrog Survey.

9. Plaintiff's non-participation for measures included in the Methodology and Safety Grades.

10. Plaintiff's formal or informal grievance or complaint process You may have initiated in response to Leapfrog's Safety Grade.

11. Plaintiff's claim in the Complaint related to harm to Your reputation.

12. Plaintiff's claim in the Complaint related to harm to Your goodwill.

13. Facts related to reports Plaintiff received from patients that they decided not to use Palm Beach Gardens Medical Center due to Leapfrog's Safety Grade.

14. Facts related to direct inquiries Plaintiff received from patients regarding their concerns about Leapfrog Safety Grades.

15. Plaintiff's communications with Defendant regarding Leapfrog, the Hospital Survey, and Plaintiff's Safety Grades based on documents produced in response to Leapfrog's requests for production.

16. Facts related to the effects of the Safety Grades and Leapfrog Scoring Methodology on Plaintiff's patient volume and referrals.

17. Facts related to the effects of the Safety Grades and Leapfrog Scoring Methodology on Plaintiff's market growth.

18. Facts related to the effects of the Safety Grades and Leapfrog Scoring Methodology on Plaintiff's patient referrals based on documents produced in response to Leapfrog's requests for production.

19. Facts related to Plaintiff's market share and position relative to Plaintiff's competitors based on documents produced in response to Leapfrog's requests for production.

20. Plaintiff's participation in consumer perception surveys or market research reports concerning how the public views Plaintiff and how it compares to other competing hospitals based on documents produced in response to Leapfrog's requests for production.

21. Plaintiff's involvement or partnership with organizations that evaluate healthcare performance, including but not limited to Vizient, Inc., Premier, Inc., HealthTrust Purchasing Group, HealthGrades, etc based on documents produced in response to Leapfrog's requests for production.

EXHIBIT 47

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

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

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

Plaintiffs,

v.

THE LEAPFROG GROUP,

Defendant.

PLAINTIFFS' WITNESS LIST

Pursuant to FRCP 26(a)(2) and Paragraph 10 of the Court's scheduling order (Dkt 36), Plaintiffs Good Samaritan Medical Center, Inc., Delray Medical Center, Inc., Palm Beach Gardens Community Hospital, Inc. d/b/a Palm Beach Gardens Medical Center, St. Mary's Medical Center, Inc., and West Boca Medical Center, Inc. (collectively, "Plaintiffs"), by and through their undersigned counsel, hereby provides the names and addresses of all witnesses that Plaintiffs currently intend to call at trial.

The list below is provided based on the information currently available to Plaintiffs, and Plaintiffs are not certifying that each of the below witnesses will actually be called to testify live at trial. Rather, the list below includes all witnesses whom Plaintiffs may or will call at trial, and Plaintiffs may present their respective testimony either live or by deposition. Plaintiffs reserve their right to supplement, amend, or modify this witness in connection with outstanding or forthcoming discovery, in response to disclosures made by Defendant The Leapfrog Group ("Defendant"), and/or rulings by the Court.

Plaintiffs reserve their right to call as witnesses Defendant and its authorized representatives. Plaintiffs further reserve the right to call as witnesses any person identified in Defendant's witness list. Plaintiffs further reserve the right to call witnesses for purposes of rebuttal or impeachment. Subject to and without waiving the foregoing rights and objections, Plaintiffs provide the following witness list:

	Witness	Address
1.	Dr. Matt Austin	c/o Zuckerman Spaeder LLP. 100 East Pratt Street, Ste. 2440 Baltimore, MD 21202-1031
2.	Lauren Bailey	c/o Wilson Elser Moskowitz Edelman & Dicker LLP 161 N. Clark, Ste. 4500 Chicago, IL 60601
3.	Kush Banerjee	c/o Wilson Elser Moskowitz Edelman & Dicker LLP 161 N. Clark, Ste. 4500 Chicago, IL 60601
4.	Dr. Jonah Berger	c/o Gibson, Dunn & Crutcher LLP 200 Park Avenue New York, NY 10166
5.	Leah Binder	c/o Wilson Elser Moskowitz Edelman & Dicker LLP 161 N. Clark, Ste. 4500 Chicago, IL 60601
6.	Alexandra Campione	c/o Wilson Elser Moskowitz Edelman & Dicker LLP 161 N. Clark, Ste. 4500 Chicago, IL 60601
7.	Erik Cazares	c/o Gibson, Dunn & Crutcher LLP 200 Park Avenue New York, NY 10166
8.	Thomas Chakurda	c/o Gibson, Dunn & Crutcher LLP 200 Park Avenue New York, NY 10166
9.	Lisa Cook	c/o Gibson, Dunn & Crutcher LLP 200 Park Avenue New York, NY 10166
10.	Missy Danforth	c/o Wilson Elser Moskowitz Edelman & Dicker LLP 161 N. Clark, Ste. 4500 Chicago, IL 60601

	Witness	Address
11.	Jerad Hanlon	c/o Gibson, Dunn & Crutcher LLP 200 Park Avenue New York, NY 10166
12.	Heather Havericak	c/o Gibson, Dunn & Crutcher LLP 200 Park Avenue New York, NY 10166
13.	Karen Jupiter	c/o Wilson Elser Moskowitz Edelman & Dicker LLP 161 N. Clark, Ste. 4500 Chicago, IL 60601
14.	Cynthia McCauley	c/o Gibson, Dunn & Crutcher LLP 200 Park Avenue New York, NY 10166
15.	Sheri Montgomery	c/o Gibson, Dunn & Crutcher LLP 200 Park Avenue New York, NY 10166
16.	Dr. Sean Nicholson	c/o Gibson, Dunn & Crutcher LLP 200 Park Avenue New York, NY 10166
17.	Dr. Patrick Romano	c/o Wilson Elser Moskowitz Edelman & Dicker LLP 161 N. Clark, Ste. 4500 Chicago, IL 60601
18.	Dr. Karen van Caulil	c/o Wilson Elser Moskowitz Edelman & Dicker LLP 161 N. Clark, Ste. 4500 Chicago, IL 60601

Plaintiffs will provide an updated witness list in due course prior to trial, as required by Local Rule 16.1(e)(10).

Dated: October 2, 2025

Respectfully submitted,

By: /s/ Michael Pineiro

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MEYERS LLP

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Michael Pineiro, Bar # 41897
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NEIMAN MAYS FLOCH & ALMEIDA
PLLC

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Attorneys for Good Samaritan Medical Center, Inc., Delray Medical Center, Inc., Palm Beach Gardens Community Hospital, Inc. d/b/a Palm Beach Gardens Medical Center, St. Mary's Medical Center, Inc., and West Boca Medical Center, Inc.

CERTIFICATE OF SERVICE

I hereby certify that on October 2, 2025, I caused the foregoing to be served via email on counsel for Defendant.

/s/ Michael Pineiro
Michael Pineiro

EXHIBIT 48

Awards & Distinctions

Delray Medical Center

- Recipient of the Healthgrades® America's 50 Best Hospitals Award for 14 years in a row (2007-2020)
- Recipient of the Healthgrades® Patient Safety Excellence Award (2018-2021)



Cardiac and Vascular

- Healthgrades Five Star Recipient for Valve Surgery in 2021
- Healthgrades® Five-Star Recipient for Treatment of Heart Failure for 19 Years in a Row (2003-2022)
- Healthgrades® Five-Star Recipient for Treatment of Heart Attack in 2020
- Recipient of U.S. News & World Report High Performing Hospitals 2019-20 for Heart Failure
- TCAR Center of Excellence for 3 years in a row (2018-2020)
- TCAR Clinical Operator of Experience (2020)



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Critical Care

- Healthgrades Five-Star Recipient for Treatment of Sepsis for 18 years in a row (2004-2022)
- Healthgrades Five-Star Recipient for Treatment of Respiratory Failure for 7 years in a row (2015-2022)



Gastrointestinal

- Healthgrades Five-Star Recipient for Small Intestine Surgeries for 5 years in a row (2017-2021)
- Healthgrades Five-Star Recipient for Colorectal Surgeries for 4 years in a row (2018-2022)
- Healthgrades Five-Star Recipient for Esophageal/Stomach Surgeries for 2 years in a row (2020-2021)
- Healthgrades Five-Star Recipient for Gastrointestinal Surgery



Pulmonary

- Recipient of U.S. News & World Report High Performing Hospitals 2019-2022 for COPD



Neuroscience/Stroke

- Joint Commission Thrombectomy-Capable Stroke Center Certification
- Named Among the Top 5% in the Nation for Treatment of Stroke by Healthgrades (2022)
- Named Among the Top 10% in the Nation for Neurosciences by Healthgrades® (2022)
- American Heart Association Get With The Guidelines® – Stroke Gold Plus Award
- Recipient of the Healthgrades® Neurosciences Excellence Award™ (2021)
- Recipient of the Healthgrades® Stroke Care Excellence Award™ for 12 years in a row (2010–2022)
- Healthgrades® Five-Star Recipient for Treatment of Stroke for 14 years in a row (2008–2022)
- DNV GL Healthcare Certified Comprehensive Stroke Center (2020)



Weight Loss

- Bariatric Surgery Center of Excellence
- Optum/United Healthcare Bariatric Center of Excellence



Good Samaritan Medical Center



Bariatric and Weight Loss Care

- Accredited as a Comprehensive Center by the Metabolic and Bariatric Surgery Accreditation and Quality Improvement Program (MBSAQIP®), a joint Quality Program of the American College of Surgeons (ACS) and the American Society for Metabolic and Bariatric Surgery (ASMBS).

[Financial Resources](#)[Bill Pay](#)[Find an ER](#)

Designated
BlueDistinction[®]
Center
Bariatric Surgery

Breast Care

- The Norma E. & Miles M. Zisson Comprehensive Breast Center of the Palm Beaches at Good Samaritan Medical Center is designated by the American College of Surgeons as a National Accreditation Program for Breast Centers (NAPBC) for 13 Years in a Row
- Designated Breast Imaging Center of Excellence by the American College of Radiology (ACR)
- Recognized as a Center of Excellence for Hidden Scar Breast Cancer Surgery™



Cancer Care

- The Cancer Care of Palm Beach at Good Samaritan Medical Center is accredited by the Commission on Cancer (CoC) of the American College of Surgeons
- Designated Lung Cancer Screening Clinic by the American College of Radiology (ACR)



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Commission on Cancer
American College of Surgeons



Cardiovascular Care

- Healthgrades Five-Star for Treatment of Heart Failure (2023)
- Healthgrades Five-Star for Treatment of Heart Failure (2022)



five-

star_treatment_of_heart_failure_2021

Gastrointestinal Care

- Healthgrades Five-Star for Treatment of GI Bleed Medallion (2024)
- Healthgrades Five-Stat for Colorectal Surgeries (2021)



Imaging

- Accredited Imaging facility by the American College of Radiology in Breast Ultrasound, CT, Mammography, MRI, Nuclear Medicine & PET, Stereotactic Breast Biopsy, and Ultrasound



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Labor & Delivery

- Healthgrades Five-Star for C-Section Delivery for two years in a row (2022-2023)
- Healthgrades Five-Star for Vaginal Delivery for nine years in a row (2014-2023)



Orthopedics

- Designated as a Blue Distinction® Center for Knee and Hip Replacement by BlueCross BlueShield
- The Joint Commission's Gold Seal of Approval® for Total Hip and Knee Replacement, Shoulder Replacement and Spine Surgery certifications by

Financial Resources

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- Recipient of the Healthgrades 2025 Outpatient Orthopedic Excellence Award
- Named Among the Top 10% in the Nation for Spine Surgery in 2025
- Five-Star Recipient for Spinal Fusion Surgery in 2025
- Five-Star Recipient for Outpatient Back and Neck Surgery in 2025
- Designated as an Aetna Institute of Quality Orthopedic Facility for Total Joint Replacement and Spine Surgery (2025)



Neuroscience/Stroke

- American Heart Association Get With The Guidelines® – Stroke Gold Plus Award (2025)
- Healthgrades Five-Star for Treatment of Stroke (2021)

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Palm Beach Gardens Medical Center

Cardiovascular Care

- 2025 Five-Star Recipient for Valve Surgery by Healthgrades
- Five-Star Recipient for Treatment of Heart Failure by Healthgrades for 3 Years in a Row (2023-2025)
- Five-Star Recipient for Carotid Procedures by Healthgrades for 3 Years in a Row (2023-2025)
- 2023 Cardiac Surgery Excellence Award™ recipient by Healthgrades
- Named Among the Top 10% in the Nation for Cardiac Surgery in 2023 by Healthgrades
- 2023 Five-Star Recipient for Valve Surgery by Healthgrades
- High Performance in Heart Attack in U.S. News & World Report's 2022-2023 Best Hospitals
- High Performance in Heart Failure in U.S. News & World Report's 2022-2023 Best Hospitals



Pulmonary Care

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- Named Among the Top 10% in the Nation for Pulmonary Care in 2024 by Healthgrades
- Five-Star Recipient for Treatment of Pneumonia for 3 Years in a Row (2023-2025)
- 2024 Five Star Recipient for Treatment of Chronic Obstructive Pulmonary Disease by Healthgrades
- High Performance in the Treatment of Chronic Obstructive Pulmonary Disease (COPD) in U.S. News & World Report's 2020-2023 Best Hospitals
- American Association of Cardiovascular and Pulmonary Rehabilitation (AACVPR) Certified Program (2014-2025)



Orthopedic Care

- The Joint Commission's Gold Seal of Approval® for Hip and Knee Replacement
- Blue Distinction® Center+ Designation for Quality and Cost-Efficiency in Knee and Hip Replacement Surgeries by Blue Cross and Blue Shield
- Aetna Institute of Quality Orthopedic Facility for Total Joint Replacement and Spine Surgery
- 2023 Five-Star Recipient for Back and Neck Surgery by Healthgrades



Neuroscience Care

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- American Heart Association Get with the Guidelines® – Stroke Gold Plus Quality Achievement Award with Target: Type 2 Diabetes Honor Roll (2022-2024)
- High Performance in the Treatment of Stroke in U.S. News & World Report's 2021-2023 Best Hospitals



Gastrointestinal Care

- 2025 Five-Star Recipient for Colorectal Surgeries by Healthgrades
- 2024 Five-Star Recipient for Treatment of GI Bleed by Healthgrades



Critical Care

- Five-Star Recipient for Treatment of Respiratory Failure for 2 Years in a Row (2024-2025)





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Report 2022-2023 Best Hospitals



Palm Beach Children's Hospital



St. Mary's Medical Center



- Joint Commission Accredited Medical Center
- Accreditation Council for Continuing Medical Education: Accredited CME Provider
- Palm Beach Post Community Choice Award – Best Hospital



Neuroscience Care

- Det Norske Veritas (DNV): Comprehensive Stroke Certification
- Get with the Guidelines: Stroke Gold Plus Award 2025 (14th Consecutive Year)
- Get with the Guidelines: Stroke Elite Plus Honor Roll 2025
- Get with the Guidelines: Stroke Advance Therapy Honor Roll 2025

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Critical Care

- Agency for Healthcare Administration: Trauma Level 1 & Level 2

Internal Medicine

- Get with the Guidelines: Type 2 Diabetes Honor Roll 2023

Surgical Care

- American College of Surgeons: Verified Pediatric Surgery Program



Orthopedic Care

- Healthgrades 5 Star: Hip fracture
- Healthgrades 5 Star: Knee Replacement
- Blue Distinction Center+: Knee, Hip Replacements & Spine Surgery
- Joint Commission Accreditation: Total Joint Replacement for Hip and Knee

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Labor & Delivery

- Blue Distinction Center+: Maternity Care
- Healthgrades 5 Star: Vaginal and C-Section
- Palm Beach Post Community Choice Award – Best Maternity / Childbirth Center
- Florida Hospital Association: Excellence in Maternity Care 2022
- Florida Perinatal Quality Consortium: 5 Star Respectful Maternity Care 2024



Imaging

- American College of Radiology: Imaging services certification in all imaging modalities (MRI, CT, Nuclear Medicine, Ultrasound, Mammography)



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Financial Resources Bill Pay Find an ER

- Center for Laboratory Improvement Amendments: Laboratory Services
- The College of American Pathologists: Laboratory Services
- The College of American Pathologists: Respiratory Services

West Boca Medical Center

West Boca Medical has received awards from South Florida Family Life Magazine for a "favorite award" in the following two categories:

- Favorite maternity hospital - Palm Beach
- Favorite pediatric hospital - Palm Beach



Excellence Award 2022, 2023, 2025.



Five Star Recipient of Sepsis for 4 years in a row.



Five Star Recipient for Treatment of Respiratory Failure for 3 years in a row - 2023, 2024, 2025.





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Five Star Recipient for Colorectal Surgeries 2025.



Excellence Award for Gastrointestinal Surgery 2025.



Healthgrades 5-Star Recipient for C-Section and Vaginal Deliveries for seven years in a row



American Heart Association and American Stroke Association Get with the Guidelines Stroke Gold Plus Award



National Certified Silver Safe Sleep Leader by Cribs for Kids





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the American College of Radiology



Designated Lung Cancer Screening Center by the American College of Radiology

 Designated Lung Cancer Screening Center by the American College of Radiology

South Florida Family Life – Broward Favorite Pediatric Emergency Department 2020

 broward-award

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West Boca Medical Center Recognized Among Top 10% of Hospitals in Nation for GI Care from Healthgrades

Nov 12, 2024

West Boca Medical Center Recognized with 10 Clinical Achievements from Healthgrades

West Boca Medical Center announced today that it has achieved numerous accolades for clinical excellence from [Healthgrades](#), one of the top sites Americans use when searching for a doctor or hospital. Among West Boca's distinctions are two Excellence Awards, one for gastrointestinal care and the other for gastrointestinal surgery and placing in the top 10% of hospitals in the nation for overall GI services and gastrointestinal surgery. West Boca Medical Center was also rated five stars for six services, including colorectal surgery for the 3rd year in a row, treatment of bowel obstruction, treatment of sepsis for the fourth year in a row, treatment of respiratory failure for the 3rd year in a row, and for the ninth year in a row for both vaginal and C-section delivery.

"Healthgrades' recognition of our hospital reflects the hard work and dedication of our staff," said Jerad Hanlon, West Boca Medical Center's CEO. "We're grateful for the opportunity to make a difference in our patients' lives and strive for excellence in every aspect of care."

West Boca Medical Center's achievements are based solely on what matters most: patient outcomes. As part of its 2025 hospital assessment, Healthgrades evaluated risk-adjusted mortality and complication rates for over 30 of the most common conditions and procedures at approximately 4,500 hospitals nationwide to determine the top performers in specialty care. By offering easy access to objective performance measures, Healthgrades helps consumers find and select a hospital that excels in providing the care they need.

As variation in performance among hospitals continues to grow, it is increasingly important for consumers to seek care at top-rated programs. Healthgrades' 2025 analysis revealed that if all hospitals as a group performed similarly to five-star hospitals during the 2021-2023 study period, on average, **224,958 lives could potentially have been saved** and **141,692 complications could potentially have been avoided**.*

"Healthgrades commends West Boca Medical Center for their clear commitment to delivering consistently superior patient outcomes in critical service areas, including gastrointestinal, critical care and OBGYN," said Brad Bowman, MD, chief medical officer and head of data science at Healthgrades. "West Boca Medical Center's leadership, expertise, and unwavering dedication to clinical excellence set a high mark for specialty care in Florida and nationwide."

Consumers can visit [healthgrades.com](#) to learn more about how Healthgrades measures hospital quality and access a patient-friendly overview of how we rate and why hospital quality matters [here](#).

**Statistics are based on Healthgrades analysis of MedPAR data for years 2021 through 2023 and represent three-year estimates for Medicare patients only. [Click here](#) to view the complete 2025 Specialty Awards and Ratings Methodology.*



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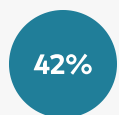
Delray Medical Center in West Palm Beach, FL



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Delray Medical Center

Delray Medical Center is a medical facility located in Delray Beach, FL. This hospital has been recognized for America's 250 Best Hospitals Award™, America's 50 Best Hospitals for Cardiac Surgery Award™, and more.



Patient Experience Rating

24% lower than the national average

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Recent Awards

Healthgrades awards tell you which hospitals deliver superior quality care. Healthgrades evaluates hospital performance using objective quality measures including clinical outcomes and patient safety, as well as patient experience.

[Learn more about our awards methodology](#)

Hospital Quality Awards



America's 250 Best Hospitals Award™ (2025)
Top 5% in the nation for consistently delivering clinical quality

Specialty Clinical Quality Awards



America's 50 Best Hospitals for Cardiac Surgery Award™ (2026)
Superior clinical outcomes in heart bypass surgery and heart valve surgery



Critical Care Excellence Award™ (2026, 2025)
Superior clinical outcomes in treating pulmonary embolism, respiratory system failure, sepsis, and diabetic emergencies



Pulmonary Care Excellence Award™ (2026)
Superior clinical outcomes in treating chronic obstructive pulmonary disease (COPD) and pneumonia

[See all awards for this hospital](#)

Safety Ratings

How well a hospital safeguards patients from potential complications

A red circle with a white exclamation mark inside.	An event relating to foreign objects left in body during a surgery or procedure
A red circle with a white exclamation mark inside.	3 ratings were worse than expected Bloodstream infection following surgery

Deep blood clots in the lungs or legs following surgery

Respiratory failure following surgery

✓ 2 ratings were better than expected [View details](#)

✓ 7 ratings were as expected [View details](#)

[Learn more about patient safety ratings](#)

Hospital Quality

Clinical Ratings

Research hospital performance and talk to your doctor about what's right for you

⊕ **Appendectomy**

⊕ **Bariatric Surgery**

⊕ **Cardiac**

⊕ **Critical Care**

⊕ **Gastrointestinal**

⊕ **Gynecologic Surgeries**

⊕ **Neurosciences**

⊕ **Orthopedic**

Outpatient Orthopedic
Outpatient Prostate Care
Prostate Surgery
Pulmonary
Spine Surgery
Vascular

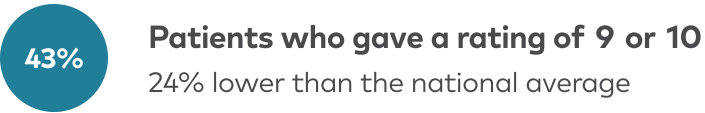
Data Source

Patient Experience

Patient experience measures tell you how patients felt about the care they received at the hospital. These measures are based on the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey data from the Centers for Medicare and Medicaid Services (CMS).

[Learn more about patient experience](#)

Patient Rating	Care Team	Facility
----------------	-----------	----------





Would definitely recommend
24% lower than the national average

Providers

All Specialties

▼

- Dr. John Abel, MD**

Internal Medicine

★★★★★ 32 Ratings


- Dr. Brian Ackerman, MD**

Emergency Medicine

★☆☆☆☆ 2 Ratings


- Dr. Oliver Acosta, MD**

Physical Medicine & Rehabilitation

☆☆☆☆☆ 0 Ratings


- Dr. Mark Adelman, MD**

Pulmonary Disease

★★★★★ 58 Ratings


- Dr. Adesoji Adenigbagbe, MD**

Pulmonary Disease

☆☆☆☆☆ 0 Ratings



Dr. Serge Alexandre, MD

Internal Medicine

★★★★★ 19 Ratings



Dr. Jacques Alexis, MD

Hospital Medicine

★★★★★ 0 Ratings



Dr. Robert Aportela, MD

Cytopathology

★★★★★ 0 Ratings



Page 1 of 58

1	2	3	4	5	...	58	>
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Provider Reviews

★★★★★

On time

Nov 06 2025

Review for [Dr. Zhang](#)

★★★★★

Dr Schwartz is a wonderful pain manageme physician , with a great bedside manner.He listens to your concerns and takes proper steps to aleave your issues.

Nov 05 2025

Review for [Dr. Schwartz](#)



Very professional and try to resolve the problem and very caring people everyone in the office is outstanding they treat everyone with the most respect we are blessed to be a patient

Nov 05 2025

Review for [Dr. Simpson](#)



It is rare to find a doctor who combines technical excellence with such humanity. Dr. Stark is a forward thinking physician who is changing the standard of what spinal surgery care can be. I am profoundly grateful and would recommend him without hesitation to anyone in need of spinal care! I left the... [Read More](#)

Nov 05 2025

Review for [Dr. Stark](#)



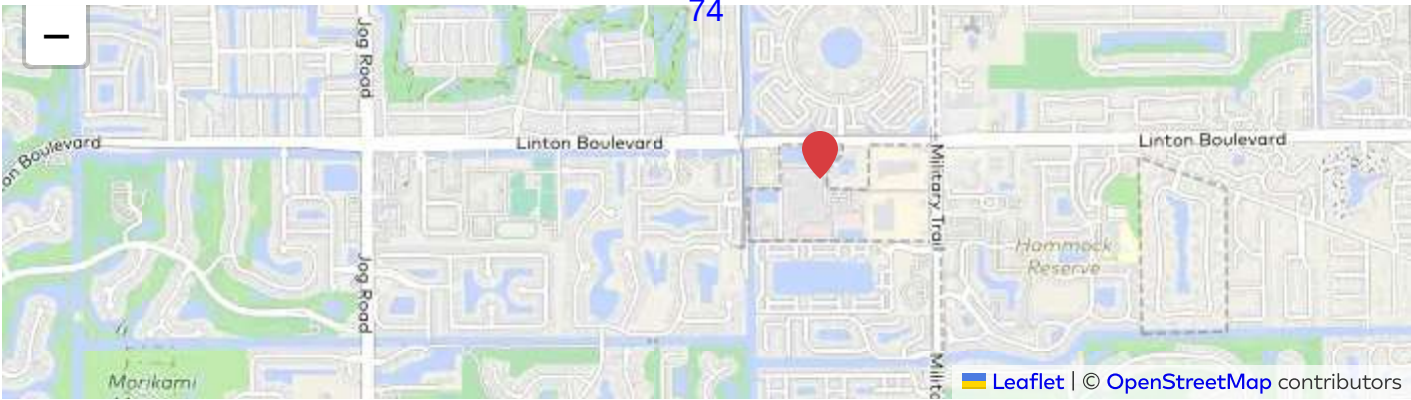
Everything about this practice is first rate. Staff are friendly and professional. Wait time in office is minimal. Dr. Chhatlani takes the time to listen and reach a diagnosis and treatment plan in conjunction with the patient. Treatments are highly effective. I highly recommend Dr Chhatlani for... [Read More](#)

Nov 05 2025

Review for [Dr. Chhatlani](#)

Location





Delray Medical Center

 5352 Linton Blvd, Delray Beach FL 33484

Call [Directions](#)

[\(561\) 498-4440](#)

Frequently Asked Questions

-  Where is Delray Medical Center located?
-  Has Delray Medical Center won any recent awards from Healthgrades?
-  Is Delray Medical Center highly rated with patients?

[View all frequently asked questions](#)

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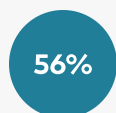
Good Samaritan Medical Center in West Palm Beach, FL



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Good Samaritan Medical Center

Good Samaritan Medical Center is a medical facility located in West Palm Beach, FL. This hospital has been recognized for Outpatient Orthopedic Surgery Excellence Award™ and America's 100 Best Hospitals for Spine Surgery Award™.



Patient Experience Rating

10% lower than the national average

Overview

Hospital Quality

Patient Experience

Providers

Reviews

Location

Recent Awards

Healthgrades awards tell you which hospitals deliver superior quality care. Healthgrades evaluates hospital performance using objective quality measures including clinical outcomes and patient safety, as well as patient experience.

[Learn more about our awards methodology](#)

Specialty Clinical Quality Awards



Outpatient Orthopedic Surgery Excellence Award™ (2026, 2025)

Superior clinical outcomes in knee and hip replacement, back and neck surgery and rotator cuff surgery.



America's 100 Best Hospitals for Spine Surgery Award™ (2025)

Superior clinical outcomes in back and neck surgeries and spinal fusion procedures

Safety Ratings

How well a hospital safeguards patients from potential complications

✓	No events relating to foreign objects left in body during a surgery or procedure
!	2 ratings were worse than expected Respiratory failure following surgery Deep blood clots in the lungs or legs following surgery
✓	9 ratings were as expected Hide details Accidental cut, puncture, perforation or hemorrhage during medical care In-Hospital Fall Associated Fracture Rate Breakdown of abdominal incision site Excessive bruising or bleeding as a consequence of a procedure or surgery Pressure sores or bed sores acquired in the hospital

- Bloodstream infection following surgery
- Collapsed lung due to a procedure or surgery in or around the chest
- Catheter-related bloodstream infections acquired at the hospital
- Acute kidney dysfunction following surgery

[Learn more about patient safety ratings](#)

Hospital Quality

Clinical Ratings

Research hospital performance and talk to your doctor about what's right for you

-  **Appendectomy**
-  **Cardiac**
-  **Critical Care**
-  **Gastrointestinal**
-  **Gynecologic Surgeries**
-  **Labor and Delivery**
-  **Neurosciences**
-  **Orthopedic**

Outpatient Orthopedic
Pulmonary
Spine Surgery

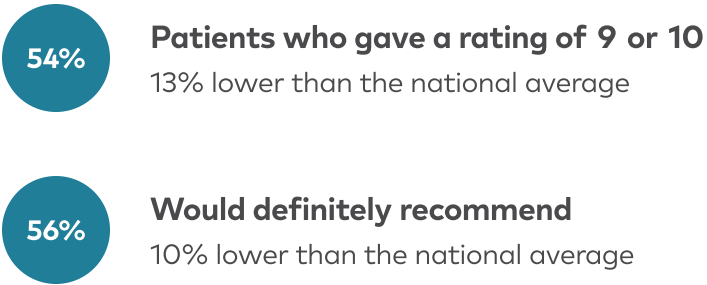
Data Source

Patient Experience

Patient experience measures tell you how patients felt about the care they received at the hospital. These measures are based on the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey data from the Centers for Medicare and Medicaid Services (CMS).

[Learn more about patient experience](#)

Patient Rating	Care Team	Facility
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Providers

All Specialties



Dr. David Abbasi, MD

Orthopedic Surgery

★★★★★ 11 Ratings



Dr. Anna Abel, MD

Internal Medicine

★★★★☆ 9 Ratings



Dr. Mourad Abouelleil, MD

Urology

★★★★★ 38 Ratings



Dr. Adrian Abreu, DO

Obstetrics & Gynecology

★★★★★ 1 Rating



Dr. Paul Acevedo, MD

Neurology

★★★★☆ 14 Ratings



Dr. Roberto Acosta, MD

Neurology

★★★★☆ 13 Ratings



Dr. Lawrence Adams, MD

Pediatric Gastroenterology

★★★★☆ 22 Ratings



Dr. David Adler, DO

Obstetrics & Gynecology

★★★★★ 47 Ratings



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Provider Reviews

★★★★★

Dr. Ortega has a a great physician. He explains everything thoroughly. His office staff is amazing as well.

Nov 06 2025

Review for [Dr. Ortega-Garcia](#)

★★★★★

I had surgery at Good Sam. The procedure could not have been better. Dr. Lee made sure I was informed of every detail. The after care instructions were easy to follow and are allowing me to help get to a speedy recovery.

Nov 06 2025

Review for [Dr. Lee](#)

★★★★★

General checkup just because it's part of my health routine. Always a pleasure.

Nov 05 2025

Review for [Dr. Fahmy](#)



Dr Schwartz is a wonderful pain manageme physician , with a great bedside manner.He listens to your concerns and takes proper steps to aleave your issues.

Nov 05 2025

Review for [Dr. Schwartz](#)

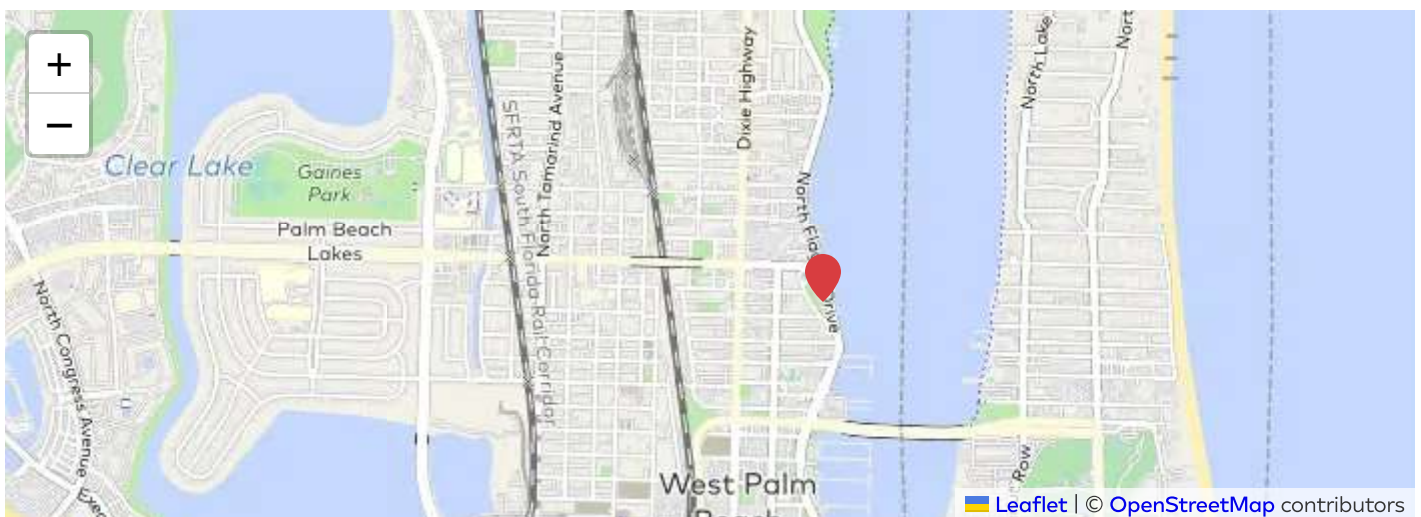


Very professional and try to resolve the problem and very caring people everyone in the office is outstanding they treat everyone with the most respect we are blessed to be a patient

Nov 05 2025

Review for [Dr. Simpson](#)

Location



Good Samaritan Medical Center

 1309 N Flagler Dr, West Palm Beach FL 33401

Call | [Directions](#)

[\(561\) 655-5511](#)

Frequently Asked Questions

- [⊕ Where is Good Samaritan Medical Center located?](#)
- [⊕ Has Good Samaritan Medical Center won any recent awards from Healthgrades?](#)
- [⊕ Is Good Samaritan Medical Center highly rated with patients?](#)

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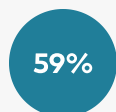
St. Mary's Medical Center in West Palm Beach, FL



[Find A Hospital](#) > [FL](#) > [Mangonia Park](#) > [St. Mary's Medical Center](#)

St. Mary's Medical Center

St. Mary's Medical Center is a medical facility located in Mangonia Park, FL. This hospital has been recognized for America's 100 Best Hospitals for Spine Surgery Award™.



Patient Experience Rating

7% lower than the national average

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[Reviews](#)

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Recent Awards

Healthgrades awards tell you which hospitals deliver superior quality care. Healthgrades evaluates hospital performance using objective quality measures including clinical outcomes and patient safety, as well as patient experience.

[Learn more about our awards methodology](#)

Specialty Clinical Quality Awards



America's 100 Best Hospitals for Spine Surgery Award™ (2026)

Superior clinical outcomes in back and neck surgeries and spinal fusion procedures

Safety Ratings

How well a hospital safeguards patients from potential complications

	No events relating to foreign objects left in body during a surgery or procedure
	1 rating was worse than expected Bloodstream infection following surgery
	10 ratings were as expected View details

[Learn more about patient safety ratings](#)

Hospital Quality

Clinical Ratings

Research hospital performance and talk to your doctor about what's right for you

+ Appendectomy
+ Cardiac
+ Critical Care
+ Gastrointestinal
+ Gynecologic Surgeries
+ Labor and Delivery
+ Neurosciences
+ Orthopedic
+ Outpatient Orthopedic
+ Pulmonary
+ Spine Surgery

Data Source

Patient Experience

Patient experience measures tell you how patients felt about the care they received at the hospital. These measures are based on the Hospital Consumer Assessment of Healthcare

Providers and Systems (HCAHPS) survey data from the Centers for Medicare and Medicaid Services (CMS).

[Learn more about patient experience](#)

Patient Rating	Care Team	Facility
----------------	-----------	----------

58%

Patients who gave a rating of 9 or 10
9% lower than the national average

59%

Would definitely recommend
7% lower than the national average

Providers

All Specialties

Dr. Dilhan Abeyewardene, MD

Orthopedic Hand Surgery

★★★★★ 5 Ratings



Dr. Paul Acevedo, MD

Neurology

★★★★★ 14 Ratings



Dr. Jude Acloque, MD

Internal Medicine

★☆☆☆☆ 2 Ratings



Dr. Jorge Acosta, MD

Family Medicine

★★★★★ 7 Ratings



Dr. Roberto Acosta, MD

Orthopedic Hand Surgery

★★★★★ 38 Ratings



Dr. Roberto Acosta, MD

Neurology

★★★★★ 13 Ratings



Dr. Lawrence Adams, MD

Pediatric Gastroenterology

★★★★★ 22 Ratings



Dr. John Afshar, MD

Neurosurgery

★★★★★ 186 Ratings



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Provider Reviews

★★★★★

Dr. Ortega has a a great physician. He explains everything thoroughly. His office staff is amazing as well.

Nov 06 2025

Review for [Dr. Ortega-Garcia](#)



This dr. Passed me off to his associate who was awful! My experience with was absurd. She was happy to renew any prescriptions I had and NEVER even asked how I was feeling?! Doctors used to care about their patients but definitely not this doctor! They were extremely dismissive of me. They were keen... [Read More](#)

Nov 06 2025

Review for [Dr. Olivera](#)



Everything about this practice is first rate. Staff are friendly and professional. Wait time in office is minimal. Dr. Chhatlani takes the time to listen and reach a diagnosis and treatment plan in conjunction with the patient. Treatments are highly effective. I highly recommend Dr Chhatlani for... [Read More](#)

Nov 05 2025

Review for [Dr. Chhatlani](#)



Fantastically professional Staff excellent

Nov 05 2025

Review for [Dr. Chhatlani](#)

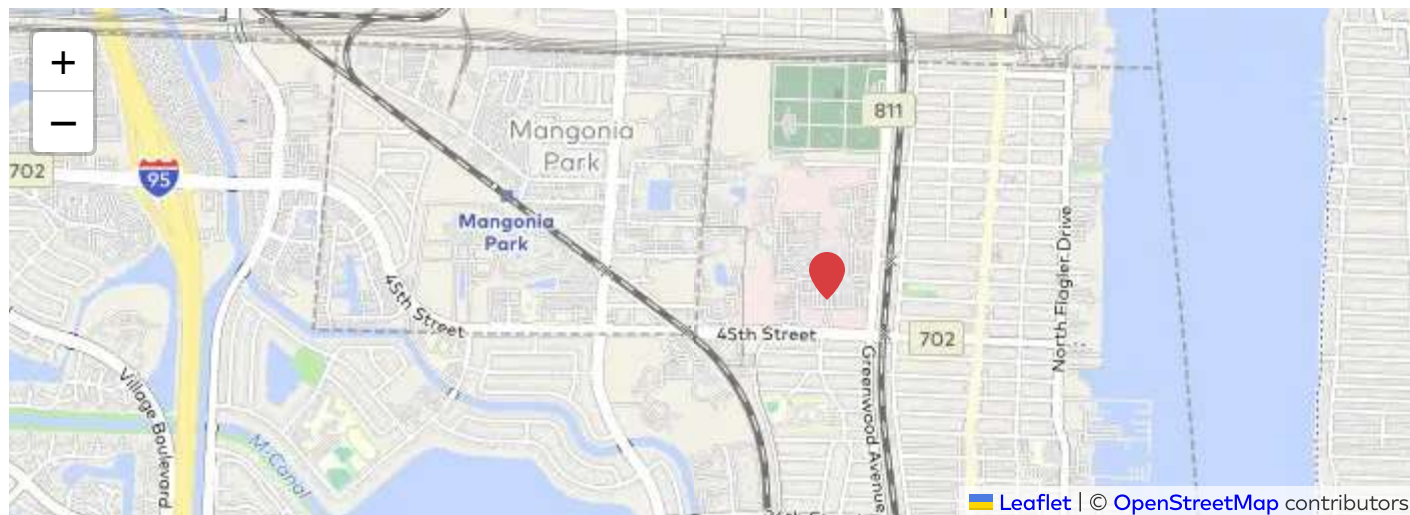


He was my primary for over 20 years and always had time for my questions and gave thoughtful answers. I moved away, but otherwise he'd still be my primary

Bob Lepa Nov 03 2025

Review for **Dr. Rattinger**

Location



St. Mary's Medical Center

 901 45th St, Mangonia Park FL 33407

Call | [Directions](#)

[\(561\) 844-6300](#)

Frequently Asked Questions

 Where is St. Mary's Medical Center located?

 Has St. Mary's Medical Center won any recent awards from Healthgrades?

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West Boca Medical Center in West Palm Beach, FL



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West Boca Medical Center

West Boca Medical Center is a medical facility located in Boca Raton, FL. This hospital has been recognized for Gastrointestinal Care Excellence Award™ and Gastrointestinal Surgery Excellence Award™.



Patient Experience Rating

19% lower than the national average

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[Patient Experience](#)

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Recent Awards

Healthgrades awards tell you which hospitals deliver superior quality care. Healthgrades evaluates hospital performance using objective quality measures including clinical outcomes and patient safety, as well as patient experience.

[Learn more about our awards methodology](#)

Specialty Clinical Quality Awards



Gastrointestinal Care Excellence Award™ (2025)

Superior clinical outcomes in colorectal surgeries, gallbladder removal, upper gastrointestinal surgery, and treating bowel obstruction, gastrointestinal bleeds, and pancreatitis



Gastrointestinal Surgery Excellence Award™ (2025)

Superior clinical outcomes in bowel obstruction treatment, colorectal surgeries, gallbladder removal, and upper gastrointestinal surgery

Safety Ratings

How well a hospital safeguards patients from potential complications

	No events relating to foreign objects left in body during a surgery or procedure
	1 rating was worse than expected Deep blood clots in the lungs or legs following surgery
	7 ratings were as expected View details

[Learn more about patient safety ratings](#)

Hospital Quality

Clinical Ratings

Research hospital performance and talk to your doctor about what's right for you

 Appendectomy
 Cardiac
 Critical Care
 Gastrointestinal
 Gynecologic Surgeries
 Labor and Delivery
 Neurosciences
 Orthopedic
 Outpatient Orthopedic
 Outpatient Prostate Care
 Pulmonary
 Spine Surgery

Patient Experience

Patient experience measures tell you how patients felt about the care they received at the hospital. These measures are based on the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey data from the Centers for Medicare and Medicaid Services (CMS).

[Learn more about patient experience](#)

Patient Rating	Care Team	Facility
----------------	-----------	----------

47%

Patients who gave a rating of 9 or 10

20% lower than the national average

47%

Would definitely recommend

19% lower than the national average

Providers

All Specialties

Dr. Brian Ackerman, MD

Emergency Medicine

★☆☆☆☆

2 Ratings



Dr. Jude Acloque, MD

Internal Medicine

★ ★ ★ ★ ★ 2 Ratings



Dr. Lawrence Adams, MD

Pediatric Gastroenterology

★ ★ ★ ★ ★ 22 Ratings



Dr. Mark Adelman, MD

Pulmonary Disease

★ ★ ★ ★ ★ 58 Ratings



Dr. Rajesh Agarwala, MD

Nephrology

★ ★ ★ ★ ★ 20 Ratings



Dr. Kanwal Akhtar-Kamal, DO

Internal Medicine

★ ★ ★ ★ ★ 1 Rating



Dr. Muaz Alabd Alrazzak, MD

Pediatric Hematology & Oncology

★ ★ ★ ★ ★ 4 Ratings



Dr. Humaira Ali, MD

Family Medicine

★ ★ ★ ★ ★ 17 Ratings



Provider Reviews



I've been a patient of Dr A Grobman for about 2.5 years. I've had a LIFETIME of ENT issues including 4 ear surgeries. Dr A is the only Dr I will trust (and his dad-ha) for counsel. The office is efficient and well run with excellent communication. Highly recommend for peds and adults

Nov 06 2025

Review for [Dr. Grobman](#)



Dr Schwartz is a wonderful pain manageme physician , with a great bedside manner.He listens to your concerns and takes proper steps to aleave your issues.

Nov 05 2025

Review for [Dr. Schwartz](#)



It is rare to find a doctor who combines technical excellence with such humanity. Dr. Stark is a forward thinking physician who is changing the standard of what spinal surgery care can be. I am profoundly grateful and would recommend him without hesitation to anyone in need of spinal care!! left the... [Read More](#)

Nov 05 2025

Review for [Dr. Stark](#)



Everything about this practice is first rate. Staff are friendly and professional. Wait time in office is minimal. Dr. Chhatlani takes the time to listen and reach a diagnosis and treatment plan in conjunction with the patient. Treatments are highly effective. I highly recommend Dr Chhatlani for... [Read More](#)

Nov 05 2025

Review for [Dr. Chhatlani](#)

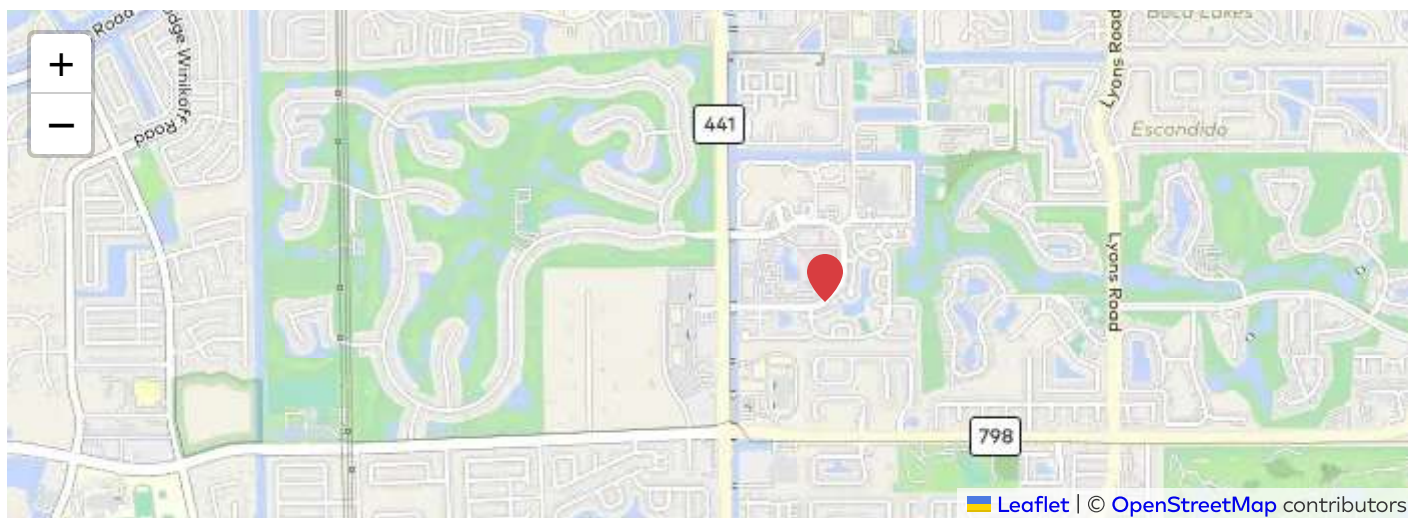


Fantastically professional Staff excellent

Nov 05 2025

Review for [Dr. Chhatlani](#)

Location



West Boca Medical Center

 21644 State Road 7, Boca Raton FL 33428

Call | [Directions](#)

[\(561\) 488-8000](#)

Frequently Asked Questions

+

Where is West Boca Medical Center located?

+

Has West Boca Medical Center won any recent awards from Healthgrades?

+

Is West Boca Medical Center highly rated with patients?

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Palm Beach Gardens Medical Center in West Palm Beach, FL



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Palm Beach Gardens Medical Center

Palm Beach Gardens Medical Center is a medical facility located in Palm Beach Gardens, FL. This hospital has been recognized for America's 50 Best Hospitals for Cardiac Surgery Award™ and Pulmonary Care Excellence Award™.

53%

Patient Experience Rating

13% lower than the national average

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Recent Awards

Healthgrades awards tell you which hospitals deliver superior quality care. Healthgrades evaluates hospital performance using objective quality measures including clinical outcomes and patient safety, as well as patient experience.

[Learn more about our awards methodology](#)

Specialty Clinical Quality Awards



America's 50 Best Hospitals for Cardiac Surgery Award™ (2026)

Superior clinical outcomes in heart bypass surgery and heart valve surgery



Pulmonary Care Excellence Award™ (2025, 2024)

Superior clinical outcomes in treating chronic obstructive pulmonary disease (COPD) and pneumonia

Safety Ratings

How well a hospital safeguards patients from potential complications

	No events relating to foreign objects left in body during a surgery or procedure
	3 ratings were worse than expected Respiratory failure following surgery Pressure sores or bed sores acquired in the hospital Bloodstream infection following surgery
	8 ratings were as expected View details

[Learn more about patient safety ratings](#)

Hospital Quality

Clinical Ratings

Research hospital performance and talk to your doctor about what's right for you

+ Appendectomy
+ Bariatric Surgery
+ Cardiac
+ Critical Care
+ Gastrointestinal
+ Gynecologic Surgeries
+ Neurosciences
+ Orthopedic
+ Outpatient Orthopedic
+ Outpatient Prostate Care
+ Prostate Surgery
+ Pulmonary
+ Spine Surgery

 **Vascular**

Data Source

Patient Experience

Patient experience measures tell you how patients felt about the care they received at the hospital. These measures are based on the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey data from the Centers for Medicare and Medicaid Services (CMS).

[Learn more about patient experience](#)

Patient Rating

Care Team

Facility

53%

Patients who gave a rating of 9 or 10

14% lower than the national average

53%

Would definitely recommend

13% lower than the national average

Providers

All Specialties



Dr. Anna Abel, MD

Internal Medicine

★★★★★ 9 Ratings



Dr. Mourad Abouelleil, MD

Urology

★★★★★ 38 Ratings



Dr. Edgar Abovich, MD

Cardiology

★★★★★ 28 Ratings



Dr. Paul Acevedo, MD

Neurology

★★★★★ 14 Ratings



Dr. John Afshar, MD

Neurosurgery

★★★★★ 186 Ratings



Dr. Rahul Aggarwal, MD

Cardiology

★★★★★ 50 Ratings



Dr. Ashraf Ahmed, MD

Infectious Disease Medicine

★★★★★ 3 Ratings



Dr. Farooq Ahmed, MD

Internal Medicine

★★★★★ 3 Ratings



Provider Reviews



Dr U is warm and friendly. Takes the time to discuss your conditions in layman's term. He lets you know he cares.

Nov 07 2025

Review for [Dr. Upadhyaya](#)



He was caring knowledgeable and explained issues in an easily understandable manner. You call his office directly not a call center . I read one negative review all I can say is "that is way off the mark" Not my experience at all.

Nov 06 2025

Review for [Dr. Sabbah](#)



General checkup just because it's part of my health routine. Always a pleasure.

Nov 05 2025

Review for [Dr. Fahmy](#)



He tells it like it is, no sugar coating. Would recommend him to everyone.

Nov 05 2025

Review for [Dr. Upadhyaya](#)

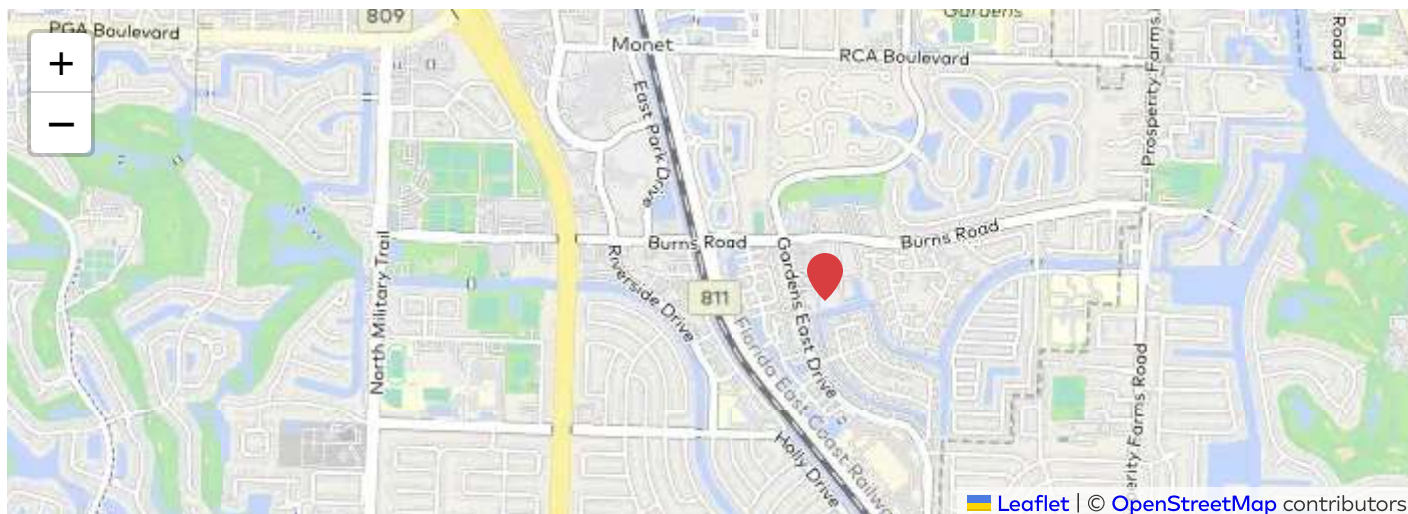


Drive Tapia is always through & concerned. Great doc

Nov 05 2025

Review for [Dr. Tapia](#)

Location



Palm Beach Gardens Medical Center

 3360 Burns Rd, Palm Beach Gardens FL 33410

Call | [Directions](#)

[\(561\) 622-1411](#)

Frequently Asked Questions

- +

Where is Palm Beach Gardens Medical Center located?
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Has Palm Beach Gardens Medical Center won any recent awards from Healthgrades?
- +

Is Palm Beach Gardens Medical Center highly rated with patients?

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Palm Beach Gardens Medical Center Achieves 2023 Healthgrades Cardiac Surgery Excellence Award™

Nov 10, 2022

Palm Beach Gardens Medical Center today announced that it has been recognized as a 2023 Cardiac Surgery Excellence Award™ recipient by [Healthgrades](#), a leading marketplace connecting doctors and patients. Healthgrades Specialty Excellence Awards recognize the top 10% of hospitals across the country in 17 specialty care areas. This achievement reflects Palm Beach Gardens Medical Center's outstanding clinical outcomes for Cardiac Surgery and distinguishes Palm Beach Gardens Medical Center as one of the nation's leading hospitals for Cardiac Surgery.

"We have a proven track record of excellence in cardiac care, and this designation is a commitment of our entire team to make us a top hospital for cardiac care," said Palm Beach Gardens Medical Center CEO, Teresa Urquhart. "From being the first hospital in Palm Beach County to perform open heart surgery, to this latest recognition, we are proud to continue our tradition of taking exceptional care of our patients' hearts."

Healthgrades evaluated patient mortality and complication rates for 31 of the most common conditions and procedures at nearly 4,500 hospitals across the country to identify the top-performing hospitals for specialty care. This year's analysis revealed significant variation in patient outcomes between hospitals with a 2023 Healthgrades Specialty Excellence Award and hospitals that did not receive the award. From 2019-2021, patients treated at hospitals receiving the Cardiac Surgery Excellence Award™ have, on average, a 54.9% lower risk of dying than if they were treated in hospitals that did not receive the award.*

"We commend Palm Beach Gardens Medical Center for their ongoing commitment to providing high-quality care to patients undergoing Cardiac Surgery," said Brad Bowman, MD, Chief Medical Officer and Head of Data Science at Healthgrades. "Consumers can feel confident that recipients of the 2023 Cardiac Surgery Excellence Award have demonstrated their ability to deliver consistently exceptional outcomes."

Consumers can visit [Healthgrades.com](#) to learn more about how Healthgrades measures hospital quality and access a patient-friendly overview of the complete methodology [here](#).

**Statistics are based on Healthgrades analysis of MedPAR data for years 2019 through 2021 and represent three-year estimates for Medicare patients only. For appendectomy and bariatric surgery, Healthgrades used inpatient data from 16 states that provide all-payer data for years 2019 through 2021. [Click here](#) to view the complete 2023 Specialty Excellence Awards and Ratings Methodology.*



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Palm Beach Gardens Medical Center Nationally Recognized by Healthgrades for Specialty Care

Nov 9, 2023

Palm Beach Gardens Medical Center Recognized with Six Five-Star Achievements from Healthgrades

Palm Beach Gardens Medical Center announced today it has achieved numerous five-star ratings for specialty care, according to new research released by [Healthgrades](#), a leading resource consumers use to find a hospital or doctor. Palm Beach Gardens Medical Center's Five-Star ratings include Heart Failure, Treatment of Chronic Obstructive Pulmonary Disease, Treatment of Pneumonia, Carotid Procedures, Treatment of GI Bleed, and Treatment of Respiratory Failure. In addition, Palm Beach Gardens Medical Center has been recognized in the Top 10% in the Nation for Overall Pulmonary Services, including the only hospital in northern Palm Beach County to earn this recognition. These achievements reflect Palm Beach Gardens Medical Center's commitment to consistently delivering the best care possible and places the organization in the upper echelon of hospitals for specialty care nationwide.

"The recognition from Healthgrades with multiple awards in 2024 is a testament to our unwavering dedication to providing exceptional healthcare at Palm Beach Gardens Medical Center," said Libby Flippo, Palm Beach Gardens Medical Center's interim CEO. "We are incredibly proud of our passionate and skilled team who consistently go the extra mile for our patients. These achievements inspire us to continue raising the bar for high-quality care."

Healthgrades evaluates hospitals solely on clinical outcomes: risk-adjusted mortality and complications. By focusing on what matters most—patient outcomes—Healthgrades ratings provide critical feedback for both patients and hospitals. By offering easy access to objective performance measures, Healthgrades gives consumers the information they need to find a hospital that excels in providing the care they need. And, by shining a light on strengths and weaknesses, Healthgrades ratings help direct hospitals to opportunities for clinical improvement. The 2024 hospital assessment evaluated patient mortality and complication rates for 35 common conditions and procedures at approximately 4,500 hospitals nationwide to identify the top performers.

The 2024 Healthgrades analysis revealed that the variation in performance between five-star and one-star hospitals continues to widen, making it increasingly important to seek care at top-rated programs. From 2020 through 2022, if all hospitals as a group performed similarly to five-star hospitals, on average, 215,667 lives could potentially have been saved, and 149,521 patients could have avoided potential complications.*

"Healthgrades congratulates Palm Beach Gardens Medical Center for being a national leader and demonstrating a deep commitment to providing high quality care to all patients," said Brad Bowman, MD, Chief Medical Officer and Head of Data Science at Healthgrades. "As health systems nationwide endeavor to elevate their quality of care, these elite facilities provide a roadmap for success. We commend [Hospital Name] for their dedication to excellence in patient care."

Consumers can visit [Healthgrades.com](#) to learn more about how Healthgrades measures hospital quality and access a patient-friendly overview of how we rate and why hospital quality matters [here](#).

**Statistics are based on Healthgrades analysis of MedPAR data for 2020 through 2022 and represent three-year estimates for Medicare patients only. [Click here](#) to view the complete 2024 Specialty Excellence Awards and Ratings Methodology.*



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#PBHNProud

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(888) 318-0764



West Boca Medical Center Nationally Recognized by Healthgrades for Specialty Care

Nov 13, 2023

West Boca Medical Center Recognized with six Five-Star Achievements from Healthgrades

West Boca Medical Center announced today it has achieved numerous five-star ratings for specialty care, according to new research released by [Healthgrades](#), a leading resource consumers use to find a hospital or doctor. West Boca Medical Center's Five-Star ratings include Vaginal Delivery, C-Section Delivery, Colorectal Surgeries, Treatment of GI Bleed, Treatment of Sepsis, and Treatment of Respiratory Failure. These five-star ratings reflect West Boca Medical Center's commitment to consistently delivering the best care possible and places the organization in the upper echelon of hospitals for specialty care nationwide.

"This remarkable achievement is a testament to our unwavering commitment to providing exceptional patient care and ensuring the highest standards of quality," Jerad Hanlon, West Boca Medical Center CEO, said. "We are dedicated to serving our community with excellence, and these awards validate our relentless pursuit of healthcare excellence."

Healthgrades evaluates hospitals solely on clinical outcomes: risk-adjusted mortality and complications. By focusing on what matters most—patient outcomes—Healthgrades ratings provide critical feedback for both patients and hospitals. By offering easy access to objective performance measures, Healthgrades gives consumers the information they need to find a hospital that excels in providing the care they need. And, by shining a light on strengths and weaknesses, Healthgrades ratings help direct hospitals to opportunities for clinical improvement. The 2024 hospital assessment evaluated patient mortality and complication rates for 35 common conditions and procedures at approximately 4,500 hospitals nationwide to identify the top performers.

The 2024 Healthgrades analysis revealed that the variation in performance between five-star and one-star hospitals continues to widen, making it increasingly important to seek care at top-rated programs. From 2020 through 2022, if all hospitals as a group performed similarly to five-star hospitals, on average, 215,667 lives could potentially have been saved, and 149,521 patients could have avoided potential complications.*

"Healthgrades congratulates West Boca Medical Center for being a national leader and demonstrating a deep commitment to providing high quality care to all patients," said Brad Bowman, MD, Chief Medical Officer and Head of Data Science at Healthgrades. "As health systems nationwide endeavor to elevate their quality of care, these elite facilities provide a roadmap for success. We commend West Boca Medical Center for their dedication to excellence in patient care."

Consumers can visit [Healthgrades.com](#) to learn more about how Healthgrades measures hospital quality and access a patient-friendly overview of how we rate and why hospital quality matters [here](#).

*Statistics are based on Healthgrades analysis of MedPAR data for 2020 through 2022 and represent three-year estimates for Medicare patients only. [Click here](#) to view the complete 2024 Specialty Excellence Awards and Ratings Methodology.

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Delray Medical Center Receives an ‘A’ for Patient Safety for the Spring 2019 Leapfrog Hospital Safety Grade

May 17, 2019

Delray Medical Center was awarded an ‘A’ from [The Leapfrog Group](#)’s spring 2019 Leapfrog [Hospital Safety Grade](#). The designation recognizes Delray Medical Center’s efforts in protecting patients from harm and providing safer health care. The Leapfrog Group is a national nonprofit organization committed to improving health care quality and safety for consumers and purchasers. The Safety Grade assigns an ‘A,’ ‘B,’ ‘C,’ ‘D’ or ‘F’ grade to hospitals across the country based on their performance in preventing medical errors, injuries, accidents, infections and other harms to patients in their care.



“With our high standard of safety and commitment to quality care at Delray Medical Center, we are so proud to achieve this distinguished award,” said Delray Medical Center Chief Executive Officer, Maggie Gill. “This designation is a testament to our patients that we are providing them with the highest level of safety and care every day when they come into our hospital.”

“To be recognized nationally as an ‘A’ hospital is an accomplishment the whole community should take pride in,” said Leah Binder, president and CEO of The Leapfrog Group. “Hospitals that earn an ‘A’ grade are making it a priority to protect patients from preventable medical harm and error. We congratulate hospital leaders, board members, staff, volunteers and clinicians who work so hard to earn this A.”

Developed under the guidance of a [national expert panel](#), the Leapfrog Hospital Safety Grade uses 28 measures of publicly available hospital safety data to assign grades to more than 2,600 U.S. acute-care hospitals twice per year. The Hospital Safety Grade’s methodology is peer-reviewed and fully transparent, and the results are free to the public.

Delray Medical Center was awarded an ‘A’ grade today, when Leapfrog announced grades for the spring 2019 update. To see Delray Medical Center’s full grade details, and to access patient tips for staying safe in the hospital, visit [hospitalsafetygrade.org](#) and follow The Leapfrog Group on [Twitter](#) and [Facebook](#).



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Healthgrades Names Delray Medical Center as One of America's Best 250 Hospitals

Jan 3, 2025

DELRAY BEACH, FL – Jan. 3rd, 2025 – Delray Medical Center announced today that it is one of the best 250 hospitals in the country, according to [Healthgrades](#), one of the top sites Americans use when searching for a doctor or hospital.

The hospital earned 25 accolades from Healthgrades recently, including being named one of America's 100 Best Hospitals for Pulmonary Care Excellence Awards, placing the hospital among the nation's top 5% for overall pulmonary services. The hospital also earned Healthgrades 2025 Critical Care Excellence Award, placing in the top 5% in the nation for critical care.

"It is an incredible honor to be among the best 250 hospitals in the country. This recognition is not earned by one person or one department, it is earned collectively as a team," said the hospital's CEO Heather Havericak. "We strive every day to put our patients first, focusing on quality care to give our patients the best chance at a positive outcome. This award is a reflection of our incredible team."

Here is the full list of all the awards earned:

Cardiac Care

- **Five-Star Recipient for Valve Surgery** (2024-2025, 2 Years in a Row)
- **Five-Star Recipient for Treatment of Heart Attack** (2024-2025, 2 Years in a Row)
- **Five-Star Recipient for Treatment of Heart Failure** (2003-2025, 23 Years in a Row)
- **Five-Star Recipient for Defibrillator Procedures** (2024-2025, 2 Years in a Row)
- **Five-Star Recipient for Treatment of Stroke** (2008-2025, 18 Years in a Row)

Pulmonary Care

- **One of Healthgrades America's 100 Best Hospitals for Pulmonary Care in 2025**
- **Recipient of the Healthgrades 2025 Pulmonary Care Excellence Award**
- **Top 5% in the Nation for Overall Pulmonary Services** (2025)
- **Top 10% in the Nation for Overall Pulmonary Services** (2025)
- **Five-Star Recipient for Treatment of Pneumonia** (2024-2025, 2 Years in a Row)

Critical Care

- **Recipient of the Healthgrades 2025 Critical Care Excellence Award**
- **Top 5% in the Nation for Critical Care** (2025)
- **Top 10% in the Nation for Critical Care** (2025)
- **Five-Star Recipient for Treatment of Sepsis** (2004-2025, 22 Years in a Row)
- **Five-Star Recipient for Treatment of Respiratory Failure** (2023-2025, 3 Years in a Row)

Delray Medical Center's achievements are based solely on what matters most: patient outcomes. As part of its 2025 hospital assessment, Healthgrades evaluated risk-adjusted mortality and complication rates for over 30 of the most common conditions and procedures at approximately 4,500 hospitals nationwide to determine the top performers in specialty care. By offering easy access to objective performance measures, Healthgrades helps consumers find and select a hospital that excels in providing the care they need.

As variation in performance among hospitals continues to grow, it is increasingly important for consumers to seek care at top-rated programs. Healthgrades' 2025 analysis revealed that if all hospitals as a group performed similarly to five-star hospitals during the 2021-2023 study period, on average, **224,958 lives could potentially have been saved** and **141,692 complications could potentially have been avoided**.*

"Healthgrades commends Delray Medical Center for their clear commitment to delivering consistently superior patient outcomes in critical service areas, including pulmonary, critical care, and cardiovascular," said Brad Bowman, MD, chief medical officer and head of data science at Healthgrades. "Delray Medical Center's leadership, expertise, and unwavering dedication to clinical excellence set a high mark for specialty care in Florida and nationwide."

Consumers can visit [healthgrades.com](#) to learn more about how Healthgrades measures hospital quality and access a patient-friendly overview of how we rate and why hospital quality matters [here](#).

**Statistics are based on Healthgrades analysis of MedPAR data for years 2021 through 2023 and represent three-year estimates for Medicare patients only. [Click here](#) to view the complete 2025 Specialty Awards and Ratings Methodology.*



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West Boca Medical Center Achieves 2023 Healthgrades Gastrointestinal Care Excellence Award™

Nov 4, 2022

West Boca Medical Center today announced that it has been recognized as a 2023 Gastrointestinal Care Excellence Award™ recipient by [Healthgrades](#), a leading marketplace connecting doctors and patients. Healthgrades Specialty Excellence Awards recognize the top 10% of hospitals across the country in 17 specialty care areas. This achievement reflects West Boca Medical Center's outstanding clinical outcomes for gastrointestinal care and distinguishes West Boca Medical Center as one of the nation's leading hospitals for gastrointestinal care.

"At West Boca Medical Center, we are so proud to be recognized for our gastrointestinal care. It is a testament to the high-quality care we provide," said West Boca Medical Center CEO, George Rizzuto. "We understand that patients have a choice, and we are proud to be recognized for our exceptional clinical outcomes."

Healthgrades evaluated patient mortality and complication rates for 31 of the most common conditions and procedures at nearly 4,500 hospitals across the country to identify the top-performing hospitals for specialty care. This year's analysis revealed significant variation in patient outcomes between hospitals with a 2023 Healthgrades Specialty Excellence Award and hospitals that did not receive the award.

From 2019-2021, patients treated at hospitals receiving the Joint Replacement Excellence Award™ have, on average, 28.4% lower risk of experiencing a complication or dying while in the hospital than if they were treated in hospitals that did not receive the award.*

"We commend West Boca Medical Center for their ongoing commitment to providing high-quality care to patients being treated for Gastrointestinal Care," said Brad Bowman, MD, Chief Medical Officer and Head of Data Science at Healthgrades. "Consumers can feel confident that recipients of the 2023 Gastrointestinal Care Excellence Award have demonstrated their ability to deliver consistently exceptional outcomes."

In addition to being recognized Among the top 10% in the Nation for Overall GI Services for 2 Years in a Row (2022-2023), West Boca Medical Center has also been recognized as a Five-Star Recipient for Treatment of Sepsis for 2 Years in a Row (2022-2023) and a Five-Star Recipient for Treatment of Respiratory Failure in 2023.

Consumers can visit [Healthgrades.com](#) to learn more about how Healthgrades measures hospital quality and access a patient-friendly overview of the complete methodology [here](#).

**Statistics are based on Healthgrades analysis of MedPAR data for years 2019 through 2021 and represent three-year estimates for Medicare patients only. For appendectomy and bariatric surgery, Healthgrades used inpatient data from 16 states that provide all-payer data for years 2019 through 2021. [Click here](#) to view the complete 2023 Specialty Excellence Awards and Ratings Methodology.*



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