Payment Guidelines on Serious Adverse Events

Adopted by the IHA Board of Directors
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Idaho's community hospitals work diligently to make patient care as safe and free from harm as possible. Despite these extensive efforts, human error can occur. Idaho hospitals recognize that certain types of serious adverse events, causing significant harm to patients, are preventable and under the direct control of the hospital. While rare, they can have tragic consequences for the patient, some resulting in permanent disability or death.

As an extension of their patient safety programs and protocol, the Idaho Hospital Association recommends to all members that they voluntarily adopt a policy to not bill or accept payment for hospital services related to any of the following seven serious adverse events that results in serious disability lasting more than seven days or death:

1. Surgery on the wrong body part;
2. Surgery on the wrong patient;
3. Wrong surgical procedure;
4. Unintended retention of a foreign object;
5. An air embolism that occurs while being treated in a hospital;
6. A medication error attributable to the hospital; and
7. A hemolytic reaction due to administration of incompatible blood or blood products.

Beyond these seven serious adverse events, Idaho hospitals should individually evaluate whether full or partial payment should be accepted for other events. When evaluating other events, hospitals are recommended to use the following criteria to guide their decision:

- **The error was <u>preventable</u>.** Hospitals should not be held accountable for something that could not be reasonably prevented by the hospital in the first place. An in-depth, internal analysis may be required to determine preventability.

- **The error or event was <u>within the control of the hospital</u>**. Hospitals should not be held accountable for errors that may have occurred, for example, in the manufacture of drugs, devices, or equipment, well before the materials reached a hospital's doors. An in-depth, internal analysis may be required to determine the source of the error.

- **The error or event was the result of <u>a mistake made in the hospital</u>**. The event must clearly and unambiguously be the result of a mistake made or hospital procedure not followed, rather than something that could otherwise occur.

- **The error or event <u>resulted in patient death or serious disability</u>**. The list of events should be limited to those that yield very serious adverse results.