S-1575.1

SUBSTITUTE SENATE BILL 5512

State of Washington 65th Legislature 2017 Regular Session

By Senate Human Services, Mental Health & Housing (originally sponsored by Senators Becker, Cleveland, and Rivers)

READ FIRST TIME 02/16/17.

1 AN ACT Relating to placing state hospitals under the licensing
2 authority of the department of health; amending RCW 70.56.010,
3 70.41.020, 70.41.320, 70.41.330, 70.41.380, and 70.41.120; adding a
4 new section to chapter 72.23 RCW; and prescribing penalties.

5 BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF WASHINGTON:

6 **Sec. 1.** RCW 70.56.010 and 2007 c 273 s 20 are each amended to
7 read as follows:
8 The definitions in this section apply throughout this chapter
9 unless the context clearly requires otherwise.
10 (1) "Adverse health event" or "adverse event" means the list of
11 serious reportable events adopted by the national quality forum in
12 2002, in its consensus report on serious reportable events in health
13 care. The department shall update the list, through adoption of
14 rules, as subsequent changes are made by the national quality forum.
15 The term does not include an incident.
16 (2) "Ambulatory surgical facility" means a facility licensed
17 under chapter 70.230 RCW.
18 (3) "Childbirth center" means a facility licensed under chapter
19 18.46 RCW.
20 (4) "Correctional medical facility" means a part or unit of a
21 correctional facility operated by the department of corrections under

1 chapter 72.10 RCW that provides medical services for lengths of stay
2 in excess of twenty-four hours to offenders.
3 (5) "Department" means the department of health.
4 (6) "Health care worker" means an employee, independent
5 contractor, licensee, or other individual who is directly involved in
6 the delivery of health services in a medical facility.
7 (7) "Hospital" means a facility licensed under chapter 70.41 RCW<u>,</u>
8 <u>or a state hospital as defined in RCW 72.23.010</u>.
9 (8) "Incident" means an event, occurrence, or situation involving
10 the clinical care of a patient in a medical facility that:
11 (a) Results in unanticipated injury to a patient that is not
12 related to the natural course of the patient's illness or underlying
13 condition and does not constitute an adverse event; or
14 (b) Could have injured the patient but did not either cause an
15 unanticipated injury or require the delivery of additional health
16 care services to the patient.
17 "Incident" does not include an adverse event.
18 (9) "Independent entity" means that entity that the department of
19 health contracts with under RCW 70.56.040 to receive notifications
20 and reports of adverse events and incidents, and carry out the
21 activities specified in RCW 70.56.040.
22 (10) "Medical facility" means a childbirth center, hospital,
23 psychiatric hospital, or correctional medical facility. An ambulatory
24 surgical facility shall be considered a medical facility for purposes
25 of this chapter upon the effective date of any requirement for state
26 registration or licensure of ambulatory surgical facilities.
27 (11) "Psychiatric hospital" means a hospital facility licensed as
28 a psychiatric hospital under chapter 71.12 RCW.

29 **Sec. 2.** RCW 70.41.020 and 2016 c 226 s 1 are each amended to
30 read as follows:
31 Unless the context clearly indicates otherwise, the following
32 terms, whenever used in this chapter, shall be deemed to have the
33 following meanings:
34 (1) "Aftercare" means the assistance provided by a lay caregiver
35 to a patient under this chapter after the patient's discharge from a
36 hospital. The assistance may include, but is not limited to,
37 assistance with activities of daily living, wound care, medication
38 assistance, and the operation of medical equipment. "Aftercare"
39 includes assistance only for conditions that were present at the time

of the patient's discharge from the hospital. "Aftercare" does not include:

(a) Assistance related to conditions for which the patient did not receive medical care, treatment, or observation in the hospital; or

(b) Tasks the performance of which requires licensure as a health care provider.

(2) "Department" means the Washington state department of health.

(3) "Discharge" means a patient's release from a hospital following the patient's admission to the hospital.

(4) "Distant site" means the site at which a physician or other licensed provider, delivering a professional service, is physically located at the time the service is provided through telemedicine.

(5) "Emergency care to victims of sexual assault" means medical examinations, procedures, and services provided by a hospital emergency room to a victim of sexual assault following an alleged sexual assault.

(6) "Emergency contraception" means any health care treatment approved by the food and drug administration that prevents pregnancy, including but not limited to administering two increased doses of certain oral contraceptive pills within seventy-two hours of sexual contact.

(7) "Hospital" means any institution, place, building, or agency which provides accommodations, facilities and services over a continuous period of twenty-four hours or more, for observation, diagnosis, or care, of two or more individuals not related to the operator who are suffering from illness, injury, deformity, or abnormality, or from any other condition for which obstetrical, medical, or surgical services would be appropriate for care or diagnosis. "Hospital" as used in this chapter does not include hotels, or similar places furnishing only food and lodging, or simply domiciliary care; nor does it include clinics, or physician's offices where patients are not regularly kept as bed patients for twenty-four hours or more; nor does it include nursing homes, as defined and which come within the scope of chapter 18.51 RCW; nor does it include birthing centers, which come within the scope of chapter 18.46 RCW; nor does it include psychiatric hospitals, which come within the scope of chapter 71.12 RCW; nor any other hospital, or institution specifically intended for use in the diagnosis and care of those suffering from mental illness, intellectual disability, convulsive

disorders, or other abnormal mental condition. Furthermore, nothing in this chapter or the rules adopted pursuant thereto shall be construed as authorizing the supervision, regulation, or control of the remedial care or treatment of residents or patients in any hospital conducted for those who rely primarily upon treatment by prayer or spiritual means in accordance with the creed or tenets of any well recognized church or religious denominations.

(8) "Lay caregiver" means any individual designated as such by a patient under this chapter who provides aftercare assistance to a patient in the patient's residence. "Lay caregiver" does not include a long-term care worker as defined in RCW 74.39A.009.

(9) "Originating site" means the physical location of a patient receiving health care services through telemedicine.

(10) "Person" means any individual, firm, partnership, corporation, company, association, or joint stock association, and the legal successor thereof.

(11) "Secretary" means the secretary of health.

(12) "Sexual assault" has the same meaning as in RCW 70.125.030.

(13) "State hospital" has the meaning provided in RCW 72.23.010.

(14) "Telemedicine" means the delivery of health care services through the use of interactive audio and video technology, permitting real-time communication between the patient at the originating site and the provider, for the purpose of diagnosis, consultation, or treatment. "Telemedicine" does not include the use of audio-only telephone, facsimile, or email.

((~~(14)~~)) (15) "Victim of sexual assault" means a person who alleges or is alleged to have been sexually assaulted and who presents as a patient.

Sec. 3. RCW 70.41.320 and 2016 c 226 s 5 are each amended to read as follows:

(1) Hospitals, state hospitals, and acute care facilities shall:

(a) Work cooperatively with the department of social and health services, area agencies on aging, and local long-term care information and assistance organizations in the planning and implementation of patient discharges to long-term care services.

(b) Establish and maintain a system for discharge planning and designate a person responsible for system management and implementation.

(c) Establish written policies and procedures to:

(i) Identify patients needing further nursing, therapy, or supportive care following discharge from the hospital;

(ii) Subject to RCW 70.41.322, develop a documented discharge plan for each identified patient, including relevant patient history, specific care requirements, and date such follow-up care is to be initiated;

(iii) Coordinate with patient, family, caregiver, lay caregiver as provided in RCW 70.41.322, and appropriate members of the health care team which may include a long-term care worker or a home and community-based service provider. For the purposes of this subsection (1)(c)(iii), long-term care worker has the meaning provided in RCW 74.39A.009 and home and community-based service provider includes an adult family home as defined in RCW 70.128.010, an assisted living facility as defined in RCW 18.20.020, or a home care agency as defined in RCW 70.127.010;

(iv) Provide any patient, regardless of income status, written information and verbal consultation regarding the array of long-term care options available in the community, including the relative cost, eligibility criteria, location, and contact persons;

(v) Promote an informed choice of long-term care services on the part of patients, family members, and legal representatives;

(vi) Coordinate with the department and specialized case management agencies, including area agencies on aging and other appropriate long-term care providers, as necessary, to ensure timely transition to appropriate home, community residential, or nursing facility care; and

(vii) Inform the patient or his or her surrogate decision maker designated under RCW 7.70.065 if it is necessary to complete a valid disclosure authorization as required by state and federal laws governing health information privacy and security, including chapter 70.02 RCW and the federal health insurance portability and accountability act of 1996 and related regulations, in order to allow disclosure of health care information, including the discharge plan, to an individual or entity that will be involved in the patient's care upon discharge, including a lay caregiver as defined in RCW 70.41.020, a long-term care worker as defined in RCW 74.39A.009, a home and community-based service provider such as an adult family home as defined in RCW 70.128.010, an assisted living facility as defined in RCW 18.20.020, or a home care agency as defined in RCW 70.127.010. If a valid disclosure authorization is obtained, the

hospital may release information as designated by the patient for care coordination or other specified purposes.

(d) Work in cooperation with the department which is responsible for ensuring that patients eligible for medicaid long-term care receive prompt assessment and appropriate service authorization.

(2) In partnership with selected hospitals, the department of social and health services shall develop and implement pilot projects in up to three areas of the state with the goal of providing information about appropriate in-home and community services to individuals and their families early during the individual's hospital stay.

The department shall not delay hospital discharges but shall assist and support the activities of hospital discharge planners. The department also shall coordinate with home health and hospice agencies whenever appropriate. The role of the department is to assist the hospital and to assist patients and their families in making informed choices by providing information regarding home and community options.

In conducting the pilot projects, the department shall:

(a) Assess and offer information regarding appropriate in-home and community services to individuals who are medicaid clients or applicants; and

(b) Offer assessment and information regarding appropriate in-home and community services to individuals who are reasonably expected to become medicaid recipients within one hundred eighty days of admission to a nursing facility.

Sec. 4. RCW 70.41.330 and 2000 c 6 s 4 are each amended to read as follows:

Every hospital <u>and state hospital</u> shall post in conspicuous locations a notice of the department's hospital complaint toll-free telephone number. The form of the notice shall be approved by the department.

Sec. 5. RCW 70.41.380 and 2005 c 118 s 1 are each amended to read as follows:

Hospitals <u>and state hospitals</u> shall have in place policies to assure that, when appropriate, information about unanticipated outcomes is provided to patients or their families or any surrogate decision makers identified pursuant to RCW 7.70.065. Notifications of

unanticipated outcomes under this section do not constitute an acknowledgment or admission of liability, nor can the fact of notification, the content disclosed, or any and all statements, affirmations, gestures, or conduct expressing apology be introduced as evidence in a civil action.

Sec. 6. RCW 70.41.120 and 2009 c 242 s 1 are each amended to read as follows:

(1) The department shall make or cause to be made an unannounced inspection of all hospitals <u>and state hospitals</u> on average at least every eighteen months. Every inspection of a hospital <u>or state hospital</u> may include an inspection of every part of the premises. The department may make an examination of all phases of the hospital <u>or state hospital</u> operation necessary to determine compliance with the law and the standards, rules and regulations adopted thereunder.

(2) The department shall not issue its final report regarding an unannounced inspection by the department until: (a) The hospital <u>or state hospital</u> is given at least two weeks following the inspection to provide any information or documentation requested by the department during the unannounced inspection that was not available at the time of the request; and (b) at least one person from the department conducting the inspection meets personally with the chief administrator or executive officer of the hospital <u>or state hospital</u> following the inspection or the chief administrator or executive officer declines such a meeting.

(3) Any licensee or applicant desiring to make alterations or additions to its facilities or to construct new facilities shall, before commencing such alteration, addition or new construction, comply with the regulations prescribed by the department.

(4) No hospital licensed pursuant to the provisions of this chapter <u>or state hospital</u> shall be required to be inspected or licensed under other state laws or rules and regulations promulgated thereunder, or local ordinances, relative to hotels, restaurants, lodging houses, boarding houses, places of refreshment, nursing homes, maternity homes, or psychiatric hospitals.

(5) To avoid unnecessary duplication in inspections, the department shall coordinate with the department of social and health services, the office of the state fire marshal, and local agencies when inspecting facilities over which each agency has jurisdiction, the facilities including but not necessarily being limited to

hospitals with both acute care and skilled nursing or psychiatric nursing functions. The department shall notify the office of the state fire marshal and the relevant local agency at least four weeks prior to any inspection conducted under this section and invite their attendance at the inspection, and shall provide a copy of its inspection report to each agency upon completion.

(6)(a) To improve the department's licensing and quality experience, the department must:

(i) Enter into a partnership with the national institutes of standards and technology, United States department of commerce, to coordinate and schedule excellence assessments of the department's operations every two years, starting no later than December 2017; and

(ii) Transmit completed excellence assessments and feedback reports to pertinent legislative committees and the office of the governor.

(b)(i) The department's goal is to progress toward achieving world-class performance by achieving a sixty percent score within seven years of its first excellence assessment. When it achieves a sixty percent score, it shall apply for an award from the national institutes of standards and technology, United States department of commerce, for its performance.

(ii) If the department meets the goal in (b)(i) of this subsection, it is not required to conduct an excellence assessment every two years, but must conduct an excellence assessment every four years.

(c) For the purposes of this subsection, "excellence assessment" means an assessment of performance using a framework approved by the national institutes of standards and technology, United States department of commerce.

NEW SECTION. **Sec. 7.** A new section is added to chapter 72.23 RCW to read as follows:

(1) Each state hospital must 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 must include at least the following:

(a) The establishment of one or more quality improvement committees with the responsibility to review the services rendered in the state hospital, both retrospectively and prospectively, in order

to improve the quality of medical care of patients and to prevent medical malpractice. Different quality improvement committees may be established as a part of a quality improvement program to review different health care services. Such committees 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 state hospital policies and procedures;

(b) A process, including a medical staff privileges sanction procedure which must be conducted substantially in accordance with medical staff bylaws and applicable rules, regulations, or policies of the medical staff through which credentials, physical and mental capacity, professional conduct, and competence in delivering health care services are periodically reviewed as part of an evaluation of staff privileges;

(c) A process for the periodic review of the credentials, physical and mental capacity, professional conduct, and competence in delivering health care services of all other health care providers who are employed or associated with the state 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 state hospital's experience with negative health care outcomes and incidents injurious to patients, including health care-associated infections as defined in RCW 43.70.056, 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 state 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 is not subject to an action for civil damages or other relief as a result of such 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 is 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 must, on at least a semiannual basis, report to the superintendent of the state hospital in which the committee is located. The report must review the quality improvement activities conducted by the committee, and any actions taken as a result of those activities.

(5) Each quality improvement committee must annually provide their quality improvement plans to the department of health for review. If the plans are insufficient, the department of health must report the deficiency to the centers for medicare and medicaid services.

(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 state hospital shall produce and make accessible to the commission or board the appropriate records and otherwise facilitate the review and audit. Information so gained is not subject to the discovery process and confidentiality must be respected as required by subsection (3) of this section. Failure of a state hospital to comply with this subsection is punishable by a civil penalty not to exceed two hundred fifty dollars.

(7) The department of health may adopt rules to implement this section.

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