



DELAWARE HOSPITALS TAKE ON PREVENTABLE ERRORS
Voluntarily Adopt Policy to Not Charge for Serious Adverse Events
Institute for Healthcare Improvement Lauds New Policy

FOR IMMEDIATE RELEASE

Date: February 13th, 2008

*Contact: Wayne A. Smith, Pres. & CEO, Delaware Healthcare Association,
(302) 674-2853*

*James Conway, Sr. Vice President, Institute for Healthcare Improvement
(617) 301-4800*

The Delaware Healthcare Association today announced that all Delaware hospitals will adopt a uniform policy to not charge patients or insurers for certain serious adverse events as defined by the National Quality Forum (NQF), including wrong site surgeries and serious medication errors. In doing so, Delaware becomes only the third state in the nation to publicly announce this voluntary action.

“This represents a major step and underscores our commitment to transparency and quality initiatives,” said Wayne Smith, President and CEO of the Delaware Healthcare Association. “This policy says to Delawareans that their hospitals are committed to doing everything possible to assure quality treatment.”

“The leadership demonstrated in this action signals strongly the energy and resolve Delaware’s healthcare executives are bringing to advancing the quality and safety of care in Delaware. It also establishes a model of accountability for other states and provider groups around the nation to learn from and emulate,” said James Conway, Senior Vice President, Institute for Healthcare Improvement. The Institute for Healthcare Improvement (IHI) is a not-for-profit organization leading the improvement of health care throughout the world. IHI was founded in 1991 and is based in Cambridge, Massachusetts.

The policy will cover nine rare but serious adverse events and is based on nationally accepted definitions. The list includes:

- ***surgery on wrong body part***
- ***surgery on wrong patient***
- ***wrong surgical procedure***
- ***retention of foreign object not designed to be retained in body***
- ***incompatible blood-associated injury***
- ***air embolism-associated injury***
- ***medication error leading to serious injury or death***
- ***artificial insemination/wrong donor***
- ***newborn infant discharged to wrong family***

The policy, to be put into effect in early 2008, will codify long standing safety practices and fortify hospitals’ commitment to preventing adverse medical events. The policy will apply to

DELAWARE HEALTHCARE ASSOCIATION



any of the defined events and any subsequent care in that hospital needed to manage the event. The hospital community will work collaboratively with an advisory group comprised of hospital members from both clinical and financial departments, the physician community, the health insurance companies, and others to implement the plan.

Under current practice, in the extremely rare case that a serious adverse event does occur, Delaware hospitals disclose the incident and apologize to the patient.

“The ultimate goal is to reduce these errors,” Smith said. “We are working towards making every hospital event a quality experience.”

*The **Delaware Healthcare Association** is a statewide trade and membership services organization that exists to represent and serve hospitals, health systems, and related health care organizations in their role of providing a continuum of appropriate, cost-effective, quality care to improve the health of the people of Delaware.*

*The **Institute for Healthcare Improvement (IHI)** is a not-for-profit organization leading the improvement of health care throughout the world. IHI was founded in 1991 and is based in Cambridge, Massachusetts. IHI is a reliable source of energy, knowledge, and support for a never-ending campaign to improve health care worldwide. The Institute helps accelerate change in health care by cultivating promising concepts for improving patient care and turning those ideas into action.*

***James Conway, MS**, Senior Vice President, Institute for Healthcare Improvement (IHI), was Senior Fellow at IHI from 2005-06. From 1995-2005, he served as Executive Vice President and Chief Operating Officer of Dana-Farber Cancer Institute. Prior to joining Dana-Farber, he had a 27-year career at Children's Hospital, Boston, in radiology administration, finance, and as assistant hospital director for patient care services. His areas of expertise and interest include executive leadership, patient safety, change management, and patient-/family-centered care. He is a member of the IOM Committee on Identifying and Preventing Medication Errors, an Advisor to the Massachusetts Coalition for the Prevention of Medical Errors, a Distinguished Advisor to the National Patient Safety Foundation, and a member of the Joint Commission Sentinel Event Alert Advisory Group.*