

LEXIS DISTRICT OF COLUMBIA CODE ANNOTATED

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*** CURRENT THROUGH D.C. LAW 16-296, EFFECTIVE MARCH 14, 2007, AND THROUGH D.C. ACT 16-655

*** ANNOTATIONS CURRENT THROUGH DECEMBER 14, 2006 ***

TITLE 7. HUMAN HEALTH CARE AND SAFETY
SUBTITLE A. GENERAL
SUBCHAPTER III-A. PATIENT SAFETY -- ADVERSE EVENTS

GO TO DISTRICT OF COLUMBIA CODE ARCHIVE DIRECTORY

D.C. Code § 7-161 (2007)

§ 7-161. Mandatory adverse event reporting

(a) For the purposes of this section, the term:

(1) "Adverse event" means an event, occurrence, or situation involving the medical care of a patient by a health care provider that results in death or an unanticipated injury to the patient.

(2) "Healthcare provider" means an individual or entity licensed or otherwise authorized under District law to provide healthcare service, including a hospital, nursing facility, comprehensive outpatient rehabilitation facility, home health agency, hospice program, renal dialysis facility, ambulatory surgical center, pharmacy, physician or health care practitioner's office, long-term care facility, behavior health residential treatment facility, health clinic, clinical laboratory, health center, physician, physician assistant, nurse practitioner, clinical nurse specialist, certified registered nurse anesthetist, certified nurse midwife, psychologist, certified social worker, registered dietitian or nutrition professional, physical or occupational therapist, pharmacist, or other individual health care practitioner.

(3) "Medical facility" means a hospital, nursing facility, comprehensive outpatient rehabilitation facility, home health agency, hospice program, renal dialysis facility, ambulatory surgical center, pharmacy, physician or health care practitioner's office, long-term care facility, behavior health residential treatment facility, health clinic, clinical laboratory, or health center.

(4) "Primary health record" means the record of continuing care maintained by a health professional, group practice, or health care facility or agency containing all diagnostic and therapeutic services rendered to an individual patient by the health professional, group practice, or health care facility, or agency.

(b) On or before July 1, 2007, the Mayor shall establish, within the Department of Health, a centralized system for the collection and analysis of adverse events in the District of Columbia.

(c) The Mayor shall appoint an employee of the Department of Health to administer the system, whose responsibilities shall include:

(1) Collecting, organizing, and storing data on adverse events occurring at medical facilities in the District of Columbia;

(2) Tracking, assessing, and analyzing the incoming reports, findings, and corrective action plans;

(3) Identifying common adverse event patterns or trends;

(4) Recommending methods to reduce systematic adverse events;

(5) Providing technical assistance to healthcare providers and medical facilities on the development and implementation of patient safety plans to prevent adverse events;

(6) Disseminating information and advising healthcare providers and medical facilities in the District of Columbia on medical best practices;

(7) Monitoring national trends in best practices and disseminating relevant information and advice to healthcare providers and medical facilities in the District of Columbia; and

(8) Publishing an annual report that includes summary data of the number and types of adverse events of the prior calendar year by type of healthcare providers and medical facility, rates of change, and other analyses and communicating recommendations to improve health care delivery in the District of Columbia.

(d) (1) Pursuant to this section, healthcare providers and medical facilities providing services in the District of Columbia shall submit biannual reports, on January 1 and July 1 of each calendar year, on adverse events to the system administrator. Each report shall contain, for each adverse event, the patient's full primary health record; provided, that medical information with respect to the patient's identity shall be de-identified and anonymous.

(2) Failure to submit a report as required by this section shall be punishable by a penalty of not less than \$ 500 or more than \$ 2,500.

(e) (1) Except as otherwise provided by this section, the files, records, findings, opinions, recommendations, evaluations, and reports of the system administrator, information provided to or obtained by the system administrator, the identity of persons providing information to the system administrator, and reports or information provided pursuant to subsection (d) of this section shall be confidential, shall not be subject to disclosure pursuant to any other provision of law, and shall not be discoverable or admissible into evidence in any civil, criminal, or legislative proceeding. The information shall not be disclosed by any person under any circumstances. This subsection shall not preclude use of reports or information provided under subsection (d) of this section by a board regulating a health profession or the Mayor in proceedings by the board or the Mayor.

(2) No person who provided information to the system administrator shall be compelled to testify in any civil, criminal, or legislative proceeding with respect to any confidential matter contained in the information provided to the system administrator.

(3) Notwithstanding subsections (a) or (b) of this section, a court may order a system administrator to provide information in a criminal proceeding in which an individual is accused of a felony if the court determines that disclosure is essential to protect the public interest and that the information being sought can be obtained from no other source. In determining whether disclosure is essential to protect the public interest, the court shall consider the seriousness of the offense with which the individual is charged, the need for disclosure of the party seeking it, and the probative value of the information. If the court orders disclosure, the identity of any patient shall not be disclosed without the consent of the patient or his or her legal representative.

(f) Implementation of this section shall be funded through the licensure fees collected by the Board of Medicine.

HISTORY: Mar. 14, 2007, D.C. Law 16-263, § 202, 54 DCR 807.

NOTES:

CROSS REFERENCES. --Licensing of health professionals, § 3-1205.01 et seq.

LEGISLATIVE HISTORY OF LAW 16-263. --Law 16-263, the "Medical Malpractice Amendment Act of 2006," was introduced in Council and assigned Bill No. 16-334. The Bill was adopted on first and second readings on Dec. 5, 2006, and Dec. 19, 2006, respectively. Signed by the Mayor on Dec. 28, 2006, it was assigned Act No. 16-619 and transmitted to Congress for its review. D.C. Law 16-263 became effective on Mar. 14, 2007.

EDITOR'S NOTES. --Section 202 of D.C. Law 16-263 was codified as § 3-1205.23 by LexisNexis in March 2007. If the act section is codified by the Codification Counsel, it may be placed elsewhere in the D.C. Code.