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ANALYSIS

LEAPFROG LEADER PUSHES FOR ADOPTION OF EXPANDED MEDICAL ERROR POLICY

BY CHRISTOPHER CHENEY | JULY 24, 2019

The nonprofit's expanded Never Event Policy is designed to hold hospitals accountable to their patients and attain high reliability in healthcare.

KEY TAKEAWAYS

- **Estimates of fatal medical errors range from 210,000 to 440,000 lives annually.**
- **The Leapfrog Group's nine-point Never Event Policy includes apologizing to patients when adverse events occur.**
- **About three-quarters of U.S. hospitals adhere to all elements of the Never Event Policy.**

Hospitals need to hold themselves accountable when errors lead to catastrophic consequences for patients, the leader of a national quality and safety organization says.

Preventable adverse events in hospitals are one of the leading causes of death in the United States, with **estimates** of lives lost ranging from 210,000 to 440,000 annually. Serious harm is as high as 20 times more common than fatal harm.

"This is really about the hospital industry declaring itself as accountable as any other industry in the country," Leah Binder, MA, MGA, president and CEO of **The Leapfrog Group** in Washington, D.C., tells ***HealthLeaders***.

Leapfrog is promoting a nine-point Never Event Policy to help health systems and hospitals address catastrophic medical errors. The nonprofit group defines a *never event* as egregious mistakes such as surgery performed on the wrong patient or foreign objects left inside a patient after surgery.

The Never Event Policy includes apologizing to patients, reporting adverse events internally when they occur, performing root cause analyses, waiving costs directly related to an adverse event, and providing a hospital's adverse event policy to patients and payers upon request.

"If an airline did not adhere to a policy like this in the event of a crash, they would be out of business. No one would tolerate it," Binder says.

NEVER EVENT POLICY ADOPTION

Leapfrog recently published a **survey report** on adoption and adherence to the group's Never Event Policy, which was expanded from five points to nine points in 2018. The report features several key recommendations and data points:

- 100% of U.S. hospitals should adopt the Never Event Policy.
- In 2018, 74.6% of hospitals met all nine elements of the Never Event Policy.
- After the Never Events Policy was expanded to nine points, performance on the policy dropped at both rural and urban hospitals. Performance dropped more significantly at rural hospitals (9.9%) than at urban hospitals (5.1%).

Human nature is the most daunting barrier to hospital adoption of the Never Event Policy, Binder says. "As human beings, when we make mistakes, we are loath to admit it. We certainly don't want to have to apologize to someone or admit a mistake when we have made a catastrophic error."

Establishing protocols to respond to never events is essential, she says. "You need to move beyond human nature—that's why you need to have a policy. The policy must be enforced and monitored carefully by leadership because it is a critical part of running a hospital that is committed to what is best for patients."

NEVER EVENT POLICY SERVES INTERESTS OF HOSPITALS AND PATIENTS

Adoption of the Never Event Policy is good for hospitals and their patients, Binder says. "It's in the interest of hospital patients because it is the right thing to do. It treats patients with the dignity and the respect that they deserve. It's in the interest of hospitals because it has been tested; and where the nine elements have been used, they reduce overall risk for the hospital."

The Never Event Policy is based on the Communication and Optimal Resolution (**CANDOR**) program developed at the federal Agency for Healthcare Research and Quality. AHRQ initially tested and applied CANDOR at three health systems. "They have seen a reduction in malpractice claims. We know from literature that people who get an apology and get treated with respect are less litigious in the long run," Binder says.

When the Never Event Policy was expanded to nine points, calling on hospitals to care for medical staff was a pivotal addition, she says.

"Hospitals need to recognize how difficult and sometimes devastating never events can be to the individuals who lead to a catastrophe for a patient. It's difficult for them to move on after an error, and they need help and protocols. The protocols need to be public, so everybody who works in a hospital knows the hospital will take care of you if you make an error."

Caring for healthcare workers when never events occur sends an important message to staff members and patients that medical errors will be addressed, Binder says. "The hospital owns up to the error, stands up for its people, and does what is right."

QUEST FOR HIGH RELIABILITY

Leapfrog's Never Event Policy is part of a national effort to achieve the same level of **high reliability** in healthcare that has been achieved in other high-risk industries such as aviation, Binder says. "I expect hospitals to achieve that level of high reliability. People place their lives in the hands of healthcare providers every day, and our lives are worth the same when we walk into a hospital as when we board a plane."

The healthcare sector has completed about 20% of its high-reliability journey, she says. "We are not at the very beginning—a lot of hospitals have embarked on the journey. But we have a very long way to go. The data and statistics on errors in hospitals are extremely disturbing."

The next big step is for the healthcare sector to commit to attaining the highest possible standards for transparency, Binder says.

Boosting transparency features two components, she says:

- Hospitals must hold themselves accountable to their patients.

- Hospitals must fully accept the shift from fee-for-service medicine to value-based medicine. "They can embrace transparency, hold themselves accountable for results, and demand payment for results. They can sit down at the table with payers and ask for rewards when they achieve better outcomes," Binder says.

Leadership will play a decisive role in the quest for high reliability in healthcare, she says. "If hospitals can reach a new level of leadership, we would see major transformation in our healthcare system. The pathway to get there is through high reliability—it's with leaders who undertake the journey to high reliability and with leaders who are willing to hold themselves accountable."

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