HOUSE BILL REPORT
SHB 1642

As Passed House:
March 18, 2003

Title: An act relating to peer review committees and coordinated quality improvement programs.

Brief Description: Modifying medical information exchange and disclosure provisions.

Sponsors: By House Committee on Judiciary (originally sponsored by Representatives Morrell, Pflug, Cody, Benson, Schual-Berke, Alexander, Clibborn, Edwards, Moeller and Kenney).

Brief History:
Committee Activity:
Judiciary: 2/21/03, 2/27/03 [DPS].
Floor Activity:
Passed House: 3/18/03, 97-0.

Brief Summary of Substitute Bill

- Allows health care coordinated quality improvement programs to share information with other coordinated quality improvement programs.
- Requires information shared between coordinated quality improvement programs to remain confidential and not discoverable or admissible in civil proceedings.
- Allows health care provider groups consisting of at least two providers to maintain coordinated quality improvement programs.
- Adds medication errors to the issues that must be included in quality improvement education programs.

HOUSE COMMITTEE ON JUDICIARY

Majority Report: The substitute bill be substituted therefor and the substitute bill do pass. Signed by 9 members: Representatives Lantz, Chair; Moeller, Vice Chair; Carrell, Ranking Minority Member; McMahan, Assistant Ranking Minority Member; Campbell, Flannigan, Kirby, Lovick and Newhouse.

Staff: Edie Adams (786-7180).

Background:

Hospitals are required to maintain coordinated quality improvement programs designed to improve the quality of health care services and prevent medical malpractice. Other health institutions and medical facilities, and health provider groups consisting of at least 10 providers, are authorized to maintain coordinated quality improvement programs. Coordinated quality improvement programs maintained by these other entities must be approved by the Department of Health and must comply, or substantially comply, with the statutorily required components of the hospital coordinated quality improvement programs.

Coordinated quality improvement programs are overseen and coordinated by quality improvement committees. The programs must include: a medical staff privileges sanction procedure; periodic review of employee credentials and competency in the delivery of health care services; a procedure for prompt resolution of patient grievances; collection of information relating to negative outcomes, patient grievances, settlements and awards, and safety improvement activities; and quality improvement education programs. Components of the education programs include quality improvement, patient safety, injury prevention, improved communication with patients, and causes of malpractice claims.

With some limited exceptions, information and documents created for or collected and maintained by a quality improvement committee are not subject to discovery, not admissible into evidence in any civil action, and are confidential and not subject to public disclosure. A person participating in a meeting of the committee or in the creation or collection of information for the committee may not testify in any civil action regarding the content of the committee proceedings or information created or collected by the committee.

A provision of law immunizes a health care provider who, in good faith, files charges or presents evidence against another provider before a regularly constituted review committee or board of a professional society or hospital on grounds of incompetency or misconduct. The proceedings and records of a review committee or board are not discoverable except in actions relating to the recommendation of the review committee or board involving restriction or revocation of the provider's privileges.

Summary of Substitute Bill:

A coordinated quality improvement program may share information created for, and collected and maintained by, a quality improvement committee, a peer review committee or review boards with other coordinated quality improvement programs for the purpose of

improving the quality of health care services and preventing medical malpractice. Information shared between coordinated quality improvement programs, and information created or maintained as a result of sharing information, is confidential and not discoverable or admissible in civil proceedings.

Health care provider groups that consist of two or more providers may maintain a coordinated quality improvement program.

Medical errors are added to the list of issues that must be included in quality improvement education programs.

Appropriation: None.

Fiscal Note: Not Requested.

Effective Date: The bill takes effect 90 days after adjournment of session in which bill is passed.

Testimony For: Coordinated quality improvement programs have been around for a long time and they work effectively. These programs help increase patient safety because they encourage reporting of errors and allow hospitals and other medical entities to openly discuss a problem or negative outcome and how to prevent it in the future. These discussions would not take place if the information was not protected from discovery. The bill allows hospitals and other medical entities to share information with each other as well. This will allow hospitals and other medical entities to learn from each other's mistakes; they shouldn't have to reinvent the wheel. The bill takes a huge step forward in patient safety in the outpatient setting as well by allowing provider groups of at least two providers to form these programs.

(With concerns) Coordinated quality improvement programs create a privilege and an immunity with respect to health care information. They create a black box that denies patients the right of access to information. Injured patients should have the right to know what happened to them and why. This bill expands the ability of hospitals and others to deny injured patients access to information and keep them in the dark. There should be some way for this information to be open to the community.

Testimony Against: None.

Testified: (In support) Representative Morrell, prime sponsor; Loren Finley; Rebecca Repp, Washington Health Care Risk Management Society; Patti Rathbun, Department of Health; Lisa Thatcher, Washington State Hospital Association; and Cliff Webster, Washington State Medical Association.

(With concerns) Carol Johnston, Washington State Trial Lawyers Association; and Rowland Thompson, Allied Daily Newspapers of Washington and Washington Newspapers Publishers.