LRB 1965

Meeting 11/18 with Dick Sweet, Laura & Matthew

Define medical staff as defined in by laws of med. staff
clinics generally have by laws even though not required to

Personal Care workers - cover as MA certified

include as HCE - or otherwise authorized by state law to provide health care services or an employee of such a person

Need to cover health care system for ex. Aurora - as HCE

cover situation where grp. of docs. on staff independently review one another

New exception - maybe - allow reviewer to determine beforehand that records won't be confidential ??

Outstand Issues:

(1) Narrow QIA so won't prohibit person suing employer for discrimination from getting records

1/18/06 (cont)

(2) Allow some mechanism to designate that records of a AIA are not protected – before conduct AIA – so anyone can use info/records

(3) when to limit (3)(c) to individuals

State of Wisconsin
2005 – 2006 LEGISLATURE

LRB–1965/P3
RLR:cjs:rl

PRELIMINARY DRAFT – NOT READY FOR INTRODUCTION

AN ACT ***to repeal*** 146.37; and ***to repeal and recreate*** 146.38 of the statutes; **relating to:** confidentiality of health care review records and immunity.

Analysis by the Legislative Reference Bureau

This is a preliminary draft. An analysis will be provided in a later version.

The people of the state of Wisconsin, represented in senate and assembly, do enact as follows:

SECTION 1. 146.37 of the statutes is repealed.

****NOTE: Cross–references to this statute will be amended in the next version of this bill to reflect this repeal.

SECTION 2. 146.38 of the statutes is repealed and recreated to read:

146.38 Health care quality improvement activity. (1) DEFINITIONS. In this section:

(a) "Adverse action" means any action or recommendation to reduce, restrict, suspend, deny, revoke, or fail to renew any of the following:

1. A health care entity's clinical privileges or clinical practice authority at a hospital or other health care entity or on a medical staff.

****NOTE: What does it mean for a health care entity to have clinical privileges or clinical practice authority on a medical staff? Does it mean anything different than membership on a medical staff?

2. A health care entity's membership on a medical staff or in a hospital or other health care entity.

3. A health care entity's participation in a defined network plan, as defined in s. 609.01 (1b).

****NOTE: Subdivision 3. uses the term "defined network plan" instead of "provider panel." Please note that the definition "participating" in s. 609.01 (3m) could be used in construing this bill, which I think is fine.

4. The accreditation, licensure, or certification of a health care entity.

(b) "Health care entity" means any of the following:

1. A health care provider, as defined in s. 146.81 (1), an ambulatory surgery center as defined in s. 153.01 (1), a home health agency, as defined in s. 50.49 (1) (a), a home health aide, as defined in s. 146.40 (1) (bm), a hospice aide, as defined in s. 146.40 (1) (bp), a nurse's assistant, as defined in s. 146.40 (1) (d), an ambulance service provider, as defined in s. 146.50 (1) (c), an emergency medical technician, as defined in s. 146.50 (1) (e), a first responder, as defined in s. 146.50 (1) (hm), or any other person who is licensed, certified, or registered to provide health care services including mental health services.

****NOTE: Dick suggested listing the providers who are missing from 146.81 (1), and leaving out the language regarding "arranging" or "furnishing," because it is vague. I agree with Dick.

2. An individual who is enrolled in a education or training program that is approved by an examining board in the department of regulation and licensing or by the department of health and family services and that the individual must complete in order to obtain credentials required of an individual under subd. 1.

(c) "Medical staff" means a health care entity's organized component of physicians, podiatrists, or dentists appointed by the governing body of the health

care entity and granted specific medical privileges for the purpose of providing adequate medical, podiatric, or dental care for the patients of the health care entity.

****NOTE: This definition is for "medical staff" as used in the definition of "adverse action." It is the same as the definition of "medical staff" in HFS 124.02 (10), except I substituted "health care entity" for "hospital," so it will cover the example of physicians on staff at a clinic. If you define a medical staff to include any group of individuals who provide health care and are employed by a health care entity, for example home health aides, it contorts the meaning of "medical." If you want to cover actions against a nurse or home health aide under the definition of "adverse action," why not include as a subdivision under the definition of adverse action, "employment of an individual as a health care entity?"

(d) "Quality improvement activity" means an evaluation, review, study, assessment, investigation, recommendation, corrective action, or any other action, including one–time, continuous, or periodic data collection relating to any of the following subjects:

****NOTE: The phrase "structure, process, or outcomes of health care" is used in the health care trade, but doesn't translate well into statutory language without definitions. I looked at the descriptions of structure, process, and outcomes on the National Quality Measures Clearinghouse Web site. Process is described as services provided by a health care entity, which is covered under subd. 1. I added subd. 9. to cover structure and subd. 10. to cover outcomes. Are these additions helpful?

****NOTE: Section 990.001 (1) provides that in the statues the singular includes the plural, and the plural includes the singular, so I just refer to a health care entity rather than one or more health care entities.

1. The quality of care provided by a health care entity or the quality of services provided by a health care entity that have an impact on care.

2. Morbidity or mortality related to a health care entity.

3. The qualification, competence, conduct, or performance of a health care entity.

4. The cost or use of health care services and resources of a health care entity.

****NOTE: I am assuming that a health care entity's services are services provided by a health care entity. Is this correct? Subdivision 4. seems to cover 4 subjects: 1) the cost of health care services provided by a health care entity; 2) the use (utilization?) of health care services provided by a health care entity; 3) the cost of a health care entity's resources; and 4) the use of a health care entity's resources. Is this what you intend? The third item is a bit cryptic.

5. Compliance with applicable legal, ethical, or behavioral standards for a health care entity.

****NOTE: You don't need to preface the subject as "pursuing compliance" or "pursuit of compliance" because the subject is compliance with standards, which necessarily includes pursuit of compliance.

6. Compliance with credentialing, accreditation, or regulatory standards for a health care entity and performance of credentialing, accreditation, or regulatory activities, including compliance with or performance of periodic performance reviews and related activities for the Joint Commission on Accreditation of Healthcare Organizations.

7. The approval or credentialing of a health care entity.

8. The health of an individual who is a health care entity.

****NOTE: Performance of a health care entity is already covered under subd. 3.

9. The organizational structure of a health care entity or other features of a health care entity that are relevant to its capacity to provide care.

10. The outcome, with respect to an individual's health or the health of a population, of services provided by a health care entity.

(e) "Records" includes, regardless of the type of communications medium or form, including oral communications, and whether in statistical form or otherwise, minutes, files, notes, reports, statements, memoranda, databases, findings, work products, and images.

****NOTE: This definition of records is from the first part of WHA's definition of "quality review records," except that I removed "proceedings" from the definition, because I don't see how a proceeding can be a record. (Does WHA mean the minutes or record of the proceeding, not the proceeding itself?)

The potential downside of listing items to be included in a definition is that a court might construe the list as all–inclusive regardless of whether the statute says "includes" rather than "means." Therefore I think it is better to limit the list. I used a more limited list in the /P1.

(f) "State agency" means a department, board, examining board, affiliated credentialing board, commission, independent agency, council, or office in the executive branch of state government.

****NOTE: This definition is for "state agency" as used in sub. (3) (a) (intro.), to clarify the types of state agencies that may not compel disclosure. It will also apply to sub. (3) (a) 1. e.

(2) IMMUNITY FOR ACTS OR OMISSIONS. (a) No person acting in good faith who participates in a quality improvement activity is liable for civil damages as a result of any act or omission by the person in the course of the quality improvement activity. Acts or omissions to which this subsection applies include censuring or reprimanding a health care entity, revoking the hospital staff privileges of a health care entity, giving notice to the medical examining board or podiatrist affiliated credentialing board under s. 50.36, or taking any other disciplinary action against a health care entity.

INS 5-11

(b) The good faith of any person participating in a quality improvement activity shall be presumed in any civil action. Any person who asserts that a person has not acted in good faith has the burden of proving that assertion by clear and convincing evidence.

(c) In determining whether a person acted in good faith under this subsection, the court shall consider whether the person sought to prevent the health care entity that is the subject of the quality improvement activity or its counsel from examining the documents and records used in the quality improvement activity, from presenting witnesses, establishing pertinent facts or circumstances, questioning or refuting testimony or evidence, or confronting or cross–examining adverse witnesses or from receiving a copy of the final report or recommendation resulting from the quality improvement activity.

(3) CONFIDENTIALITY AND PRIVILEGE. (a) Except as provided in sub. (4), all of the following are confidential and privileged; are not subject to discovery, subpoena, or any other means of legal compulsion requiring release or permitting inspection, including compulsion by a state agency; and are not admissible as evidence in any civil, criminal, or other judicial or administrative proceeding:

1. Records and information contained in records that are created or collected by or presented to a person who requests or conducts any of the following types of quality improvement activities in preparation for or as part of the quality improvement activity:

****NOTE: I changed this subdivision to specify who creates or collects the records and also added presented records, which were covered under sub. (2) (a) 3. in the /P2 draft. Please review whether the specification of who creates or collects records or who receives presented records is accurate.

a. A quality improvement activity concerning a health care entity that is conducted by or at the request of a person who employs or contracts with the health care entity.

****NOTE: I added this subdivision paragraph to cover several scenarios we discussed: 1) a review by a hospital of a doctor; and 2) a review by an entity that owns several hospitals of one or more of the hospitals.

b. A quality improvement activity that is conducted by the health care entity that is the subject of the activity, either alone or with another health care entity.

c. A quality improvement activity that is conducted by an employee or a fixed or ad hoc committee of the health care entity or entities that are the subject of the quality improvement activity.

****NOTE: The definition in Webster's for "ad hoc" is: a) 1. concerned with a particular end or purpose, 2. formed or used for specific or immediate problems or needs; b) fashioned from whatever is immediately available. I think this definition fits your intent.

****NOTE: I removed agent, because activities by agents are covered under subdivision paragraph d.

d. A quality improvement activity that is conducted by a person to whom the health care entity or entities that are the subject of the activity have granted authority to conduct the activity.

e. A quality improvement activity conducted by a state agency at the request of the health care entity or entities that are the subject of the activity.

****NOTE: This subdivision paragraph is sub. (2) (a) 2. from the /P2 draft.

2. A request for records or information made as part of a quality improvement activity described under subd. 1. by a person conducting the quality improvement activity.

3. Notice to a health care entity that he or she is or will be the subject of a quality improvement activity described under subd. 1.

4. The product of aggregating or reorganizing records or information under subds. 1. to 3. that are voluntarily disclosed by a health care entity for the purpose of aggregation or reorganization.

(b) A person who conducts or participates in a quality improvement activity described under par. (a) 1. may not disclose whether the quality improvement activity was conducted or disclose action or lack of action taken as a consequence of the quality improvement activity.

(c) The confidentially and privilege afforded to records and information under par. (a) is not waived by unauthorized or authorized disclosure of records or information. A person who receives records or information under par. (a) 1. to 4. may not further disclose the records or information unless permitted to do so under sub. (4).

(d) Records relating to a quality improvement activity described under par. (a) 1. e. are not subject to inspection or copying under s. 19.35 (1) if the subject of the quality improvement activity is not a government entity.

****NOTE: I changed the provision concerning public records so that records relating to a review conducted by DHFS at the request of a public health care entity are not exempted from inspection under the public records law. However, the bill still makes confidential records of any quality improvement activity related to a public health care entity that is conducted by the health care entity or by a private entity. This may set up a conflict with the public records law.

(4) EXCEPTIONS TO CONFIDENTIALITY AND PRIVILEGE. (a) Subsection (3) does not apply to records or information maintained by or for a health care entity for the particular purpose of diagnosing, treating, or documenting care provided to an individual patient.

(b) A person mandated by Wisconsin or federal law to report may disclose a record or information from a record that is confidential and privileged under sub. (3) to make the mandated report.

(c) If a person takes an adverse action against a health care entity as part of a quality improvement activity described under sub. (3) (a) 1., or notifies the health care entity of a proposed adverse action, the person shall, upon request by the health care entity, disclose to the health care entity any records in the person's possession relating to the quality improvement activity that are relevant to the adverse action. The person may at any time disclose to the health care entity records relating to the quality improvement activity that is relevant to the proposed adverse action by the person against the health care entity. Records relating to the quality improvement activity that are relevant to the adverse action are admissible in any criminal, civil, or other judicial or administrative proceeding in which the health care entity contests the adverse action. → INS 8-21

(d) If the person who conducts or requests a quality improvement activity described under sub. (3) (a) 1. a., or the health care entity that is the subject of a quality improvement activity described under sub. (3) (a) 1. b. to e., provides written authorization for disclosure of records and information related to the quality improvement activity, the records or information may be disclosed to the extent allowed in the written authorization.

(4) CONSTRUCTION. This section shall be liberally construed in favor of identifying records and information as confidential, privileged, and inadmissible as evidence.

JNS 9-9

****NOTE: I added inadmissibility here — does it help? We discussed removing reference in the bill to "privilege," since a privilege is generally a right of a person that extends to communications or work product and the bill does not establish who holds the privilege. Also privileges are generally established under ch. 905. However, some of the court cases on peer review records do refer to "privileged material." I am still in favor of removing the term, because the language on confidentiality, protection against discovery, and on inadmissibility accomplishes your intent.

(END)

Ins 2–5:

5. Employment of an individual as a health care entity.

Ins 2–18:

3. A person who is certified as a provider of medical assistance under s. 49.45 (2) (a) 11.

4. A parent organization, subsidiary, or affiliate of a person under subd. 1. or subd. 3.

Ins 5–11:

****NOTE: Should sub. (2) (a) refer to "quality improvement activity described under sub. (3) (a) 1." or simply to the unqualified term "quality review activity," as in this draft?

Ins 6–10:

a. A quality improvement activity concerning a health care entity that is conducted by or at the request of a person who employs, contracts with, or grants clinical privileges or clinical practice authority to the health care entity or by a parent organization, subsidiary, or affiliate of that person.

Ins 6–17:

c. A quality improvement activity concerning a health care entity, an employee of the health care entity, a person with whom the health care entity contracts or to whom the health care entity has granted clinical privileges or clinical practice authority that is conducted by an employee or a fixed or ad hoc committee of the

health care entity or by a person with whom the health care entity contracts or to whom the health care entity has granted clinical privileges or clinical practice authority.

****NOTE: 1. Please look at the changes to subdivision paragraph c. The function of c. in the /P3 is to cover reviews of a health care entity by a person who works for the health care entity and conducts the review at his or her own initiative. Also, c. provides that any committee of a health care entity, not just the formal "peer review" committee, can conduct quality improvement activity. If I remember correctly, the intent of the change we discussed is to expand the possible subjects of the review to include employees of a health care entity and persons with whom the entity contracts or to whom the health care entity has granted clinical privileges or clinical practice authority. Also, we wanted to provide that a person with whom the health care entity contracts or to whom the entity grants practice privileges may be the person conducting the review. The scenario we discussed was a group of doctors on staff independently reviewing other doctors.

2. Now that a. and c. use the format: a quality improvement activity concerning X that is conducted by Y, do you want to apply the same format to b., d., and e. for the sake of readability? They would read: b. A quality improvement activity concerning a health care entity that is conducted by the health care entity, either alone or with another health care entity. d. A quality improvement activity concerning a health care entity or entities that is conducted by a person to whom the health care entity or entities have granted authority to conduct the activity. e. A quality improvement activity concerning a health care entity or entities that is conducted b a state agency at the request of the health care entity or entities.

3. We should look again at whether we refer to a "health care entity" versus "a health care entity or entities." Since the goal is to be clear that the singular always also means the plural, the worst thing we can do is to be inconsistent in usage of singular or plural.

Ins 8–21:

A person who has authority to take an adverse action against a health care entity as part of a quality improvement activity described under sub. (3) (a) 1. may at any time disclose to the health care entity records relating to a quality improvement activity that are relevant to a proposed adverse action against the health care entity.

Ins 9–9:

SECTION 1. 146.55 (7) of the statutes is amended to read:

146.55 **(7)** INSURANCE. A physician who participates in an emergency medical services program under this section or as required under s. 146.50 shall purchase health care liability insurance in compliance with subch. III of ch. 655, except for those acts or omissions of a physician who, as a medical director, ~~reviews~~ as defined in s. 146.50 (1) (j), conducts a quality improvement activity ~~under s. 146.38 that relates~~ to the performance of emergency medical technicians or ambulance service providers, ~~as specified under s. 146.37 (1g)~~.

History: 1989 a. 102 ss. 15 to 17, 23, 25, 26, 60; 1991 a. 39, 269; 1993 a. 16, 251, 399, 491; 1997 a. 27, 79; 2001 a. 16, 109; 2005 a. 25.

SECTION 2. 187.33 (3) (a) 5. of the statutes is amended to read:

187.33 **(3)** (a) 5. Proceedings based upon a cause of action for which the volunteer is immune from liability under s. 146.31 (2) and (3), ~~146.37~~ 146.38 (2), 895.44, 895.48, 895.482, 895.51, or 895.52.

History: 1989 a. 306; 1991 a. 318; 1993 a. 213.

SECTION 3. 187.43 (3) (a) 5. of the statutes is amended to read:

187.43 **(3)** (a) 5. Proceedings based upon a cause of action for which the volunteer is immune from liability under s. 146.31 (2) and (3), ~~146.37~~ 146.38 (2), 895.44, 895.48, 895.482, 895.51, or 895.52.

History: 1995 a. 260.

SECTION 4. 655.27 (1m) (b) of the statutes is amended to read:

655.27 **(1m)** (b) A health care provider who engages in ~~the activities described in s. 146.37 (1g) and (3)~~ a quality improvement activity under 146.38 shall be liable for not more than the limits expressed under s. 655.23 (4) or the maximum liability limit for which the health care provider is insured, whichever limit is greater, if he or she is found to be liable under s. ~~146.37~~ 146.38, and the fund shall pay the excess amount, unless the health care provider is found not to have acted in good faith

during those activities and the failure to act in good faith is found by the trier of fact, by clear and convincing evidence, to be both malicious and intentional.

History: 1975 c. 37, 79, 199; 1977 c. 29, 131; 1979 c. 34, 194; 1981 c. 20; 1983 a. 27, 158; 1985 a. 340; 1987 a. 27, 186, 247, 399; 1989 a. 102, 187, 332; 1991 a. 214, 315; 1993 a. 473; 1995 a. 10; 2001 a. 65; 2003 a. 111; 2005 a. 36.

SECTION 5. 655.27 (5) (a) 1. and 2. of the statutes are amended to read:

655.27 **(5)** (a) 1. Any person may file a claim for damages arising out of the rendering of medical care or services or participation in ~~peer review activities~~ a quality improvement activity under s. ~~146.37~~ 146.38 within this state against a health care provider or an employee of a health care provider. A person filing a claim may recover from the fund only if the health care provider or the employee of the health care provider has coverage under the fund, the fund is named as a party in the action, and the action against the fund is commenced within the same time limitation within which the action against the health care provider or employee of the health care provider must be commenced.

History: 1975 c. 37, 79, 199; 1977 c. 29, 131; 1979 c. 34, 194; 1981 c. 20; 1983 a. 27, 158; 1985 a. 340; 1987 a. 27, 186, 247, 399; 1989 a. 102, 187, 332; 1991 a. 214, 315; 1993 a. 473; 1995 a. 10; 2001 a. 65; 2003 a. 111; 2005 a. 36.

2. Any person may file an action for damages arising out of the rendering of medical care or services or participation in ~~peer review activities~~ a quality review activity under s. ~~146.37~~ 146.38 outside this state against a health care provider or an employee of a health care provider. A person filing an action may recover from the fund only if the health care provider or the employee of the health care provider has coverage under the fund, the fund is named as a party in the action, and the action against the fund is commenced within the same time limitation within which the action against the health care provider or employee of the health care provider must be commenced. If the rules of procedure of the jurisdiction in which the action is brought do not permit naming the fund as a party, the person filing the action may recover from the fund only if the health care provider or the employee of the health

care provider has coverage under the fund and the fund is notified of the action within 60 days of service of process on the health care provider or the employee of the health care provider. The board of governors may extend this time limit if it finds that enforcement of the time limit would be prejudicial to the purposes of the fund and would benefit neither insureds nor claimants.

History: 1975 c. 37, 79, 199; 1977 c. 29, 131; 1979 c. 34, 194; 1981 c. 20; 1983 a. 27, 158; 1985 a. 340; 1987 a. 27, 186, 247, 399; 1989 a. 102, 187, 332; 1991 a. 214, 315; 1993 a. 473; 1995 a. 10; 2001 a. 65; 2003 a. 111; 2005 a. 36.

State of Wisconsin
2005 – 2006 LEGISLATURE

LRB–1965/P4
RLR:cjs:pg

PRELIMINARY DRAFT – NOT READY FOR INTRODUCTION

AN ACT ***to repeal*** 146.37; ***to amend*** 146.55 (7), 187.33 (3) (a) 5., 187.43 (3) (a) 5., 655.27 (1m) (b) and 655.27 (5) (a) 1. and 2.; and ***to repeal and recreate*** 146.38 of the statutes; **relating to:** confidentiality of health care review records and immunity.

Analysis by the Legislative Reference Bureau

This is a preliminary draft. An analysis will be provided in a later version.

The people of the state of Wisconsin, represented in senate and assembly, do enact as follows:

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1. A health care entity's clinical privileges or clinical practice authority at a hospital or other health care entity.

2. A health care entity's membership on a medical staff that is organized under by–laws or in another health care entity.

3. A health care entity's participation in a defined network plan, as defined in s. 609.01 (1b).

4. The accreditation, licensure, or certification of a health care entity.

5. Employment of an individual as a health care entity.

(b) "Health care entity" means any of the following:

1. A health care provider, as defined in s. 146.81 (1), an ambulatory surgery center as defined in s. 153.01 (1), a home health agency, as defined in s. 50.49 (1) (a), a home health aide, as defined in s. 146.40 (1) (bm), a hospice aide, as defined in s. 146.40 (1) (bp), a nurse's assistant, as defined in s. 146.40 (1) (d), an ambulance service provider, as defined in s. 146.50 (1) (c), an emergency medical technician, as defined in s. 146.50 (1) (e), a first responder, as defined in s. 146.50 (1) (hm), or any other person who is licensed, certified, or registered to provide health care services including mental health services.

2. An individual who is enrolled in an education or training program that is approved by an examining board or affiliated credentialing board in the department of regulation and licensing or by the department of health and family services and that the individual must complete in order to obtain credentials required of an individual under subd. 1.

3. A person who is certified as a provider of medical assistance under s. 49.45 (2) (a) 11.

4. A parent organization, subsidiary, or affiliate of a person described under subd. 1. or 3.

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4. The cost or use of health care services and resources of a health care entity.

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6. Compliance with credentialing, accreditation, or regulatory standards for a health care entity and performance of credentialing, accreditation, or regulatory activities, including compliance with or performance of periodic performance reviews and related activities for the Joint Commission on Accreditation of Healthcare Organizations.

7. The approval or credentialing of a health care entity.

(e) "Records" includes minutes, files, notes, reports, statements, memoranda, databases, findings, work products, and images, regardless of the type of communications medium or form, including oral communications, and whether in statistical form or otherwise.

(f) "State agency" means a department, board, examining board, affiliated credentialing board, commission, independent agency, council, or office in the executive branch of state government.

(2) IMMUNITY FOR ACTS OR OMISSIONS. (a) No person acting in good faith who participates in a quality improvement activity is liable for civil damages as a result of any act or omission by the person in the course of the quality improvement activity. Acts or omissions to which this subsection applies include censuring or reprimanding a health care entity, revoking the hospital staff privileges of a health care entity, giving notice to the medical examining board or podiatrist affiliated credentialing board under s. 50.36, or taking any other disciplinary action against a health care entity.

****NOTE: Should sub. (2) (a) refer to "quality improvement activity described under sub. (3) (a) 1." or simply to the unqualified term "quality review activity," as in this draft?

(b) The good faith of any person participating in a quality improvement activity shall be presumed in any civil action. Any person who asserts that a person has not acted in good faith has the burden of proving that assertion by clear and convincing evidence.

(c) In determining whether a person acted in good faith under this subsection, the court shall consider whether the person sought to prevent the health care entity that is the subject of the quality improvement activity or its counsel from examining the records used in the quality improvement activity, from presenting witnesses, establishing pertinent facts or circumstances, questioning or refuting testimony or evidence, or confronting or cross–examining adverse witnesses or from receiving a copy of the final report or recommendation resulting from the quality improvement activity.

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1. Records and information contained in records that are created or collected by or presented to a person who requests or conducts any of the following types of quality improvement activities in preparation for or as part of the quality improvement activity:

a. A quality improvement activity concerning a health care entity that is conducted by or at the request of a person who employs, contracts with, or grants clinical privileges or clinical practice authority to the health care entity or by a parent organization, subsidiary, or affiliate of that person.

b. A quality improvement activity that is conducted by the health care entity that is the subject of the activity, either alone or with another health care entity.

c. A quality improvement activity concerning a health care entity, an employee of the health care entity, a person with whom the health care entity contracts or to whom the health care entity has granted clinical privileges or clinical practice authority that is conducted by an employee or a fixed or ad hoc committee of the health care entity or by a person with whom the health care entity contracts or to whom the health care entity has granted clinical privileges or clinical practice authority.

****NOTE: 1. Please look at the changes to subdivision paragraph c. The function of c. in the /P3 is to cover reviews of a health care entity by a person who works for the health care entity and conducts the review at his or her own initiative. Also, c. provides that any committee of a health care entity, not just the formal "peer review" committee, can conduct quality improvement activity. If I remember correctly, the intent of the

change we discussed is to expand the possible subjects of the review to include employees of a health care entity and persons with whom the entity contracts or to whom the health care entity has granted clinical privileges or clinical practice authority. Also, we wanted to provide that a person with whom the health care entity contracts or to whom the entity grants practice privileges may be the person conducting the review. The scenario we discussed was a group of doctors on staff independently reviewing other doctors.

2. Now that a. and c. use the format: a quality improvement activity concerning X that is conducted by Y, do you want to apply the same format to b., d., and e. for the sake of readability? They would read: b. A quality improvement activity concerning a health care entity that is conducted by the health care entity, either alone or with another health care entity. d. A quality improvement activity concerning a health care entity or entities that is conducted by a person to whom the health care entity or entities have granted authority to conduct the activity. e. A quality improvement activity concerning a health care entity or entities that is conducted b a state agency at the request of the health care entity or entities.

3. We should look again at whether we refer to a "health care entity" versus "a health care entity or entities." Since the goal is to be clear that the singular always also means the plural, the worst thing we can do is to be inconsistent in usage of singular or plural.

d. A quality improvement activity that is conducted by a person to whom the health care entity or entities that are the subject of the activity have granted authority to conduct the activity.

e. A quality improvement activity conducted by a state agency at the request of the health care entity or entities that are the subject of the activity.

2. A request for records or information made as part of a quality improvement activity described under subd. 1. by a person conducting the quality improvement activity.

3. Notice to a health care entity that the entity is or will be the subject of a quality improvement activity described under subd. 1.

4. The product of aggregating or reorganizing records or information under subds. 1. to 3. that are voluntarily disclosed by a health care entity for the purpose of aggregation or reorganization.

(b) A person who conducts or participates in a quality improvement activity described under par. (a) 1. may not disclose whether the quality improvement

activity was conducted or disclose action or lack of action taken as a consequence of the quality improvement activity.

(c) The confidentially and privilege afforded to records and information under par. (a) is not waived by unauthorized or authorized disclosure of records or information. A person who receives records or information under par. (a) 1. to 4. may not further disclose the records or information unless permitted to do so under sub. (4).

(d) Records relating to a quality improvement activity described under par. (a) 1. e. are not subject to inspection or copying under s. 19.35 (1) if the subject of the quality improvement activity is not a government entity.

(4) EXCEPTIONS TO CONFIDENTIALITY AND PRIVILEGE. (a) Subsection (3) does not apply to records or information maintained by or for a health care entity for the particular purpose of diagnosing, treating, or documenting care provided to an individual patient.

(b) A person mandated by Wisconsin or federal law to report may disclose a record or information from a record that is confidential and privileged under sub. (3) to make the mandated report.

(c) If a person takes an adverse action against a health care entity as part of a quality improvement activity described under sub. (3) (a) 1., or notifies the health care entity of a proposed adverse action, the person shall, upon request by the health care entity, disclose to the health care entity any records in the person's possession relating to the quality improvement activity that are relevant to the adverse action. Records relating to the quality improvement activity that are relevant to the adverse action are admissible in any criminal, civil, or other judicial or administrative proceeding in which the health care entity contests the adverse action. A person who

has authority to take an adverse action against a health care entity as part of a quality improvement activity described under sub. (3) (a) 1. may at any time disclose to the health care entity records relating to a quality improvement activity that are relevant to a proposed adverse action against the health care entity.

(d) If the person who conducts or requests a quality improvement activity described under sub. (3) (a) 1. a., or the health care entity that is the subject of a quality improvement activity described under sub. (3) (a) 1. b. to e., provides written authorization for disclosure of records and information related to the quality improvement activity, the records or information may be disclosed to the extent allowed in the written authorization.

(5) CONSTRUCTION. This section shall be liberally construed in favor of identifying records and information as confidential, privileged, and inadmissible as evidence.

SECTION 3. 146.55 (7) of the statutes is amended to read:

146.55 **(7)** INSURANCE. A physician who participates in an emergency medical services program under this section or as required under s. 146.50 shall purchase health care liability insurance in compliance with subch. III of ch. 655, except for those acts or omissions of a physician who, as a medical director, ~~reviews~~ as defined in s. 146.50 (1) (j), conducts a quality improvement activity relating to the performance of emergency medical technicians or ambulance service providers, as specified under s. ~~146.37 (1g)~~ 146.38 (2).

SECTION 4. 187.33 (3) (a) 5. of the statutes is amended to read:

187.33 **(3)** (a) 5. Proceedings based upon a cause of action for which the volunteer is immune from liability under s. 146.31 (2) and (3), ~~146.37~~ 146.38 (2), 895.44, 895.48, 895.482, 895.51, or 895.52.

SECTION 5. 187.43 (3) (a) 5. of the statutes is amended to read:

187.43 **(3)** (a) 5. Proceedings based upon a cause of action for which the volunteer is immune from liability under s. 146.31 (2) and (3), ~~146.37~~ 146.38 (2), 895.44, 895.48, 895.482, 895.51, or 895.52.

SECTION 6. 655.27 (1m) (b) of the statutes is amended to read:

655.27 **(1m)** (b) A health care provider who engages in ~~the activities described in s. 146.37 (1g) and (3)~~ a quality improvement activity under 146.38 shall be liable for not more than the limits expressed under s. 655.23 (4) or the maximum liability limit for which the health care provider is insured, whichever limit is greater, if he or she is found to be liable under s. ~~146.37~~ 146.38, and the fund shall pay the excess amount, unless the health care provider is found not to have acted in good faith during those activities and the failure to act in good faith is found by the trier of fact, by clear and convincing evidence, to be both malicious and intentional.

SECTION 7. 655.27 (5) (a) 1. and 2. of the statutes are amended to read:

655.27 **(5)** (a) 1. Any person may file a claim for damages arising out of the rendering of medical care or services or participation in ~~peer review activities~~ a quality improvement activity under s. ~~146.37~~ 146.38 within this state against a health care provider or an employee of a health care provider. A person filing a claim may recover from the fund only if the health care provider or the employee of the health care provider has coverage under the fund, the fund is named as a party in the action, and the action against the fund is commenced within the same time limitation within which the action against the health care provider or employee of the health care provider must be commenced.

2. Any person may file an action for damages arising out of the rendering of medical care or services or participation in ~~peer review activities~~ a quality review

activity under s. ~~146.37~~ 146.38 outside this state against a health care provider or an employee of a health care provider. A person filing an action may recover from the fund only if the health care provider or the employee of the health care provider has coverage under the fund, the fund is named as a party in the action, and the action against the fund is commenced within the same time limitation within which the action against the health care provider or employee of the health care provider must be commenced. If the rules of procedure of the jurisdiction in which the action is brought do not permit naming the fund as a party, the person filing the action may recover from the fund only if the health care provider or the employee of the health care provider has coverage under the fund and the fund is notified of the action within 60 days of service of process on the health care provider or the employee of the health care provider. The board of governors may extend this time limit if it finds that enforcement of the time limit would be prejudicial to the purposes of the fund and would benefit neither insureds nor claimants.

(END)

DRAFTER'S NOTE
FROM THE
LEGISLATIVE REFERENCE BUREAU

LRB-1965/P5dn
RLR:...:...

Proposed s. 146.38

This redraft adds an analysis. I made no changes to the statutory language other than adding a comma on page 3, line 4 of the /P4.

Immunity provisions:

1. The bill retains some of the examples from s. 146.37 of reviews to which the immunity provision applies and redacts others. Since all of the examples are covered as quality improvement activities, what will a court make of the selective retention?

2. Sub. (2) uses the term "hospital staff privileges," which is not used elsewhere in the bill. Elsewhere the bill refers to "clinical privileges," "clinical practice authority," or "membership on a medical staff."

Confidentiality/privilege

1. Should proposed s. 146.38 (3) (b) be prefaced with, "Except as provided in sub. (4)(f)," Otherwise, the mandated reporting, adverse action, and written authorization exceptions will not apply.

2. Similarly, should the first sentence under proposed s. 146.38 (3) (c) be prefaced with "Except as provided in sub. (4)(f)"

3. The exception to confidentiality and privilege under proposed s. 146.38 (4) (c) for adverse actions refers to both disclosure and admissibility of evidence. The exceptions for mandated reports, under proposed sub. (4) (b), and for written authorizations, under proposed sub. (4) (d), only refer to disclosure. Is this problematic? Do you want the bill to address when records and information that are disclosed in compliance with a federal or state mandate may be admitted as evidence? Should a person be able to affect admissibility in a written authorization under proposed sub. (4) (d)? (2)

Construction: We discussed, but never resolved, whether to delete "inadmissible as evidence" from the provision on construction under proposed s. 146.38 (5).

Quality improvement activities related to public entities:

In the context of drafting proposed s. 146.38 (3) (d), Laura, Matthew, Dick, and I discussed the question of how the confidentiality and privilege provisions in the draft

In addition,

intersect with the public records law when the subject of a quality improvement activity is a public agency, for example, a county nursing home. Proposed s. 146.38 (3) (d) specifies that if a state agency reviews a health care entity at the request of the health care entity, the records of the review are not subject to public inspection or copying if the health care entity is not a public agency. This may create ~~and~~ inference that the public records law does apply if the health care entity that requested the review is a public agency. The bill is silent on how the public records law applies to a review of a public health care entity conducted by someone other than a state agency. It is my understanding that WHA does not intend to change current law with respect to public access to records relating to health care entities that are public agencies.

an

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INS ANALYSIS

INS A

Current law confidentiality and peer review provisions

Under current law a person who participates in a review or evaluation of the services of a health care provider (a review or evaluation) may not disclose any information acquired in connection with the review or evaluation. Further, records that an organization or evaluator keeps of investigations, inquiries, proceedings and conclusions in connection with a review or evaluation are confidential and may not be used in a civil action for personal injuries against the health care provider. (An "evaluator" is defined as a medical director or registered nurse who coordinates review of an emergency medical services program. "Organization" and "health care provider" are not defined.)

Current law provides several exceptions to the confidentiality provisions for records and information related to reviews or evaluations, which allow release of information or records to the health care provider who is the subject of the review; to others if the subject of the review or evaluation consents to release or to the person who requested the review, for use for certain purposes, including improving the quality of health care. Other exceptions to confidentiality allow the release of information that is subpoenaed in a criminal action, allow release of information to an examining or licensing board, and allow release of information in a statistical report. Current law provides that information or records presented during a review or evaluation are not immune from discovery or use in a civil action simply because they were presented for the review or evaluation. Further, a person who participates in a review or evaluation may testify in a civil action as to matters within his or her knowledge, but may not testify regarding information obtained through the review or evaluation or regarding conclusions of the review or evaluation.

The courts have ruled that records of a review or evaluation conducted by an organization are confidential only if: 1) the review or evaluation is part of a program organized and operated to improve the quality of care of a health care provider; and 2) the person or entity conducting the review or evaluation is part of, or acting on the behalf of, a group with relatively constant membership, officers, a purpose, and a set of regulations. The courts have found that the following types of information and records are not confidential or protected: information learned by a hospital administrator in investigating care provided to a patient in a particular incident; a physician's application for reappointment to a hospital staff; information as to whether a hospital investigated a physician or whether the physician's medical privileges were ever limited; and a letter written by a doctor on staff at a hospital to the supervisor of the hospital's residency program that concerned an investigation initiated by the hospital of a resident's performance during a particular incident (the hospital peer review committee was not convened to investigate). Courts have determined that a review or evaluation by a hospital credentials committee or by the Joint Committee on Accreditation of Healthcare Organizations is confidential and protected.

Commission

(a private accrediting body)

Finally, current law provides that a person who discloses records or information of a review or evaluation in violation of the confidentiality or privilege provisions is civilly liable for the disclosure.

Bill provisions concerning confidentiality and privilege

This bill repeals the confidentiality and privilege provisions for a review or evaluation of the services of a health care provider and creates a new confidentiality provision and privilege for quality improvement activities concerning health care providers.

Who may be the subject of protected quality improvement activity. The bill broadly defines who may be the subject of protected quality improvement activities. Potential subjects or "health care entities" include:

1. Individuals who must obtain licensure or some other form of certification before providing health care services, such as doctors, nurses, pharmacists, emergency medical technicians, first responders, dieticians, and various therapists.

2. People in training to obtain certification to serve as a health care provider, such as a resident.

3. Organizations that provide health care, such as hospitals, clinics, nursing homes, home health agencies, and hospices.

4. People or organizations that are certified by the Department of Health and Family services to provide services under the Medical Assistance program, such as personal care workers and providers of transportation by specialized medical vehicle.

5. A parent organization, subsidiary, or affiliate of other health care entities such as a company that owns multiple hospitals or clinics.

People or organizations who may conduct protected quality improvement activity. The bill specifies who may conduct a protected quality improvement activity concerning various health care entities:

1. A review by a health care entity of health care providers who work for the entity or to whom the entity grants clinical privileges or clinical practice authority. This includes, for example, a review by a hospital of its doctors or nurses or a review by a home health agency of its home health aides.

2. A review by a health care entity of its own performance, or a review of the health care entity by a person or organization to whom the health care entity has granted authority to conduct a review.

3. A review by a fixed or ad hoc committee of a health care entity concerning the health care entity or concerning health care providers who work for the entity or to whom the entity grants clinical privileges or clinical practice authority. This includes, for example, a review by a hospital committee that is not a formal "peer review" committee.

4. A review by a provider who works for a health care entity or a provider to whom a health care entity grants clinical privileges or clinical practice authority of any other provider who works for a health care entity or to whom a health care entity grants clinical privileges or clinical practice authority. This includes, for example, a review by one doctor who is on staff at a hospital of another doctor on staff.

5. A review by a state agency of a health care entity, which is not mandated by law and is conducted at the request of a health care entity.

Topics of quality improvement activity. The bill identifies the potential topics of a protected quality review activity. The topics include quality of care; qualifications, competence, and performance of providers; compliance with credentialing, accreditation or regulatory standards; compliance with legal, ethical, or behavioral standards; utilization of resources; costs; the approval or credentialing of a health care provider or organization; and morbidity or mortality.

Types of quality improvement activities. The bill identifies the types of activities that are protected, including evaluations, studies, investigations, corrective actions, or any other activity, and specifies that data collection is a protected activity.

Protection afforded. The bill provides several forms of protection for records of quality improvement activities. Under the bill, records of quality improvement activities, and information in those records, are confidential and privileged, are not subject to discovery, subpoena, or other means of legal compulsion requiring release or permitting inspection; and are not admissible in evidence in an civil or criminal action or administrative proceeding.

The protections extend to records or information that is created during or in preparation for a quality improvement activity, as well as to records or information that is presented to a person or organization that conducts or requests the quality improvement activity. The protections extend to a request for records or information made as part of a quality improvement activity, notice to a health care entity that the entity is or will be the subject of a quality improvement activity, and any aggregation or reorganization of other protected records or information. Also, a person who conducts or participates in quality improvement activity may not disclose whether the activity was conducted or any action or lack of action taken as a consequence of the activity. Finally, the protections are not waived by an unauthorized or authorized disclosure of records or information.

Exceptions to confidentiality and privilege. The bill creates several exceptions to the protections afforded to records and information concerning quality improvement activities. Records or information maintained by a health care entity for the particular purpose of diagnosing, treating, or documenting care provided to an individual patient are not protected. A person who is required by federal or state law to report information may disclose quality improvement records and information to the extent necessary to make the mandated report. A person who, as a result of a quality improvement activity, takes action to limit or deny a health care entity's ability to serve as a health care entity must disclose relevant quality improvement records and information to the health care entity, and such records are admissible in judicial and administrative proceedings. Finally, if either the subject of a quality improvement activity or the the person or organization that conducts or requests the quality improvement, depending on the type of activity, provides written authorization to disclose quality improvement records or information, the records or information may be disclosed to the extent of the written authorization.

The bill does not provide civil liability for disclosing records or information in violation of the confidentiality and privilege provisions for records or information relating to quality improvement activity.

Immunity provisions

Under current law, a person acting in good faith is immune from civil liability for acts or omissions taken while participating in a review or evaluation of the services of health care providers or facilities or of charges for services if the review or evaluation is conducted in connection with a program organized and operated to help improve the quality of health care, to avoid improper utilization of services, or to determine reasonable charges.

The bill provides that a person is immune from civil liability for acts or omissions taken while participating in a quality review activity, as described under the heading "Types of quality improvement activities" above, that relates to a health care entity.

2005–2006 DRAFTING INSERT
FROM THE
LEGISLATIVE REFERENCE BUREAU

Ins A:

"Organization" is not defined. Current law specifies that three particular types of providers are "health care providers," but does not otherwise define "health care provider.")

Ins B:

"Quality improvement activity is defined as any action, such as a review, study, investigation, corrective action, or recommendation, relating to a health care entity and concerning certain topics, including: quality of care; qualifications, competence, and performance of providers; compliance with credentialing, accreditation, or regulatory standards; compliance with legal, ethical, or behavioral standards; utilization of resources; costs; the approval of credentialing of a health care provider or organization; and morbidity or mortality.

Ins C:

Who may conduct a quality improvement activity concerning various health care entities. The bill specifies that the confidentiality and privilege provisions apply only to a quality improvement activity conducted by and of the following combinations of people or organizations:

DRAFTER'S NOTE
FROM THE
LEGISLATIVE REFERENCE BUREAU

LRB–1965/P5dn
RLR:cjs:rs

January 25, 2006

This redraft adds an analysis. I made no changes to the statutory language other than adding a comma on page 3, line 4, of the /P4.

Immunity provisions:

1. The bill retains some of the examples from s. 146.37 of reviews to which the immunity provision applies and redacts others. Since all of the examples are covered as quality improvement activities, what will a court make of the selective retention?

2. Proposed s. 146.38 (2) uses the term "hospital staff privileges," which is not used elsewhere in the bill. Elsewhere the bill refers to "clinical privileges," "clinical practice authority," or "membership on a medical staff."

Confidentiality/privilege

1. Should proposed s. 146.38 (3) (b) be prefaced with, "Except as provided in sub. (4)"? Otherwise, the mandated reporting, adverse action, and written authorization exceptions will not apply.

2. Similarly, should the first sentence under proposed s. 146.38 (3) (c) be prefaced with "Except as provided in sub. (4)"?

3. The exception to confidentiality and privilege under proposed s. 146.38 (4) (c) for adverse actions refers to both disclosure and admissibility of evidence. The exceptions for mandated reports, under proposed sub. (4) (b), and for written authorizations, under proposed sub. (4) (d), refer only to disclosure. Is this problematic? Do you want the bill to address when records and information that are disclosed in compliance with a federal or state mandate may be admitted as evidence? Should a person be able to affect admissibility in a written authorization under proposed sub. (4) (d)?

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Quality improvement activities related to public entities:

In the context of drafting proposed s. 146.38 (3) (d), Laura, Matthew, Dick, and I discussed the question of how the confidentiality and privilege provisions in the draft intersect with the public records law when the subject of a quality improvement activity is a public agency, for example, a county nursing home. Proposed s. 146.38 (3)

(d) specifies that if a state agency reviews a health care entity at the request of the health care entity, the records of the review are not subject to public inspection or copying if the health care entity is not a public agency. This may create an inference that the public records law does apply if the health care entity that requested the review is a public agency. In addition, the bill is silent on how the public records law applies to a review of a public health care entity conducted by someone other than a state agency. It is my understanding that WHA does not intend to change current law with respect to public access to records relating to health care entities that are public agencies.

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1965/P4
PG

Meeting 1/26/05
Laura Matthew (WITA)
Randy Thorson
Dick Sweet
Several private attys working w/ WITA

p 7-20 (P4) record rel to adverse action

Immunity - just 1st sentence in (a)
- yes to my note
- delete (c)

add "adverse action" in def. of QIA

remove e'ment from adverse action

Public records - apparently peer review records not subject to public records law now - Keep this? State set in bill - regardless of whether subject of review is private or public entity.

description
for definition of re-review program - not all approved by DHFS

Elim prohib against disclosing that QIA occurred

1/26/06 (cont.)

Use Matthew's language on Conf & Exception

add "authorized" under (3)(a)1.b.

add – condition of accreditation
– policy
– resolution under (3)(a)1.a.