2786-S2
Sponsor(s): House Committee on Appropriations (originally sponsored by Representatives Cody, Campbell, Morrell, Schual-Berke, Lantz, Clibborn, G. Simpson, Moeller, Upthegrove and Kagi)

Brief Description: Improving patient safety practices.

HB 2786-S2.E - DIGEST

(AS OF HOUSE 2ND READING 2/16/04)

Finds that: (1) 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

(2) 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 work cooperatively in their patient safety efforts, and increasing funding available to implement proven patient safety strategies.

Declares an intent to positively influence the safety and quality of care provided in Washington state's health care system.

Provides that 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 this act, 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 and the department shall assure that all rules relating to coordinated quality improvement programs and the sharing of individually identifiable patient information by these programs comply with these laws.

Declares that 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 this act and by RCW 43.70.510(4) and 70.41.200(3).

Provides that 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.

Establishes provisions for funding patient safety efforts.

Requires that, 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.