SENATE BILL REPORT
SB 5370

As of February 7, 2011

Title: An act relating to the adverse health events and incident reporting system.

Brief Description: Concerning the adverse health events and incident reporting system.

Sponsors: Senators Keiser and Conway.

Brief History:
Committee Activity: Health & Long-Term Care: 2/02/11.

SENATE COMMITTEE ON HEALTH & LONG-TERM CARE

Staff: Kathleen Buchli (786-7488)

Background: Adverse events are medical errors that could and should have been avoided by health care facilities. These errors, called Serious Reportable Events as defined by the National Quality Forum, may result in patient death or serious disability. Medical facilities must report to the Department of Health (DOH) when adverse events occur in order to facilitate quality improvement in the health care system, improve patient safety, assist the public in making informed health care choices, and decrease medical errors in a nonpunitive manner. DOH produces reports highlighting adverse events by type, facility, and date and provides this information on its website.

Health professions are regulated through the Uniform Disciplinary Act. Complaints regarding a health care professional may be filed with the disciplining authority for that profession, and if it is determined that the complaint shows a violation of the law, an investigation will take place.

Summary of Bill: The bill as referred to committee not considered.

Summary of Bill (Proposed Substitute): Medical facilities or health care practitioners must report to DOH when they confirm that an adverse event has occurred. This report must also be submitted to any payer for services relating to the adverse event. Medical facilities or health care practitioners must submit notice to the patient or the patient's family affected by the adverse event that the notification has been filed with DOH.

This analysis was prepared by non-partisan legislative staff for the use of legislative members in their deliberations. This analysis is not a part of the legislation nor does it constitute a statement of legislative intent.

Disciplinary authorities who receive complaints under the Uniform Disciplinary Act, must submit a copy of the complaint to the Adverse Health Events and Incident Notification and Reporting System which will be used, where necessary, by DOH in conducting investigations on reports of adverse events.

Beginning July 1, 2012, child birth centers, hospitals, and psychiatric hospitals must submit an annual fee of $1,000 to DOH to fund the Adverse Health Events and Incident Notification and Reporting System. DOH may adjust the fee annually for inflation.

Appropriation: None.

Fiscal Note: Requested on January 21, 2011.
[OFM requested ten-year cost projection pursuant to I-960.]

Committee/Commission/Task Force Created: No.

Effective Date: Ninety days after adjournment of session in which bill is passed.

Staff Summary of Public Testimony: CON: This bill may result in HIPAA violations. We are concerned about the sharing of information on impaired practitioners. We are already involved with addressing never events.

OTHER: Requiring health care professionals to report as well as medical facilities could result in double reporting of some events. The number of medical facilities subject to the fee would not be sufficient to support the bill. The root causes analysis should not be shared with payers. Rather than have the notification sent to the patient's family, a surrogate decision maker should be substituted. Hospitals already pay multiple fees every year and the imposition of the fee is a matter of concern. We are supportive of adverse event reporting and decreasing medical errors in a non-punitive manner. The bill might inhibit reporting. The inclusion of the health care professional may lead to confusion as to who should be reporting. Complaints of providers are already available at DOH and forwarding these complaints to the adverse events system would be duplicative.

Persons Testifying: CON: Carl Nelson, Washington State Medical Association.

OTHER: Karen Jensen, DOH; Lisa Thatcher, Brenda Suiter, Washington State Hospital Association; Emily Studebaker, Washington Ambulatory Surgery Center Association; Sofia Aragon, Washington State Nurses Association.