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HOUSE BILL 1106

State of Washington 60th Legislature 2007 Regular Session

By Representatives Campbell, Chase, Hankins, Morrell, Appleton, Hudgins, McDermott and Wallace

Read first time 01/10/2007. Referred to Committee on Health Care & Wellness.

AN ACT Relating to the reporting of infections acquired in health care facilities; reenacting and amending RCW 70.41.200; adding a new section to chapter 43.70 RCW; adding a new section to chapter 42.56 RCW; and creating a new section.

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, including hospital-owned ambulatory surgical centers or outpatient surgical centers.

(2) The department shall:

(a) Adopt guidelines and rules for identifying, tracking, reporting, and releasing information related to outcome measures as related to health care-associated infections acquired in hospitals. In adopting these guidelines and rules related to health care-associated infections, the department shall consider the recommendations of the advisory committee established in (c) of this subsection as well as the recommendations, definitions, and methodologies, of the United States centers for disease control and prevention, the centers for health care research and quality, the centers for medicare and medicaid services, the joint commission on accreditation of health care organizations, the national quality forum, the institute for health care improvement, or other organizations with recognized expertise in infection control or quality improvement. The guidelines and rules shall establish criteria for excluding data from reporting where 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 measure. The guidelines and rules shall consider outcome measures, for an entire hospital or specified units, in the following categories:

(i) Surgical site infections for selected procedures;

(ii) Surgical antimicrobial prophylaxis;

(iii) Outcome measures on ventilator-associated pneumonia;

(iv) Central line-associated, laboratory-confirmed bloodstream infections in the intensive care unit; and

(v) Other categories for which there are established, evidence-based measures and the department determines are necessary to protect public health and safety as provided in subsection (3) of this section;

(b) Publish an annual report on the department's web site that compares the hospital-acquired infection outcomes described in (a)(i) of this subsection at each individual hospital in the state.

Comparisons among hospitals shall be adjusted to consider patient mix and other relevant risk factors and control for provider peer groups, when appropriate. The annual report shall disclose data in a format so that no health information about any individual patient is released. The report shall not include data where the guidelines have determined 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 measure. The department may respond to requests for data and other information, at the requestor's expense, for special studies and analysis consistent with requirements for confidentiality of patient records and quality improvement information;

(c) Establish an advisory committee to make recommendations to the department in the development of guidelines and rules for the collection, reporting, and release of information related to health care-associated infections. The advisory committee shall consist of infection control professionals and epidemiologists. In developing its recommendations, the department shall consider the definitions, methodologies, and practices of the United States centers for disease control, centers for medicare and medicaid services, joint commission for the accreditation of health care organizations, and the institute for health care improvement related to health care-associated infections. The advisory committee shall meet as often as necessary to complete its duties, but not less than three times per year; and

(d) Report to the legislature in November 2009 regarding the activities of United States centers for disease control, centers for medicare and medicaid services, joint commission for the accreditation of health care organizations, and the institute for health care improvement related to reporting health care-associated infections.

(3) As guidelines are developed for preventing health care-associated infections and tracking outcomes and performance regarding health care-associated infections, the department shall include any procedures or categories of infections, including clostridium dificile, in the infection guidelines and rules developed pursuant to subsection (2)(a) of this section if the department determines that the guidelines are evidence-based, have been demonstrated to reduce health care-associated infections, and are feasible for hospitals to track. The department may consider guidelines from organizations with recognized expertise in infection

control or quality improvement including the United States centers for disease control and prevention, the centers for medicare and medicaid services, the centers for health care research and quality, the joint commission on accreditation of health care organizations, the national quality forum, and the institute of health care improvement.

(4) Each hospital shall:

(a) Collect information regarding health care-associated infection outcome measures for the categories identified in subsections (2) and (3) of this section; and

(b) Prepare a report every three months and submit the reports to the department. The collection and reporting of information shall be performed in accordance with the guidelines and rules of the department.

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

(6) Neither the reports submitted by hospitals to the department under this section, nor any of the data contained in them, are subject to discovery by subpoena or admissible as evidence in a civil proceeding.

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 including health care-associated infections, 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.

NEW SECTION. **Sec. 4.** A new section is added to chapter 42.56 RCW to read as follows:

Any information and reports exchanged between hospitals and the department of health under section 2 of this act are exempt from disclosure under this chapter.

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