2008 -- S 2474

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S T A T E O F R H O D E I S L A N D

IN GENERAL ASSEMBLY

JANUARY SESSION, A.D. 2008

A N A C T

RELATING TO HEALTH AND SAFETY -- DEPARTMENT OF HEALTH

Introduced By: Senators Bates, Walaska, Perry, C Levesque, and Breene

Date Introduced: February 13, 2008

Referred To: Senate Health & Human Services

It is enacted by the General Assembly as follows:

SECTION 1. Title 23 of the General Laws entitled "Health and Safety" is hereby amended by adding thereto the following chapter:

CHAPTER 17.21

THE RHODE ISLAND PATIENT SAFETY AND QUALITY IMPROVEMENT ACT OF 2008

23-17.21-1. Title. – This act shall be known and may be cited as "The Rhode Island Patient Safety and Quality Improvement Act of 2008."

23-17.21-2. Legislative findings. – The legislature finds:

(a) There are an unacceptable high number of preventable medical errors in the health care system;

(b) Current solutions that focus on discipline and retraining of individuals have proven inadequate to address this systemic problem;

(c) The federal patient safety and quality improvement act of 2005 authorizes the creation of a national patient safety system based on voluntary reporting and evaluation of medical errors and near misses to advance patient safety and quality systems improvements;

(d) Other industries such as aviation, nuclear power, and petrochemical processing have confidential reporting mechanisms for errors and near misses to advance public safety and quality improvement.

23-17.21-3. Legislative purpose and intent. – This act proposes:

(a) A Rhode Island patient safety organization that:

(1) Is in accordance with the federal patient safety and quality improvement act of 2005 as a critical component to Rhode Island's participation in a national patient safety data reporting system;

(2) Works with Rhode Island licensed health care facilities, providers and payors for both the reporting of medical errors including situations in which a medical error was averted (near misses) and evaluating the root causes of the errors;

(3) Investigates system causes related to the errors and makes recommendations to the health care providers about changes to improve their patient safety and to the department for statewide changes and policies that will advance patient safety and quality improvement;

(4) Complements the mandatory incidents and events reporting to the department required in section 23-17-40 and related regulations; and

(5) Shall facilitate the creation of, and maintain, a non-identifiable patient safety database that provides an interactive evidence-based management resource for providers, patient safety organizations, and other entities as shall be determined. The database shall have the capacity to accept, aggregate and analyze non-identifiable patient safety work product and data reported by facilities, providers and provide this to the national network of patient safety databases.

(b) The health care leadership, including providers, facilities, and payors, accept their role in advancing a culture of safety and quality improvement.

23-17.21-4. Definitions. – Except as otherwise defined in this chapter, this act adopts and incorporates by reference all the definitions and provisions of public law 109, USC 299 et seq.

"Covered entities" means all hospitals, nursing homes, physician operatories and organized ambulatory surgery centers and other licensed health centers entities as determined by the director in regulation. The director of health shall promulgate rules and regulations in order to further define the powers and duties of the PSO. These regulations may expand the "covered entities" as the director shall determine.

"Director" means the director of the Rhode Island state department of health.

"Medical errors" means all reportable incidents and events as set forth in section 23-17-40 and medical errors as defined by the national quality forum, institute of medicine or center for Medicare & Medicaid studies (CMS).

"Near misses" means a circumstance in which a medical error is narrowly averted and includes those associated with medical errors.

"Rhode Island patient safety organization (PSO)" means the organization created by this chapter called the "Rhode Island Patient Safety Organization" in accordance with the federal patient safety and quality improvement act of 2005 (PSQIA).

"Payor" means any third-party payor for medical services provided at covered entities. Medicare and Medicaid are specifically excluded under this definition.

"Reporting entities" means licensed health care facilities, providers and payors.

23-17.21-5. Powers and duties. – The powers necessary to carry out the duties of this chapter shall be vested in the director of health and are as follows:

(a) The director shall approve a qualified agency through a contracting process to serve as the PSO that shall have the authority to investigate reports from licensed health care facilities and providers and payors. The director may delegate the following investigative authorities to the PSO:

(1) medical record review;

(2) access to peer review;(3) interview personnel and witnesses as appropriate.

(b) The director may also provide the PSO information concerning required incident and event reporting established in chapter 23-17, licensing of health care facilities, including results of any formal investigation.

(c) The PSO shall provide guidance on reporting from licensed healthcare facilities and providers and payors, shall develop recommendations to the director for modifications to reporting requirements, and shall maintain all reports as confidential and privileged, including any reports or information with identifiable information from the director. The director may establish standards in regulation for reporting to the PSO.

(d) The PSO shall require that a report from a reporting entity shall also be submitted to the health department in those instances where the PSO determines that such a report is required under the reporting requirements established in section 23-17-40 and in regulations. The establishment of PSO does not obviate required incident and event reporting established elsewhere in statute and regulation.

(e) The director is authorized to require any and all data submitted and stored, confidential work product and recommendations that address systemic concerns and advance patient safety and quality care submitted to and developed by the PSO to be transferred to the awardee of a subsequent PSO contract. Any stored patient specific information must be maintained according to the requirements of the federal PSQIA and HIPPA. The PSO shall utilize common data standards to comply with the federal requirements to the PSQIA.

(f) The contract shall require the PSO to:

(1) submit at least an annual report to the director including activity, staffing, revenues, expenditures, administration and patient safety and quality improvement recommendations; and

(2) regularly convene leadership of reporting entities to address systems concerns and to

advance patient safety and quality of care through adoption of best practices.

23-17.21-6. Privilege and confidentiality. – The PSO shall comply with the confidentiality requirements and be afforded the privileges and protections articulated in the PSQIA related to discovery and public release of any information and the following:

(a) PSO recommendations and investigative work product may not be used in any fashion prohibited by the PSQIA including, but not limited to, its use by regulatory and administrative bodies as part of disciplinary or civil proceedings;

(b) The PSO shall maintain confidentiality and privilege consistent with PSQIA, comply with federal reporting requirements through the patient safety organization privacy protection center, network of patient safety databases and as directed by the federal requirements;

(c) The PSO shall recommend patient safety and quality systems improvements to individual reporting entities and as appropriate to collective facilities, providers, payors and the director; and

(d) The PSO shall share only non-identifiable information from reporting entities with the director.

23-17.21-7. Funding. – Funding for the PSO shall be through a patient safety surcharge and shared among the reporting entities starting with hospitals, nursing homes and health insurers with exemptions for state funded and operated hospitals and nursing homes, and Medicare and Medicaid insurance programs.

(a) Hospitals, nursing homes and insurers each in the aggregate shall share one-third (1.3) the surcharge on a yearly basis. Hospitals and nursing homes shall individually be assessed a licensing surcharge according to the number of licensed beds and insurers according to the number of Rhode Island subscribers.

(b) The total funding from the surcharge to support the PSO through this mechanism shall not exceed six hundred thousand dollars ($600,000) per annum for 2009-2011, and shall thereafter be reviewed yearly by the director with a limitation to any increase to three percent (3%) per annum.

(c) The department shall develop regulations that describes and outlines the following:

(1) process for and the basis of the surcharge requirements;

(2) process for setting the annual budget and any increase in the surcharge; and

(3) process for additional reporting entities participating in the surcharge requirement.

(d) There is hereby created within the general fund a restricted receipt account to be known as the "PSO account." All money in the account shall be utilized by the department to effectuate the provisions of this act received by the department from sources other than the

surcharge may also be deposited in the PSO account. Up to ten percent (10%) of the annual revenues from this account may be used to support costs associated with the administration of this program by the department. The general treasurer is authorized and directed to draw his or her orders on the account upon receipt of properly authenticated vouchers from the department.

SECTION 2. This act shall take effect upon passage.

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EXPLANATION

BY THE LEGISLATIVE COUNCIL

OF

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RELATING TO HEALTH AND SAFETY -- DEPARTMENT OF HEALTH

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This act would establish the Rhode Island patient safety and quality improvement act of 2008. The goals of this act would be to promote patient safety, reduce medical errors, and encourage better reporting of medical errors and related incidents.

This act would take effect upon passage.

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