Patients For Patient Safety US

Submitted: The Leapfrog Group Via Electronic Portal, December 18, 2025

Re: Public Comment on Proposed 2026 Hospital Survey Changes to Section 6D: Diagnostic Excellence

Patients for Patient Safety US (PFPS US) appreciates the opportunity to submit public comment on Proposed Changes to the 2026 Leapfrog Hospital Survey. As members of PFPS US leadership as well as members of Leapfrog's Patient and Family Caregiver Expert Panel (PFC EP), we are pleased to see proposed changes that reflect matters and suggestions that were considered by the PFC EP. However, we have significant concerns with the proposed changes to Section 6D: Diagnostic Excellence.

Section 6A: NQF Safe Practice #1 – Culture of Safety Leadership Structures and Systems

The Definitional Change

We support the modification in language describing lay caregivers of patients, from "families of patients" to "care partners," in order to be more inclusive of a broader population lay caregivers. As the population ages and more persons in need of healthcare live in isolation or at greater distance from blood or marriage-related family members, more friends and neighbors are stepping into the lay caregiver role (Home Alone Alliance Special Report, *Home Alone Revisited: Family Caregivers Providing Complex Care*, 2019). The proposed change acknowledges this demographic shift with appropriate terminology.

Strengthening Participation of Patients or Care Partners on the Hospital-Wide Safety and Quality Committee

We appreciate Leapfrog's consideration of the recommendation made by the PFC EP that more than one patient or lay "care partner" be included as members of the hospital-wide safety and quality committee. The shift would expand the resource of lived experience and diversity of demographics that patients contribute to such committees. We encourage Leapfrog to move forward as soon as possible with a survey question that incorporates this recommendation.

Section 6D: Diagnostic Excellence

We do not support and, in fact, are very concerned about the proposals to remove Questions #1 and #2 in Section 6D, which address hospital CEO and CMO commitment to reducing diagnostic error-related harm and communicating specific actions in support of that commitment, as well as Questions #3 and #4, which address engagement of Patient and Family Advisory Councils (PFACs) in diagnostic safety initiatives.

The Scope and Impact of Diagnostic Errors

It is time to move forward from positioning delayed, missed, wrong or inadequately communicated diagnoses as an "emerging area of patient safety." This bolus of diagnostic failures has emerged as the most common, catastrophic, and costly category of patient harm events. The Institute of Medicine (now National Academy of Medicine) call to action is a decade old (Committee on Diagnostic Error in Health Care; *Improving Diagnosis in Health*, National Academies Press (US); 2015). Research now estimates that 900,000 patient deaths or serious harm events occur annually in the United States due to diagnostic errors (Newman-Toker DE. *Just how many diagnostic errors and harms are out there, really? It depends on how you count*. BMJ Qual Saf. ;34(6):355-360, 2025). Liability insurers report that diagnostic errors

are the costliest of their payouts. (Newman-Toker DE , et al. *Serious misdiagnosis-related harms in malpractice claims: the "big three" - vascular events, infections, and cancers.* Diagnosis (Berl) 6:227–40, 2019). The current estimate of healthcare spending waste associated with diagnostic failure is $200 billion annually (PFPS US estimate). These findings point to the conclusion that diagnostic failures harm more patients and cost more than all other preventable harm events combined.

Proposed Changes Affecting Executive Leadership Commitment

We view focused attention on diagnostic excellence as the most promising opportunity to protect patients from harm in the United States. Hospital leadership commitment to this goal is essential. This is a critical moment to encourage hospital CEOs and CMOs to strengthen their attention to diagnostic safety and implement comprehensive programs to ensure it.

As Leapfrog Group community knows, measuring leadership commitment to patient safety goals strengthens organizational commitment to pursuing those goals. Removal of Section 6D Questions #1 and #2 would signal to hospitals nationwide that work on diagnostic excellence is the responsibility of a team or committee rather than the strategic priority it should be. While the revised Question #1 set forth in Appendix VIII would require CEO or CMO sponsorship of the team, this shift weakens the message that should be conveyed given the magnitude of the opportunity to prevent harm. The change in language from "commitment" to "sponsorship" creates ambiguity that could position diagnostic safety as one among many non-prioritized programs.

Proposed Changes Affecting Patient and Family Engagement

Recent assessments of hospital patient safety programs by the Agency for Healthcare Research and Quality and the Institute for Healthcare Improvement demonstrate that most hospitals continue to underperform in structured engagement of patients and families. We believe that Leapfrog Survey questions that assess patient and family engagement have most likely been effective in driving improvement that is helping to close this performance gap. Looking forward, they can be even more effective as hospital leaders grapple with best practice expectations set forth in the new Centers for Medicare and Medicaid Services (CMS) Patient Safety Structural Measure about engagement of PFACs in patient safety improvement work.

Sadly, and strangely, it is not a given that all hospitals do actively recruit persons with lived experience of preventable harm to serve on their PFACs. But those that do invariably include individuals affected by diagnostic error. These individuals could provide essential patient voice to the multidisciplinary team described in the proposed revisions to Section 6D survey questions. Hospital PFACs engaged in patient safety would naturally be interested in the activities, work product, and outcomes of such multidisciplinary teams.

We view the proposed removal of Questions #3 and #4 as a significant step back from Leapfrog's mission to drive improvement. Given the Leapfrog Group's prominent public commitment to patient and family engagement and its recognition of the contributions users of care can make to diagnostic safety efforts—as evidenced by the development of its Patient and Family Advisory Council (PFAC) Toolkit for Exploring Diagnostic Quality—it is disappointing to see the complete elimination in the proposed 6D revisions of any reference to patient input, PFACs, or reporting of diagnostic excellence work to patient audiences. Patients and/or caregivers are not included on the list of who should serve on multi-disciplinary teams. And while provider reporting of diagnostic safety concerns is stressed in the proposed survey changes, potential reporting by patients is not even acknowledged as an improvement resource.

This feels out of touch with the growing attention to the role of patient reported experiences and outcomes in helping close the gap in under-reporting of diagnostic errors.

We also are concerned that relegating the sole reference in the proposed 6D survey questions to the Leapfrog PFAC diagnostic safety toolkit to an FAQ will, we fear, weaken its uptake and use, therefore its potential impact.

We wonder whether Leapfrog's Diagnostic Excellence Expert Panel had any discussion about the role of patient and family advisors as it considered the recommended changes to Section 6D. Going forward, we encourage Leapfrog to foster greater collaboration between its TEPs when interests intersect, particularly in cases where the role of patient and family advisors in patient safety improvement is significantly affected on issues of such high importance to patients, as diagnostic improvement most certainly is. Alternatively, Leapfrog should consider establishing a mechanism that deploys Patient and Family Caregiver TEP members to serve as liaisons to other Expert Panels.

For these reasons, we respectfully urge the Leapfrog Group to reconsider the proposed changes to Section 6D discussed herein.

Sincerely,

Martin Hatlie, JD, PFPS US Founding Member and Director for Policy and Advocacy; Co-chair, Leapfrog Group Patient and Family Caregiver Expert Panel; Member Emeritus, Leapfrog Group Board of Directors (2010-2022)

Carole Hemmelgarn, MS, MS, PFPS US Founding Member and BoD Chair; Member, Leapfrog Group Board of Directors; Member, Leapfrog Group Patient and Family Caregiver Expert Panel

Armando Nahum, PFPS US Founding Member and Chief Operating Officer; Member, Leapfrog Group Patient and Family Caregiver Expert Panel

Sue Sheridan, MIM, MBA, DHL, PFPS US Founding Member and President & CEO; Member, Leapfrog Group Board of Directors; Co-chair, Leapfrog Group Patient and Family Caregiver Expert Panel