SENATE BILL REPORT
E2SHB 2786

As Reported By Senate Committee On:
Health & Long-Term Care, February 26, 2004

Title: An act relating to improving health care professional and health care facility patient safety practices.

Brief Description: Improving patient safety practices.

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

Brief History:
Committee Activity: Health & Long-Term Care: 2/25/04, 2/26/04 [DPA-WM].
Ways & Means: 3/1/04.

SENATE COMMITTEE ON HEALTH & LONG-TERM CARE

Majority Report: Do pass as amended and be referred to Committee on Ways & Means.
Signed by Senators Deccio, Chair; Winsley, Vice Chair; Brandland, Franklin, Keiser, Parlette and Thibaudeau.

Staff: Tanya Karwaki (786-7447)

SENATE COMMITTEE ON WAYS & MEANS

Staff: Tim Yowell (786-7435)

Background: Coordinated Quality Improvement Programs. Under Washington law, 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 ten providers, are authorized to maintain coordinated quality improvement programs. 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 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 included 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.

Patient Safety. Studies have indicated that medical errors are a leading cause of death and injury in the United States. According to the Institute of Medicine, between 44,000 and 98,000 Americans die each year as a result of medical errors.

Offers of Settlement. In Washington, evidence of furnishing or offering to pay medical expenses needed as the result of an injury is not admissible in a civil action to prove liability for the injury. This applies in medical malpractice cases against a health care provider, an employee or agent of a health care provider, or an entity, facility, or institution employing a health care provider. Additionally, evidence of offers of compromise are not admissible to prove liability for a claim. Evidence of conduct or statements made in compromise negotiations are likewise not admissible.

In 2002, the Legislature passed legislation that makes inadmissible in a civil trial expressions of sympathy relating to the pain, suffering, or death of a person involved in an accident. A statement of fault, however, is not made inadmissible under this provision.

Summary of Bill: Coordinated Quality Improvement Programs. A coordinated quality improvement program or regularly constituted review committee or board of a professional society or hospital with a duty to evaluate health professionals may share information and documents created specifically for a quality improvement committee or peer review committee with other such programs, committees, or boards for the purpose of improving health care services and identifying and preventing medical malpractice. The information shared is confidential and is neither subject to discovery nor admissible in civil proceedings. The privacy protection of Washington's Uniform Health Care Information Act and the federal Health Insurance Portability and Accountability Act apply to the sharing of individually identifiable patient information held by a coordinated quality improvement program.

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

A presumption of good faith is created for persons and entities who share information or documents with other programs, committees, or boards. This presumption, however, may be rebutted upon a showing of clear, cogent, and convincing evidence.

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

Patient Safety. The "Patient Safety Account" is created. The account is funded by a $2 surcharge on licenses for 16 health professionals, a $2 charge per licensed bed per year for hospitals and psychiatric hospitals, and one percent of any attorney contingency fee for a prevailing plaintiff in a medical malpractice action. The account is to be used for grants, loans, and other arrangements that support efforts to reduce medical errors and enhance patient safety.

By December 1, 2007, the Department of Health must report to the Legislature about the funds raised, criteria developed, and projects funded. The patient safety account provisions expire December 31, 2010.

Hospitals are required to have policies to assure that, when appropriate, information about unanticipated outcomes is provided to patients, their families, or surrogate decision makers. Notification of unanticipated outcomes does not constitute an acknowledgment or admission of liability, nor can it be introduced as evidence in a civil action.

Hospitals must post notification of whistleblower protections for reporting improper quality of care in conspicuous places where notices to affected employees are usually posted.

The Medical Quality Assurance Commission, upon a finding that a license holder or applicant has committed unprofessional conduct or is unable to practice medicine safely, may consider imposing sanctions and may take into account the arguments of participants, including other charges or sanctions.

Offers of Settlement. In any civil action against a health care provider for personal injuries based upon alleged professional negligence, evidence of furnishing or offering to pay medical expenses needed as the result of an injury is not admissible to prove liability. Provisions applying this to an employee or agent of a health care provider, or an entity, facility, or institution employing a health care provider are removed.

An early offer of settlement means an offer that is made prior to the filing of a claim and that makes an offer of compensation for the injury. Evidence of an early offer of settlement is inadmissible, not discoverable, and otherwise not available for use in a medical malpractice action even if it contains an apology, admission of fault, or statement regarding remedial measures that might be taken.

Amended Bill Compared to Second Substitute Bill: The striking amendment requires hospitals to post notices of whistleblower protections in conspicuous places and permits the Medical Quality Assurance Commission, upon a finding of unprofessional conduct, to take into account other charges or sanctions against the provider. The amendment also requires hospitals to have policies in place to assure that, when appropriate, information about unanticipated outcomes is provided to patients, their families, or their surrogate decision makers. Finally, it permits regularly constituted review committees or boards of a professional society or hospital whose duty it is to evaluate the competency and qualifications of members of the profession to share information with other such committees, boards, or coordinated quality improvement programs.

Appropriation: None.

Fiscal Note: Available.

Effective Date: Ninety days after adjournment of session in which bill is passed, except for Section 203, relating to a surcharge on licenses for health care providers and facilities, which takes effect July 1, 2004.

Testimony For (Health & Long-Term Care): The delivery of health care is complex. An error is often systemic and we need to move to an atmosphere of openness and trust. This bill

would improve patient safety. It needs, however, to be part of comprehensive tort reform. This bill will help the health care community and the Department of Health work together to enhance patient safety.

Testimony Against (Health & Long-Term Care): There is concern that the bill is not compliant with the Health Insurance Portability and Accountability Act.

Testified (Health & Long-Term Care): PRO: Maureen Callaghamns, WSMA; Patti Rathbun, DOH; Karen Merrikin, Group Health.

Testimony For (Ways & Means): There is no opposition to the $2 fee increase from the licensed health care professionals and hospitals who would pay it. They recognize that reducing medical errors is expensive, and that a source of funds to help do that is in their interest.

Testimony Against (Ways & Means): None.

Testified (Ways & Means): Representative Eileen Cody, prime sponsor.