



**Testimony of  
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**Adverse Event Reporting in the District of Columbia  
Public Oversight Roundtable  
Committee on Health  
District of Columbia City Council**

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Founded in 1871, Children's National Medical Center (Children's National) is a 283 bed not-for-profit academic medical center located at 111 Michigan Avenue, NW. Children's National's mission is to improve health outcomes for children regionally, nationally and internationally, to be a leader in creating innovative solutions to pediatric healthcare problems, and to excel in care, advocacy, research and education to meet the unique needs of children, adolescents and their families. Children's National is consistently ranked among the best pediatric hospitals in America by *US News & World Report* and has twice been named to The LeapFrog Group's Top Hospitals list for quality and safety.

Chairman Catania and members of the committee, thank you for allowing me to attend this public oversight roundtable and to comment on adverse event reporting in the District of Columbia. My name is Mary Anne Hilliard, and I am Chief Risk Counsel for Children's National Medical Center. I have been involved on a national level with the issues of adverse event reporting and analysis for many years. There are several observations I would like to share with you based upon my experience and on the December 2008 report from ECRI regarding adverse events in the District of Columbia.

Children's National strongly supports the sharing of adverse event data. Since inception of the law, we have reported our data as required to the District of Columbia's Department of Health (DOH) and to the federal Centers for Disease Control and Prevention (CDC). The medical literature, as well as my own experience, shows that aggregation of data amongst multiple facilities is a very powerful tool in helping to reduce adverse patient events. We know that, statistically speaking, certain adverse events occur with such infrequency that gleaning any meaningful, and by that I mean statistically significant, data from each event as to the causes and solutions is problematic. Thus, an individual facility looking at only its own adverse event data would rarely, if ever, be able to identify causes and craft real solutions that would materially drive down the frequency of those events. When facilities are able to combine their data, patterns emerge much more quickly both in terms of the types of events that occur as well as causes of those events. This allows facilities who share data to be more proactive and nimble in responding to situations and practices that put patients at risk for an adverse event.

So why isn't every facility in the country participating in some type of data sharing? To be candid, the only real barrier to doing so has been the risk that the data could be misinterpreted and lead to unintended consequences. One of the cardinal rules that experts in patient safety and adverse event reporting live by is that without protection of data, transparent reporting will not occur. Just as individual providers are unlikely to candidly and completely report the facts surrounding an incident if a punitive outcome will occur as a result of the report; facilities are also constrained by these concerns.

Wisely recognizing that the only way to get quality data on adverse events requires evidentiary protection, the federal government built into the Patient Safety and Quality Improvement Act protections for facilities to conduct investigations related to improving patient safety and to act on the data gleaned from those investigations. With the federal legislation establishing Patient Safety Organizations, the next step has been taken at a federal level to allow sharing of data amongst hospitals to allow for more powerful and rapid analysis of adverse events.

The Council of the District of Columbia has taken leadership in bringing a shared adverse event reporting system to the District that will positively impact the safety of patients in our area. The Department of Health has crafted regulations that achieve the goal of sharing data in a protected way, and has built a thoughtful and thorough reporting system with ECRI. The December 2008 report provides valuable information for hospitals in the District, most importantly by providing evidence-based recommendations from the data collected during the first year of this system. We at Children's National applaud the Council for the great achievement this represents.

I would like to make two observations about the first year's data. First, it is important to keep in mind that there are times when facilities do not experience certain adverse events. As the name implies, "never events" are ones that may occur with rarity. As such, a lack of reported events is not necessarily a reflection of poor compliance with reporting requirements. Second, the recent amendments that increase the frequency of reporting will likely remedy any issues that facilities may have had with understanding the reporting requirements, as well as with compliance.

Thank you for your time, and I would be happy to answer any questions you may have.