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Robert A. Malson

President

June 6, 2007

Gregg A. Pane, MD
Director
District of Columbia Department of Health
825 North Capitol Street, NE, Suite 4400
Washington, DC 20002

Dear Dr. Pane:

Attached is a copy of the DCHA comments on the proposed regulations for the new physician discipline and adverse event reporting laws in the District of Columbia. We appreciate the opportunity to participate in the rulemaking process.

District hospitals are both excited and apprehensive about the implementation of these new and important regulations. We are eager and hopeful about the opportunity to work with the DC Department of Health in using adverse event data to drive meaningful safety improvements in the hospitals that serve our community. Further, the hospitals are experienced in collecting and mining this sort of data and are interested in working collaboratively with the city to design a process that is among the best in the nation. It is our sincere hope that we can serve as a model for other states in using safety data to effect meaningful and measurable change.

Our hospitals are of the opinion, however, that the single greatest obstacle to our success will be the perceived or real risk of the data being used to drive up professional liability exposures in area hospitals. Hospitals are also aware and concerned about the risk that the success of the effort could be compromised by definitions that are overly-broad and/or unclear. Fortunately, the current law as written is well designed to mitigate these barriers. All we need to do is ensure that the regulations maintain the intended protections and efficacy. With that in mind, we make the following recommendations that we detail in our attached specific comments to your draft regulations:

- The regulations should aim to match, at a minimum, the confidentiality and discovery protections offered to the states in the Federal Patient Safety and Quality Improvement Act of 2005.
- The DOH should apply for Patient Safety Organization Status as soon as reasonably practical.
- The definition of “adverse event” for purposes of mandatory reporting should be clear and easy to follow.
- The hospitals strongly discourage the use of a broad definition such as “all adverse events” and respectfully advise the DOH that this sort of open-ended definition could cause significant confusion and very large volumes of data that could overwhelm the city with significant cost and waste.

- The regulations could streamline the process and promote the collection of useful data by defining adverse events to include only serious and sentinel events.
- DCHA supports a “never event” approach to define adverse events. Preferably, we could simply define adverse events reporting as being limited to serious and sentinel events.
- The DCHA also recommends an advisory panel comprised of public and private membership to guide the successful implementation of this important initiative.

Fortunately, there are many good models to follow from other states that have mandatory adverse event programs in place. Most of the states limit the adverse event reporting to serious and sentinel events. And, many of the states achieve clarity in the definition by adopting language from the National Quality Forum definitions of “never events.” We welcome an opportunity to discuss our proposed changes with you if you have questions or need additional information.

Sincerely,

A handwritten signature in black ink, appearing to read "Robert H. Miller", is written over a thin red horizontal line.

CC: Feseha Woldu, Ph. D
Senior Deputy Director