CERTIFICATION OF ENROLLMENT

SECOND SUBSTITUTE HOUSE BILL 1106

60th Legislature
2007 Regular Session

Passed by the House April 16, 2007
Yeas 93 Nays 2

Speaker of the House of Representatives

Passed by the Senate April 11, 2007
Yeas 49 Nays 0

President of the Senate

Approved

Governor of the State of Washington

CERTIFICATE

I, Richard Nafziger, Chief Clerk of the House of Representatives of the State of Washington, do hereby certify that the attached is **SECOND SUBSTITUTE HOUSE BILL 1106** as passed by the House of Representatives and the Senate on the dates hereon set forth.

Chief Clerk

FILED

Secretary of State
State of Washington

SECOND SUBSTITUTE HOUSE BILL 1106

AS AMENDED BY THE SENATE

Passed Legislature - 2007 Regular Session

State of Washington 60th Legislature 2007 Regular Session

By House Committee on Appropriations (originally sponsored by Representatives Campbell, Chase, Hankins, Morrell, Appleton, Hudgins, McDermott and Wallace)

READ FIRST TIME 02/28/07.

AN ACT Relating to the reporting of infections acquired in health care facilities; reenacting and amending RCW 70.41.200 and 42.56.360; adding new sections to chapter 43.70 RCW; and creating new sections.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF WASHINGTON:

NEW SECTION. **Sec. 1.** The legislature finds that each year health care-associated infections affect two million Americans. These infections result in the unnecessary death of ninety thousand patients and costs the health care system 4.5 billion dollars. Hospitals should be implementing evidence-based measures to reduce hospital-acquired infections. The legislature further finds the public should have access to data on outcome measures regarding hospital-acquired infections. Data reporting should be consistent with national hospital reporting standards.

NEW SECTION. **Sec. 2.** A new section is added to chapter 43.70 RCW to read as follows:

(1) The definitions in this subsection apply throughout this section unless the context clearly requires otherwise.

(a) "Health care-associated infection" means a localized or systemic condition that results from adverse reaction to the presence of an infectious agent or its toxins and that was not present or incubating at the time of admission to the hospital.

(b) "Hospital" means a health care facility licensed under chapter 70.41 RCW.

(2)(a) A hospital shall collect data related to health care-associated infections as required under this subsection (2) on the following:

(i) Beginning July 1, 2008, central line-associated bloodstream infection in the intensive care unit;

(ii) Beginning January 1, 2009, ventilator-associated pneumonia; and

(iii) Beginning January 1, 2010, surgical site infection for the following procedures:

(A) Deep sternal wound for cardiac surgery, including coronary artery bypass graft;

(B) Total hip and knee replacement surgery; and

(C) Hysterectomy, abdominal and vaginal.

(b) Until required otherwise under (c) of this subsection, a hospital must routinely collect and submit the data required to be collected under (a) of this subsection to the national healthcare safety network of the United States centers for disease control and prevention in accordance with national healthcare safety network definitions, methods, requirements, and procedures.

(c)(i) With respect to any of the health care-associated infection measures for which reporting is required under (a) of this subsection, the department must, by rule, require hospitals to collect and submit the data to the centers for medicare and medicaid services according to the definitions, methods, requirements, and procedures of the hospital compare program, or its successor, instead of to the national healthcare safety network, if the department determines that:

(A) The measure is available for reporting under the hospital compare program, or its successor, under substantially the same definition; and

(B) Reporting under this subsection (2)(c) will provide substantially the same information to the public.

(ii) If the department determines that reporting of a measure must be conducted under this subsection (2)(c), the department must adopt rules to implement such reporting. The department's rules must require reporting to the centers for medicare and medicaid services as soon as practicable, but not more than one hundred twenty days, after the centers for medicare and medicaid services allow hospitals to report the respective measure to the hospital compare program, or its successor. However, if the centers for medicare and medicaid services allow infection rates to be reported using the centers for disease control and prevention's national healthcare safety network, the department's rules must require reporting that reduces the burden of data reporting and minimizes changes that hospitals must make to accommodate requirements for reporting.

(d) Data collection and submission required under this subsection (2) must be overseen by a qualified individual with the appropriate level of skill and knowledge to oversee data collection and submission.

(e)(i) A hospital must release to the department, or grant the department access to, its hospital-specific information contained in the reports submitted under this subsection (2), as requested by the department.

(ii) The hospital reports obtained by the department under this subsection (2), and any of the information contained in them, are not subject to discovery by subpoena or admissible as evidence in a civil proceeding, and are not subject to public disclosure as provided in RCW 42.56.360.

(3) The department shall:

(a) Provide oversight of the health care-associated infection reporting program established in this section;

(b) By January 1, 2011, submit a report to the appropriate committees of the legislature based on the recommendations of the advisory committee established in subsection (5) of this section for additional reporting requirements related to health care-associated infections, considering the methodologies and practices of the United States centers for disease control and prevention, the centers for medicare and medicaid services, the joint commission, the national quality forum, the institute for healthcare improvement, and other relevant organizations;

(c) Delete, by rule, the reporting of categories that the department determines are no longer necessary to protect public health and safety;

(d) By December 1, 2009, and by each December 1st thereafter, prepare and publish a report on the department's web site that compares the health care-associated infection rates at individual hospitals in the state using the data reported in the previous calendar year pursuant to subsection (2) of this section. The department may update the reports quarterly. In developing a methodology for the report and determining its contents, the department shall consider the recommendations of the advisory committee established in subsection (5) of this section. The report is subject to the following:

(i) The report must disclose data in a format that does not release health information about any individual patient; and

(ii) The report must not include data if the department determines that a data set is too small or possesses other characteristics that make it otherwise unrepresentative of a hospital's particular ability to achieve a specific outcome; and

(e) Evaluate, on a regular basis, the quality and accuracy of health care-associated infection reporting required under subsection (2) of this section and the data collection, analysis, and reporting methodologies.

(4) The department may respond to requests for data and other information from the data required to be reported under subsection (2) of this section, at the requestor's expense, for special studies and analysis consistent with requirements for confidentiality of patient records.

(5)(a) The department shall establish an advisory committee which may include members representing infection control professionals and epidemiologists, licensed health care providers, nursing staff, organizations that represent health care providers and facilities, health maintenance organizations, health care payers and consumers, and the department. The advisory committee shall make recommendations to assist the department in carrying out its responsibilities under this section, including making recommendations on allowing a hospital to review and verify data to be released in the report and on excluding from the report selected data from certified critical access hospitals.

(b) In developing its recommendations, the advisory committee shall consider methodologies and practices related to health care-associated infections of the United States centers for disease control and prevention, the centers for medicare and medicaid services, the joint commission, the national quality forum, the institute for healthcare improvement, and other relevant organizations.

(6) The department shall adopt rules as necessary to carry out its responsibilities under this section.

Sec. 3. RCW 70.41.200 and 2005 c 291 s 3 and 2005 c 33 s 7 are each reenacted and amended to read as follows:

(1) Every hospital shall maintain a coordinated quality improvement program for the improvement of the quality of health care services rendered to patients and the identification and prevention of medical malpractice. The program shall include at least the following:

(a) The establishment of a quality improvement committee with the responsibility to review the services rendered in the hospital, both retrospectively and prospectively, in order to improve the quality of medical care of patients and to prevent medical malpractice. The committee shall oversee and coordinate the quality improvement and medical malpractice prevention program and shall ensure that information gathered pursuant to the program is used to review and to revise hospital policies and procedures;

(b) A medical staff privileges sanction procedure through which credentials, physical and mental capacity, and competence in delivering health care services are periodically reviewed as part of an evaluation of staff privileges;

(c) The periodic review of the credentials, physical and mental capacity, and competence in delivering health care services of all persons who are employed or associated with the hospital;

(d) A procedure for the prompt resolution of grievances by patients or their representatives related to accidents, injuries, treatment, and other events that may result in claims of medical malpractice;

(e) The maintenance and continuous collection of information concerning the hospital's experience with negative health care outcomes and incidents injurious to patients <u>including health care-associated infections as defined in section 2 of this act</u>, patient grievances,

professional liability premiums, settlements, awards, costs incurred by the hospital for patient injury prevention, and safety improvement activities;

(f) The maintenance of relevant and appropriate information gathered pursuant to (a) through (e) of this subsection concerning individual physicians within the physician's personnel or credential file maintained by the hospital;

(g) Education programs dealing with quality improvement, patient safety, medication errors, injury prevention, infection control, staff responsibility to report professional misconduct, the legal aspects of patient care, improved communication with patients, and causes of malpractice claims for staff personnel engaged in patient care activities; and

(h) Policies to ensure compliance with the reporting requirements of this section.

(2) Any person who, in substantial good faith, provides information to further the purposes of the quality improvement and medical malpractice prevention program or who, in substantial good faith, participates on the quality improvement committee shall not be subject to an action for civil damages or other relief as a result of such activity. Any person or entity participating in a coordinated quality improvement program that, in substantial good faith, shares information or documents with one or more other programs, committees, or boards under subsection (8) of this section is not subject to an action for civil damages or other relief as a result of the activity. For the purposes of this section, sharing information is presumed to be in substantial good faith. However, the presumption may be rebutted upon a showing of clear, cogent, and convincing evidence that the information shared was knowingly false or deliberately misleading.

(3) Information and documents, including complaints and incident reports, created specifically for, and collected and maintained by, a quality improvement committee are not subject to review or disclosure, except as provided in this section, or discovery or introduction into evidence in any civil action, and no person who was in attendance at a meeting of such committee or who participated in the creation, collection, or maintenance of information or documents specifically for the committee shall be permitted or required to testify in any civil action as to the content of such proceedings or the documents and

information prepared specifically for the committee. This subsection does not preclude: (a) In any civil action, the discovery of the identity of persons involved in the medical care that is the basis of the civil action whose involvement was independent of any quality improvement activity; (b) in any civil action, the testimony of any person concerning the facts which form the basis for the institution of such proceedings of which the person had personal knowledge acquired independently of such proceedings; (c) in any civil action by a health care provider regarding the restriction or revocation of that individual's clinical or staff privileges, introduction into evidence information collected and maintained by quality improvement committees regarding such health care provider; (d) in any civil action, disclosure of the fact that staff privileges were terminated or restricted, including the specific restrictions imposed, if any and the reasons for the restrictions; or (e) in any civil action, discovery and introduction into evidence of the patient's medical records required by regulation of the department of health to be made regarding the care and treatment received.

(4) Each quality improvement committee shall, on at least a semiannual basis, report to the governing board of the hospital in which the committee is located. The report shall review the quality improvement activities conducted by the committee, and any actions taken as a result of those activities.

(5) The department of health shall adopt such rules as are deemed appropriate to effectuate the purposes of this section.

(6) The medical quality assurance commission or the board of osteopathic medicine and surgery, as appropriate, may review and audit the records of committee decisions in which a physician's privileges are terminated or restricted. Each hospital shall produce and make accessible to the commission or board the appropriate records and otherwise facilitate the review and audit. Information so gained shall not be subject to the discovery process and confidentiality shall be respected as required by subsection (3) of this section. Failure of a hospital to comply with this subsection is punishable by a civil penalty not to exceed two hundred fifty dollars.

(7) The department, the joint commission on accreditation of health care organizations, and any other accrediting organization may review and audit the records of a quality improvement committee or peer review

committee in connection with their inspection and review of hospitals. Information so obtained shall not be subject to the discovery process, and confidentiality shall be respected as required by subsection (3) of this section. Each hospital shall produce and make accessible to the department the appropriate records and otherwise facilitate the review and audit.

(8) A coordinated quality improvement program may share information and documents, including complaints and incident reports, created specifically for, and collected and maintained by, a quality improvement committee or a peer review committee under RCW 4.24.250 with one or more other coordinated quality improvement programs maintained in accordance with this section or RCW 43.70.510, a quality assurance committee maintained in accordance with RCW 18.20.390 or 74.42.640, or a peer review committee under RCW 4.24.250, for the improvement of the quality of health care services rendered to patients and the identification and prevention of medical malpractice. The privacy protections of chapter 70.02 RCW and the federal health insurance portability and accountability act of 1996 and its implementing regulations apply to the sharing of individually identifiable patient information held by a coordinated quality improvement program. Any rules necessary to implement this section shall meet the requirements of applicable federal and state privacy laws. Information and documents disclosed by one coordinated quality improvement program to another coordinated quality improvement program or a peer review committee under RCW 4.24.250 and any information and documents created or maintained as a result of the sharing of information and documents shall not be subject to the discovery process and confidentiality shall be respected as required by subsection (3) of this section, RCW 18.20.390 (6) and (8), 74.42.640 (7) and (9), and 4.24.250.

(9) A hospital that operates a nursing home as defined in RCW 18.51.010 may conduct quality improvement activities for both the hospital and the nursing home through a quality improvement committee under this section, and such activities shall be subject to the provisions of subsections (2) through (8) of this section.

(10) Violation of this section shall not be considered negligence per se.

Sec. 4. RCW 42.56.360 and 2006 c 209 s 9 and 2006 c 8 s 112 are each reenacted and amended to read as follows:

(1) The following health care information is exempt from disclosure under this chapter:

(a) Information obtained by the board of pharmacy as provided in RCW 69.45.090;

(b) Information obtained by the board of pharmacy or the department of health and its representatives as provided in RCW 69.41.044, 69.41.280, and 18.64.420;

(c) Information and documents created specifically for, and collected and maintained by a quality improvement committee under RCW 43.70.510 or 70.41.200, or by a peer review committee under RCW 4.24.250, or by a quality assurance committee pursuant to RCW 74.42.640 or 18.20.390, or by a hospital, as defined in section 2 of this act, for reporting of health care-associated infections under section 2 of this act, and notifications or reports of adverse events or incidents made under RCW 70.56.020 or 70.56.040, regardless of which agency is in possession of the information and documents;

(d)(i) Proprietary financial and commercial information that the submitting entity, with review by the department of health, specifically identifies at the time it is submitted and that is provided to or obtained by the department of health in connection with an application for, or the supervision of, an antitrust exemption sought by the submitting entity under RCW 43.72.310;

(ii) If a request for such information is received, the submitting entity must be notified of the request. Within ten business days of receipt of the notice, the submitting entity shall provide a written statement of the continuing need for confidentiality, which shall be provided to the requester. Upon receipt of such notice, the department of health shall continue to treat information designated under this subsection (1)(d) as exempt from disclosure;

(iii) If the requester initiates an action to compel disclosure under this chapter, the submitting entity must be joined as a party to demonstrate the continuing need for confidentiality;

(e) Records of the entity obtained in an action under RCW 18.71.300 through 18.71.340;

(f) Except for published statistical compilations and reports relating to the infant mortality review studies that do not identify

individual cases and sources of information, any records or documents obtained, prepared, or maintained by the local health department for the purposes of an infant mortality review conducted by the department of health under RCW 70.05.170; and

(g) Complaints filed under chapter 18.130 RCW after July 27, 1997, to the extent provided in RCW 18.130.095(1).

(2) Chapter 70.02 RCW applies to public inspection and copying of health care information of patients.

NEW SECTION. **Sec. 5.** A new section is added to chapter 43.70 RCW to read as follows:

The hospital infection control grant account is created in the custody of the state treasury. All receipts from gifts, grants, bequests, devises, or other funds from public or private sources to support its activities must be deposited into the account. Expenditures from the account may be used only for awarding hospital infection control grants to hospitals and public agencies for establishing and maintaining hospital infection control and surveillance programs, for providing support for such programs, and for the administrative costs associated with the grant program. Only the secretary or the secretary's designee may authorize expenditures from the account. The account is subject to allotment procedures under chapter 43.88 RCW, but an appropriation is not required for expenditures.

NEW SECTION. **Sec. 6.** A stakeholder group shall be convened by the department of health to review available data regarding existing infection control protocols at ambulatory surgical facilities. Based on its review of the data, the stakeholder group must make a recommendation to the department no later than December 15, 2008, regarding whether these facilities should be included within the coverage of this act. The department must report the stakeholder group recommendation to the appropriate committees of the legislature by January 1, 2009.

NEW SECTION. **Sec. 7.** If specific funding for the purposes of this act, referencing this act by bill or chapter number, is not provided by

June 30, 2007, in the omnibus appropriations act, this act is null and void.

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