H-4957.2

SECOND SUBSTITUTE HOUSE BILL 2786

State of Washington 58th Legislature 2004 Regular Session

By House Committee on Appropriations (originally sponsored by Representatives Cody, Campbell, Morrell, Schual-Berke, Lantz, Clibborn, G. Simpson, Moeller, Upthegrove and Kagi)

READ FIRST TIME 02/10/04.

AN ACT Relating to improving health care professional and health care facility patient safety practices; amending RCW 4.24.250, 43.70.510, 70.41.200, 43.70.110, 43.70.250, and 5.64.010; adding new sections to chapter 43.70 RCW; adding a new section to chapter 7.70 RCW; creating new sections; providing an effective date; and providing an expiration date.

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

NEW SECTION. **Sec. 1.** (1) The legislature finds that:

(a) Thousands of patients are injured each year in the United States as a result of medical errors, and that a comprehensive approach is needed to effectively reduce the incidence of medical errors in our health care system. Implementation of proven patient safety strategies can reduce medical errors, and thereby potentially reduce the need for disciplinary actions against licensed health care professionals and facilities, and the frequency and severity of medical malpractice claims; and

(b) Health care providers, health care facilities, and health carriers can and should be supported in their efforts to improve patient safety and reduce medical errors by authorizing the sharing of

successful quality improvement efforts, encouraging health care facilities and providers to communicate openly with patients regarding medical errors that have occurred and steps that can be taken to prevent errors from occurring in the future, encouraging health care facilities and providers to work cooperatively in their patient safety efforts, and increasing funding available to implement proven patient safety strategies.

(2) Through the adoption of this act, the legislature intends to positively influence the safety and quality of care provided in Washington state's health care system.

PART I: ENCOURAGING PATIENT SAFETY THROUGH SHARED QUALITY IMPROVEMENT EFFORTS

Sec. 101. RCW 4.24.250 and 1981 c 181 s 1 are each amended to read as follows:

(1) Any health care provider as defined in RCW 7.70.020 (1) and (2) as now existing or hereafter amended who, in good faith, files charges or presents evidence against another member of their profession based on the claimed incompetency or gross misconduct of such person before a regularly constituted review committee or board of a professional society or hospital whose duty it is to evaluate the competency and qualifications of members of the profession, including limiting the extent of practice of such person in a hospital or similar institution, or before a regularly constituted committee or board of a hospital whose duty it is to review and evaluate the quality of patient care, shall be immune from civil action for damages arising out of such activities. The proceedings, reports, and written records of such committees or boards, or of a member, employee, staff person, or investigator of such a committee or board, shall not be subject to subpoena or discovery proceedings in any civil action, except actions arising out of the recommendations of such committees or boards involving the restriction or revocation of the clinical or staff privileges of a health care provider as defined above.

(2) A coordinated quality improvement program maintained in accordance with RCW 43.70.510 or 70.41.200 may share information and documents, including complaints and incident reports, created specifically for, and collected and maintained by a coordinated quality

improvement committee or committees or boards under subsection (1) of this section, with one or more other coordinated quality improvement programs 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. Information and documents disclosed by one coordinated quality improvement program to another coordinated quality improvement program 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 (1) of this section and by RCW 43.70.510(4) and 70.41.200(3).

Sec. 102. RCW 43.70.510 and 1995 c 267 s 7 are each amended to read as follows:

(1)(a) Health care institutions and medical facilities, other than hospitals, that are licensed by the department, professional societies or organizations, health care service contractors, health maintenance organizations, health carriers approved pursuant to chapter 48.43 RCW, and any other person or entity providing health care coverage under chapter 48.42 RCW that is subject to the jurisdiction and regulation of any state agency or any subdivision thereof may 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 as set forth in RCW 70.41.200.

(b) All such programs shall comply with the requirements of RCW 70.41.200(1)(a), (c), (d), (e), (f), (g), and (h) as modified to reflect the structural organization of the institution, facility, professional societies or organizations, health care service contractors, health maintenance organizations, health carriers, or any other person or entity providing health care coverage under chapter 48.42 RCW that is subject to the jurisdiction and regulation of any state agency or any subdivision thereof, unless an alternative quality improvement program substantially equivalent to RCW 70.41.200(1)(a) is developed. All such programs, whether complying with the requirement

set forth in RCW 70.41.200(1)(a) or in the form of an alternative program, must be approved by the department before the discovery limitations provided in subsections (3) and (4) of this section and the exemption under RCW 42.17.310(1)(hh) and subsection (5) of this section shall apply. In reviewing plans submitted by licensed entities that are associated with physicians' offices, the department shall ensure that the exemption under RCW 42.17.310(1)(hh) and the discovery limitations of this section are applied only to information and documents related specifically to quality improvement activities undertaken by the licensed entity.

(2) Health care provider groups of ((~~ten~~)) five or more providers may 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 as set forth in RCW 70.41.200. All such programs shall comply with the requirements of RCW 70.41.200(1)(a), (c), (d), (e), (f), (g), and (h) as modified to reflect the structural organization of the health care provider group. All such programs must be approved by the department before the discovery limitations provided in subsections (3) and (4) of this section and the exemption under RCW 42.17.310(1)(hh) and subsection (5) of this section shall apply.

(3) 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 shares information or documents with one or more other programs in good faith and in accordance with applicable confidentiality and disclosure requirements of the coordinated quality improvement committee is not subject to an action for civil damages or other relief arising out of the act of sharing them.

(4) Information and documents, including complaints and incident reports, created specifically for, and collected, and maintained by a quality improvement committee are not subject to 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 that 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 challenging the termination of a contract by a state agency with any entity maintaining a coordinated quality improvement program under this section if the termination was on the basis of quality of care concerns, introduction into evidence of information created, collected, or maintained by the quality improvement committees of the subject entity, which may be under terms of a protective order as specified by the court; (e) 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 (f) in any civil action, discovery and introduction into evidence of the patient's medical records required by rule of the department of health to be made regarding the care and treatment received.

(5) Information and documents created specifically for, and collected and maintained by a quality improvement committee are exempt from disclosure under chapter 42.17 RCW.

(6) 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 with RCW 70.41.200, 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. Information and documents disclosed by one coordinated quality improvement program to another coordinated quality improvement program 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 (4) of this section and RCW 4.24.250.

(7) The department of health shall adopt rules as are necessary to implement this section.

Sec. 103. RCW 70.41.200 and 2000 c 6 s 3 are each 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, 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, 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 shares information or documents with one or more other programs in good faith and in accordance with applicable confidentiality and disclosure requirements of the coordinated quality improvement committee is not subject to an action for civil damages or other relief arising out of the act of sharing them.

(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 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 with RCW 43.70.510, 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. Information and documents disclosed by one coordinated quality improvement program to another coordinated quality improvement program 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 and RCW 4.24.250.

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

PART II: FUNDING PATIENT SAFETY EFFORTS

Sec. 201. RCW 43.70.110 and 1993 sp.s. c 24 s 918 are each amended to read as follows:

(1) The secretary shall charge fees to the licensee for obtaining a license. After June 30, 1995, municipal corporations providing emergency medical care and transportation services pursuant to chapter 18.73 RCW shall be exempt from such fees, provided that such other emergency services shall only be charged for their pro rata share of the cost of licensure and inspection, if appropriate. The secretary may waive the fees when, in the discretion of the secretary, the fees would not be in the best interest of public health and safety, or when the fees would be to the financial disadvantage of the state.

(2) Except as provided in section 203 of this act, fees charged shall be based on, but shall not exceed, the cost to the department for the licensure of the activity or class of activities and may include costs of necessary inspection.

(3) Department of health advisory committees may review fees established by the secretary for licenses and comment upon the appropriateness of the level of such fees.

Sec. 202. RCW 43.70.250 and 1996 c 191 s 1 are each amended to read as follows:

It shall be the policy of the state of Washington that the cost of each professional, occupational, or business licensing program be fully borne by the members of that profession, occupation, or business. The secretary shall from time to time establish the amount of all application fees, license fees, registration fees, examination fees, permit fees, renewal fees, and any other fee associated with licensing or regulation of professions, occupations, or businesses administered by the department. In fixing said fees, the secretary shall set the fees for each program at a sufficient level to defray the costs of administering that program and the patient safety fee established in section 203 of this act. All such fees shall be fixed by rule adopted by the secretary in accordance with the provisions of the administrative procedure act, chapter 34.05 RCW.

NEW SECTION. **Sec. 203.** A new section is added to chapter 43.70 RCW to read as follows:

(1) The secretary shall increase the licensing fee established under RCW 43.70.110 by two dollars per year for the health care professionals designated in subsection (2) of this section and by two dollars per licensed bed per year for the health care facilities designated in subsection (2) of this section. Proceeds of the patient safety fee must be deposited into the patient safety account in section 207 of this act and dedicated to patient safety and medical error reduction efforts that have been proven to improve, or have a substantial likelihood of improving the quality of care provided by health care professionals and facilities.

(2) The health care professionals and facilities subject to the patient safety fee are:

(a) The following health care professionals licensed under Title 18 RCW:

(i) Advanced registered nurse practitioners, registered nurses, and licensed practical nurses licensed under chapter 18.79 RCW;

(ii) Chiropractors licensed under chapter 18.25 RCW;

(iii) Dentists licensed under chapter 18.32 RCW;

(iv) Midwives licensed under chapter 18.50 RCW;

(v) Naturopaths licensed under chapter 18.36A RCW;

(vi) Nursing home administrators licensed under chapter 18.52 RCW;

(vii) Optometrists licensed under chapter 18.53 RCW;

(viii) Osteopathic physicians licensed under chapter 18.57 RCW;

(ix) Osteopathic physicians' assistants licensed under chapter 18.57A RCW;

(x) Pharmacists and pharmacies licensed under chapter 18.64 RCW;

(xi) Physicians licensed under chapter 18.71 RCW;

(xii) Physician assistants licensed under chapter 18.71A RCW;

(xiii) Podiatrists licensed under chapter 18.22 RCW; and

(xiv) Psychologists licensed under chapter 18.83 RCW; and

(b) Hospitals licensed under chapter 70.41 RCW and psychiatric hospitals licensed under chapter 71.12 RCW.

NEW SECTION. **Sec. 204.** A new section is added to chapter 7.70 RCW to read as follows:

(1)(a) One percent of any attorney contingency fee as contracted with a prevailing plaintiff in any action for damages based upon injuries resulting from health care shall be deducted from the contingency fee as a patient safety set aside. Proceeds of the patient safety set aside will be distributed by the department of health in the form of grants, loans, or other appropriate arrangements to support strategies that have been proven to reduce medical errors and enhance patient safety, or have a substantial likelihood of reducing medical errors and enhancing patient safety, as provided in section 203 of this act.

(b) A patient safety set aside shall be transmitted to the secretary of the department of health by the person or entity paying the claim, settlement, or verdict for deposit into the patient safety account established in section 207 of this act.

(c) The supreme court shall by rule adopt procedures to implement this section.

(2) If the patient safety set aside established by this section is invalidated by the Washington state supreme court, then any attorney representing a claimant who receives a settlement or verdict in any action for damages based upon injuries resulting from health care under this chapter shall provide information to the claimant regarding the existence and purpose of the patient safety account and notify the claimant that he or she may make a contribution to that account under section 206 of this act.

NEW SECTION. **Sec. 205.** A new section is added to chapter 43.70 RCW to read as follows:

(1)(a) Patient safety fee and set aside proceeds shall be administered by the department, after seeking input from health care providers engaged in direct patient care activities, health care facilities, and other interested parties. In developing criteria for the award of grants, loans, or other appropriate arrangements under this section, the department shall rely primarily upon evidence-based practices to improve patient safety that have been identified and recommended by governmental and private organizations, including, but not limited to:

(i) The federal agency for health care quality and research;

(ii) The institute of medicine of the national academy of sciences;

(iii) The joint commission on accreditation of health care organizations; and

(iv) The national quality forum.

(b) The department shall award grants, loans, or other appropriate arrangements for at least two strategies that are designed to meet the goals and recommendations of the federal institute of medicine's report, "Keeping Patients Safe: Transforming the Work Environment of Nurses."

(2) Projects that have been proven to reduce medical errors and enhance patient safety shall receive priority for funding over those that are not proven, but have a substantial likelihood of reducing medical errors and enhancing patient safety. All project proposals must include specific performance and outcome measures by which to evaluate the effectiveness of the project. Project proposals that do

not propose to use a proven patient safety strategy must include, in addition to performance and outcome measures, a detailed description of the anticipated outcomes of the project based upon any available related research and the steps for achieving those outcomes.

(3) The department may use a portion of the patient safety fee proceeds for the costs of administering the program.

NEW SECTION. **Sec. 206.** A new section is added to chapter 43.70 RCW to read as follows:

The secretary may solicit and accept grants or other funds from public and private sources to support patient safety and medical error reduction efforts under this act. Any grants or funds received may be used to enhance these activities as long as program standards established by the secretary are followed.

NEW SECTION. **Sec. 207.** A new section is added to chapter 43.70 RCW to read as follows:

The patient safety account is created in the state treasury. All receipts from the fees and set asides created in sections 203 and 204 of this act must be deposited into the account. Expenditures from the account may be used only for the purposes of this act. Moneys in the account may be spent only after appropriation.

NEW SECTION. **Sec. 208.** A new section is added to chapter 43.70 RCW to read as follows:

By December 1, 2007, the department shall report the following information to the governor and the health policy and fiscal committees of the legislature:

(1) The amount of patient safety fees and set asides deposited to date in the patient safety account;

(2) The criteria for distribution of grants, loans, or other appropriate arrangements under this act; and

(3) A description of the medical error reduction and patient safety grants and loans distributed to date, including the stated performance measures, activities, timelines, and detailed information regarding outcomes for each project.

PART III: ENCOURAGING PATIENT SAFETY THROUGH COMMUNICATIONS WITH PATIENTS

Sec. 301. RCW 5.64.010 and 1975-'76 2nd ex.s. c 56 s 3 are each amended to read as follows:

(1) In any civil action against a health care provider for personal injuries which is based upon alleged professional negligence ((~~and which is against:~~

~~(1) A person licensed by this state to provide health care or related services, including, but not limited to, a physician, osteopathic physician, dentist, nurse, optometrist, podiatrist, chiropractor, physical therapist, psychologist, pharmacist, optician, physician's assistant, osteopathic physician's assistant, nurse practitioner, or physician's trained mobile intensive care paramedic, including, in the event such person is deceased, his estate or personal representative;~~

~~(2) An employee or agent of a person described in subsection (1) of this section, acting in the course and scope of his employment, including, in the event such employee or agent is deceased, his estate or personal representative; or~~

~~(3) An entity, whether or not incorporated, facility, or institution employing one or more persons described in subsection (1) of this section, including, but not limited to, a hospital, clinic, health maintenance organization, or nursing home; or an officer, director, employee, or agent thereof acting in the course and scope of his employment, including, in the event such officer, director, employee, or agent is deceased, his estate or personal representative;~~)), evidence of furnishing or offering or promising to pay medical, hospital, or similar expenses occasioned by an injury is not admissible to prove liability for the injury.

(2) In a civil action against a health care provider for personal injuries which is based upon alleged professional negligence, evidence of an early offer of settlement is inadmissible, not discoverable, and otherwise unavailable for use in the action. An early offer of settlement means an offer that is made before the filing of a claim and that makes an offer of compensation for the injury suffered. An early offer of settlement may include an apology or an admission of fault on the part of the person making the offer, or a statement regarding remedial actions that may be taken to address the act or omission that

is the basis for the allegation of negligence, and does not become admissible, discoverable, or otherwise available for use in the action because it contains an apology, admission of fault, or statement of remedial actions that may be taken. Compensation means payment of money or other property to or on behalf of the injured party, rendering of services to the injured party free of charge, or indemnification of expenses incurred by or on behalf of the injured party.

(3) For the purposes of this section, "health care provider" has the same meaning provided in RCW 7.70.020.

PART IV: MISCELLANEOUS PROVISIONS

NEW SECTION. **Sec. 401.** Part headings used in this act are not any part of the law.

NEW SECTION. **Sec. 402.** If any provision of this act or its application to any person or circumstance is held invalid, the remainder of the act or the application of the provision to other persons or circumstances is not affected.

NEW SECTION. **Sec. 403.** Sections 201 through 208 of this act expire December 31, 2010.

NEW SECTION. **Sec. 404.** Section 203 of this act takes effect July 1, 2004.

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