NEVER EVENTS

DATA BY HOSPITAL ON NATIONALLY STANDARDIZED METRICS

FIGURE 1

FOUR OUT OF FIVE HOSPITALS MEET LEAPFROG'S STANDARD FOR NEVER EVENTS POLICY

80%

of hospitals reported that if a Never Event occurs, their policy requires them to

- Apologize
- Report to an outside agency
- Perform a root-cause analysis
- Waive related costs
- Make the policy available

Some mistakes in the hospital are so egregious that they are referred to as "Never Events." These errors include surgery performed on the wrong part of the body or the wrong patient, objects left inside a patient after surgery, deaths from medication errors, and death or serious injury from a fall in a hospital. In all, 29 types of serious reportable events have been identified as Never Events by the National Quality Forum.[1]

Despite their name, Never Events continue to occur, and when they do, Leapfrog asks hospitals to take a proactive stance on managing them. All hospitals should have a policy in place that includes apologizing to the patient and/or family, reporting the event to an outside agency within 10 days of becoming aware that the event has occurred, performing a root-cause analysis, waiving costs directly related to the Never Event, and making a copy of the policy available to patients, patients' family members, and payers upon request.

By meeting each of these requirements, hospitals demonstrate their accountability to their patients and dedication to continuous improvement.

NEVER EVENTS HAVE BECOME A NATIONAL PRIORITY OVER THE PAST DECADE

The National Quality Forum elevated Never Events to national attention in 2006 with the publication of its first report defining and listing these errors. Soon after, the Centers for Medicare & Medicaid Services released a statement noting that Never Events "cause serious injury or death to patients, and result in increased costs to the Medicare program to treat the consequences of the error."[2] Beginning in 2007, Medicare

stopped paying a higher reimbursement to the hospital when certain Never Events occurred.[3] Some health plans have adopted a similar policy.[4]

In response to this national attention, Leapfrog added this topic to its Hospital Survey in 2007 by asking hospitals to report whether they had implemented best practices identified in literature and in other national programs. Leapfrog asks that hospitals take the following steps after a Never Event has occurred:

1. **Apologize to the patient and/or family.** This act can preserve the patient's sense of dignity, help to rebuild trust between the hospital and the patient, and reduce the risk of a malpractice suit.[5]
2. **Report the event to an outside agency within 10 days of becoming aware that the event has occurred.** The National Quality Forum originally created the list of Never Events to "facilitate uniform and comparable public reporting" among hospitals to improve safety.[6] Hospitals can fulfill this requirement by reporting to the Joint Commission, a state reporting program, or a Patient Safety Organization (as defined in The Patient Safety and Quality Improvement Act of 2005).
3. **Perform a root-cause analysis.** To identify the cause of the error and prevent future occurrences, hospitals must formally investigate the circumstances contributing to a Never Event. This requirement is in line with other national policies such as the one specified by The Joint Commission's hospital accreditation program.[7]
4. **Waive costs directly related to the Never Event.** Hospitals must review these cases to determine which costs are attributable to the Never Event, and waive those costs so that neither the patient nor payer is billed.
5. **Make a copy of the policy available to patients, patients' family members, and payers upon request.** This step shows the hospitals' transparency with those affected by the event.

ONE IN FIVE REPORTING HOSPITALS FAIL TO MEET LEAPFROG'S STANDARD

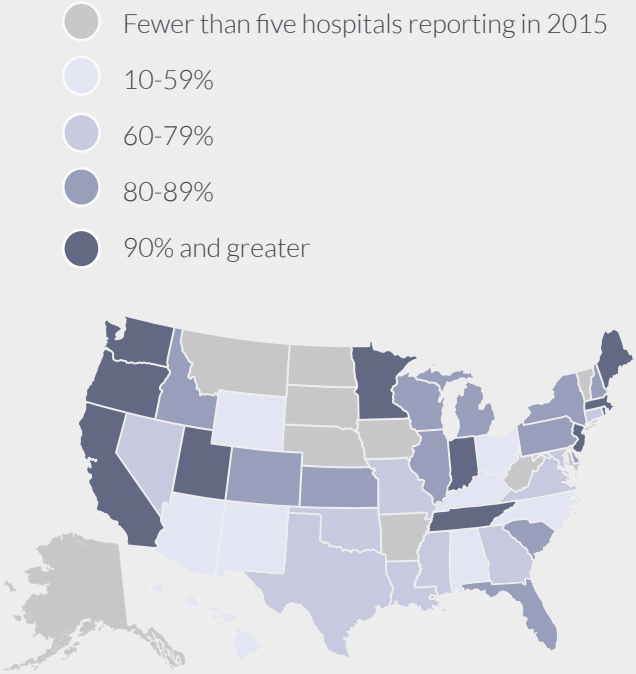
In 2015, 80% of reporting hospitals met Leapfrog's standard for Never Events management. This means one out of five reporting hospitals lack a Never Events policy that conforms to all criteria in Leapfrog's standard (Figure 1). More disconcerting, Never Events information is unavailable for hospitals that decline to report to the Leapfrog Hospital Survey.

Hospitals' adoption of Never Event policies varies by state. The percentage of hospitals meeting Leapfrog's standard was highest in Maine, Massachusetts, and Washington where 100% of hospitals reporting in those states met the standard. Eight other states had at least 90% of hospitals meeting the standard. Yet in Arizona, only 10% of hospitals met the standard. Seven other states also had fewer than 60% of hospitals meeting the standard (Figure 2).

FIGURE 2

ADOPTION OF NEVER EVENTS POLICY STANDARDS VARIES WIDELY BY STATE

THE PERCENTAGE OF REPORTING HOSPITALS MEETING LEAPFROG'S STANDARD FOR NEVER EVENTS POLICY



Visit www.leapfroggroup.org/compare-hospitals to view performance by hospital.

IMPLEMENTATION OF NEVER EVENTS POLICIES HAS PLATEAUED

In the years following the addition of Never Events management to the annual survey, Leapfrog saw a surge of hospitals meeting the standard. In 2007, only 53.2% of hospitals had a Never Events policy meeting Leapfrog's standards. By 2012, that rate had increased to 79.4%. While progress since the first year of reporting has been substantial, improvement has plateaued. The past four annual surveys have all shown 79% to 80% of hospitals meeting the standard (Figure 3). Furthermore, there has been an increase in the proportion of hospitals that respond to the Leapfrog survey, but decline to report their policy on Never Events. While this percentage hovered around 2% for the first few years of surveying on this topic, it has increased to approximately 7% in the 2014 and 2015 surveys.

MORE TRANSPARENCY AND QUALITY IMPROVEMENT ARE NEEDED

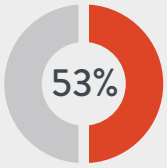
Wrong-site surgery occurs in an estimated one out of 100,000 procedures, and doctors or staff leave a foreign object inside a patient in an estimated one out of 10,000 procedures.[8] While any given patient has a low probability of experiencing one of these events, the patients who do experience these errors can often face severe and irreversible consequences.

Moreover, some hospitals decline to report their data at all. Without Leapfrog's independent, evidence-based survey, there would be limited national data on Never Events policies and other critical information on hospital safety and quality. An increase in the number of hospitals reporting to the Leapfrog Hospital Survey can help enable patients to make more informed decisions when seeking care, and can help providers to benchmark their own progress in achieving appropriate standards of care.

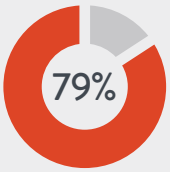
FIGURE 3

ADOPTION OF NEVER EVENTS POLICY STANDARDS HAS PLATEAUED

THE PERCENTAGE OF REPORTING HOSPITALS MEETING LEAPFROG'S STANDARD FOR NEVER EVENTS POLICY



2007 – First year of reporting to Leapfrog



2012 – 26 percentage point increase compared to 2007

2015– 1 percentage point increase compared to 2012

METHODS

The Leapfrog Group annually invites all adult general acute-care and free-standing pediatric hospitals in the United States to voluntarily report on topics such as high-risk procedures, maternity care, health care-associated infections, medication safety, nursing safety, and Never Events through its annual hospital survey. In 2015, a record 1,750 hospitals submitted a survey, representing 46% of hospitals nationwide and 60% of U.S. hospital beds. This report uses final hospital data from the 2015 Leapfrog Hospital Survey (data submitted through December 31, 2015).

The Leapfrog Hospital Survey includes measures that are endorsed by the National Quality Forum (NQF) and/or aligned with those of other significant data-collection entities, including the Centers for Medicare and Medicaid Services (CMS) and The Joint Commission. Leapfrog partners with the Armstrong Institute for Patient Safety and Quality at Johns Hopkins Medicine to review survey measures and standards, and updates them annually to reflect the latest science. Additionally, panels of volunteer experts meet regularly to review the survey measures and recommend performance standards for each subject area covered in the Leapfrog Hospital Survey. The full list of survey measures included in the 2015 survey is available here.

This is the fourth in a series of reports Castlight Health is preparing based on its analysis of data from the 2015 Leapfrog Hospital Survey.

1. Serious Reportable Events in Healthcare – 2011 Update: A Consensus Report, National Quality Forum, 2011.
2. Eliminating Serious, Preventable, and Costly Medical Errors – Never Events, Centers for Medicare and Medicaid Services, May 2006.
3. Patient Safety Primer: Never Events, Agency for Healthcare Research and Quality, December 2014.
4. Insurers Stop Paying for Care Linked to Errors, *Wall Street Journal*, January 2008.
5. When Things Go Wrong: Responding to Adverse Events. A Consensus Statement of the Harvard Hospitals, Massachusetts Coalition for the Prevention of Medical Errors, March 2016.
6. Serious Reportable Events, National Quality Forum, 2011.
7. Sentinel Event Policy and Procedures: Comprehensive Accreditation Manual for Hospitals, The Joint Commission, January 2016.
8. Wrong-Site Surgery, Retained Surgical Items, and Surgical Fires: A Systematic Review of Surgical Never Events, *JAMA Surgery*, August 2015.

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 forward in the quality and safety of American health care. The flagship Leapfrog Hospital Survey collects and transparently reports hospital performance, empowering purchasers to find the highest-value care and giving consumers the lifesaving information they need to make informed decisions. Hospital Safety Score, 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.

About Castlight Health: Our mission is to empower people to make the best choices for their health and to help companies make the most of their health benefits. We offer a health benefits platform that engages employees to make better healthcare decisions and guide them to the right program, care, and provider. The platform also enables benefit leaders to communicate and measure their programs while driving employee engagement with targeted, relevant communications. Castlight has partnered with enterprise customers, spanning millions of lives, to improve healthcare outcomes, lower costs, and increase benefits satisfaction.

For more information, visit www.castlighthealth.com and connect with us on Twitter and LinkedIn and Facebook.

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