Provided by Matthew at meeting 1/26/06 with WHA, Randy Thorson, Dick Sweet and several attys. working with WHA

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:

SECTION 1. 146.37 of the statutes is repealed.

SECTION 2. 146.38 of the statutes is repealed and recreated to read: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

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.

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

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.

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

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.

(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, collected, reported, aggregated, or organized by any person ~~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~~ a quality improvement activity that is conducted by any person, organization, department, single or joint committee, governing body, or committee of a governing body that is any of the following:

a. A person that has responsibility by statute, regulation, or organization bylaw to conduct ~~the~~ a quality improvement activity, except for state agencies. [subd. (4) addresses disclosure - this group controls disclosure, reviewees have no independent power to disclose.],

b. A person that is directed by a health care entity to conduct the quality improvement activity in which the directing health care entity or another health care entity is the subject of the quality improvement activity. [subd. (4) addresses disclosure - the directing health care entity controls the power to disclose, reviewees have no independent power to disclose.]

~~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.~~[covered by a. for direct reviews, covered by b. for requested reviews]

~~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.~~ [covered by a. Joint actions would be by b.]

~~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.~~ [covered by a or b.]

~~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.~~ [covered by b. or a.]

~~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.~~ [covered by b.]

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. [can this be cut and put into 1. as suggested?]

(b) Except as provided in sub. (4), ~~A~~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. [Concerns were raised that there are times hospitals may want to communicate to another hospital that an action has occurred. Usually this is in the context of a hospital doing a reference check before granting a new physician privleges at the hospital. Subject to the restrictions in (4), subd. (4) would now permit this kind of disclosure]

(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, except as provided under subd. (4)(g). [Or put it here if you want. Since its an exception to privilege, I put it in (4).~~ 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).~~ [Crossed out provision seemed to only apply to persons conducting the QIA, but not to persons who have received disclosed records. Disclosures by persons conducting QIA are already covered by (3)(a) so the sentence seemed both redundant with (3)(a) but

also could be interepreted to allow redisclosure in every instance. (4) limits disclosure and redisclosure except when the records are widely distributed – i.e. public reporting.]

(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 created apart from quality improvement activity that are maintained by or for a health care entity for the particular purpose of diagnosing, treating, or documenting care provided to an individual patient. [to address concern about "documenting care." The "created apart" is similar to language in the federal act.]

(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. A record received by a person pursuant to this subparagraph shall not be subject to sub. (3) or (4). [Should such records required to be disclosed be admissible?]

(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 or taken 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.~~ [The difficulty with this section is that one review might meet one category in (3)(a)1., in which ambiguity is caused here.] [Have simplified (3)(a)1. to make this provision more specific.]

(d) A person conducting a quality improvement activity pursuant to (3)(a)1.a. may disclose the records and information that are confidential and privilged pursuant to (3) to any person conducting quality improvement activity that is described in (3)(a)1. or any health care entity that is identified by name in the records of the quality improvement activity [so can disclose regardless of whether a provider is identified for this purpose.]

(e) A person conducting a quality improvement activity pursuant to (3)(a)1.b. may disclose the records and information that that are confidential and privilged pursuant to (3). to any person conducting quality improvement activity that is described in (3)(a)1. or any health care entity that is identified by name in the records of the quality improvement activity, *if the disclosing person has written authorization from the health care entity that directed the person to conduct the quality improvement activity.* [so can disclose regardless of whether a provider is identified for this purpose.]

(f) A person conducting a quality improvement activity pursuant to (3)(a)1. [THAT IS NOT RELATED TO ADVERSE ACTION?] may disclose the records and information that are confidential and privileged pursuant to (3). and that also identify a health care provider by name if the disclosing person has written authorization from the health care entity identified or from a person who has legal [CONTRACT/EMPLOYMENT] authority to authorize on behalf of the identified health care entity the disclosure of otherwise confidential and privileged records and information. [THIS ALLOWS FOR PUBLIC REPORTING AND PROVIDES THAT THE IDENTIFIED SUBJECTS NEED TO GIVE PERMISSION. At first this provision could be used as a sword but I amended (3)(c) so that the rule is that the info is still privileged, and then added (g) so that dispersed public reports are not privileged.]

(g) The confidentially and privilege afforded to records and information under par. (3) is waived for records widely disclosed to persons that are not health care entities pursuant to subd. (f)

(h) An entity contemplating/planning an activity that would be quality improvement activity under sub. (3)(a)1. may in advance of the activity designate in writing that sub. (3), and sub. (4)(a)-(g) shall not apply to the records and information in records created, collected, reported, aggregated, or organized by any persons as part of the designated activity.

(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:

(h) 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.

Ryan, Robin

From: Stanford, Matthew [mstanford@wha.org]
Sent: Monday, January 30, 2006 4:10 PM
To: Ryan, Robin
Cc: Leitch, Laura
Subject: QIA draft
Attachments: Discussion of changes 013006.doc; QIARedline 013005.doc

Hello Robin,

A few issues have popped up in the Quality Improvement Act draft over the weekend pertaining to the revisions discussed on Thursday. Primarily, all of the issues involve cleaning up language to make sure the correct intent is articulated - there are no major substantive changes. Attached is an explanation of the new issues and language that would address the issues. In each case, we used the clearest language possible to completely convey the intent, but you may be able to draft language that preserves that intent but is drafted in a more economical way (see (f) and new (ff) for example).

These will be our last suggestions for revisions to a final draft; if needed, a simple amendment can take care of any other minor changes as things move forward. Please contact Laura or I if you have any questions.

Matthew

Matthew Stanford
Associate Counsel
Wisconsin Hospital Association, Inc.
PO Box 259038
5510 Research Park Drive
Madison, WI 53725-9038
608-274-1820
mstanford@wha.org

1/30/06

Explanation of Revisions

During the Thursday meeting several revisions were proposed to the P5 draft in which there was agreement. Over the weekend, a few needed tweaks to those revisions were identified. This document explains the changes to the Thursday revisions. The attached draft of the Act addresses these revisions with proposed language. Only the revisions identified in this explanation document appear in redline in the draft Act. Note that the rest of the language in the attached draft Act does not reflect all of the changes agreed to at the Thursday meeting (for example, neither the changes to (2) nor the addition of adverse action to the definition of QIA appear in this draft though it was agreed that they would be incorporated into the Act).

(1)(d)6. Discussion:

REVISION: Removed reference to Joint Commission.

INTENT OF REVISION: Reference was not necessarily helpful.

(3)(a)1.a Discussion:

REVISION: Removed "organization" from the qualifiers.

INTENT OF REVISION: During the Thursday meeting, the participants discussed expanding (3)(a)1.a. to read "by statute, regulation, condition of accreditation, or organization bylaw, policy, or resolution..." to provide additional flexibility to health care providers' ability to conduct QIA. Concerns rose during further discussions over the weekend that the term "organization" in this context might preclude joint quality improvement activities between hospitals. To remove that concern, the revision simply eliminates "organization" for the qualifiers.(3)(a)1.a.

(4)(aa) Discussion:

REVISION: This provision was added to allow anyone to disclose the fact of the actual reduction, restriction, suspension, etc. of a health care entity's privileges, membership, licensure, etc.

INTENT OF (4)(aa): The reason for the addition is to allow, for example, a hospital to tell staff, insurers, or patients that Dr. X no longer has privileges at the hospital. This issue was addressed at the Thursday meeting in the context of deleting (3)(b), however, after further discussions over the weekend it was determined that the actual fact of such a revocation of privileges should not confidential and privileged. However, the underlying work, actions, recommendations, conclusions, etc. would remain confidential and privileged.

(4)(d) Discussion

REVISION: No changes made since Thursday meeting. (Discussion is here simply to help explain (d), (e), (f), and (ff).)

INTENT OF (4)(d): This provision is a permissive disclosure for the narrow situation where a quality improvement entity with independent authority to conduct quality improvement ((3)(a)1.a. entity) discloses information to i) another quality improvement entity conducting protected quality improvement activities (such as another quality improvement committee, JCAHO, or CheckPoint) or to ii) a health care entity that is identified by name in the records of the quality improvement activity. A disclosure pursuant to (d) can be made without authorization of individual health care providers identified in the records disclosed. In other words, the intent is that if a disclosure could be made under (d), then (f) and its authorizations do not apply.

(4)(e) Discussion

REVISION: One technical change has been made. As (e) was written yesterday, it could be argued that the disclosing person would have to personally have the written authorization of the directing health care entity. The rewrite just says that there is written authorization. It does not require that the disclosing person personally have the written authorization. Authorization language in (f) and (ff) has also been revised to address this issue.

INTENT OF (4)(e): This provision is a permissive disclosure for the narrow situation where a person that has been directed by a health care entity to conduct quality improvement ((3)(a)1.b. entity) discloses information to i) another quality improvement entity conducting protected quality improvement activities (such as another quality improvement committee, JCAHO, or CheckPoint) or to ii) a health care entity that is identified by name in the records of the quality improvement activity. This specific disclosure can be made without authorization of individual health care providers identified in the records disclosed. In other words, the intent is that if a disclosure could be made under (e), then (ff) and its authorizations do not apply. However, the health care entity that directed the person to conduct the disclosed quality improvement must give authorization to disclose any of information.

(4)(f) and (4)(ff) Discussion

REVISION 1: Like the technical change discussed for (4)(e) above, the written authorization language has been changed so that the requirement is simply that there be written authorization, not that it is specifically held by the disclosing person.

REVISION 2: Since Thursday's draft, (4)(f) has been limited to (3)(a)1.a. entities. A provision parallel to (4)(f) that is limited to (3)(a)1.b. entities has been created in (4)(ff). Why? In yesterday's draft it was intended that if a (3)(a)1.b. entity disclosed information pursuant to (f), the health care entity that directed the person to conduct the disclosed quality improvement must give authorization to disclose the information (just as is the case for disclosures under (e)). However, that intent did not make it into the language of

(f). To address this, (ff) was created to address (f)-type disclosures by (3)(a)1.b. entities and includes additional authorization by the health care entity directing the (3)(a)1.b. entity. Thus, (f) has been limited to just (3)(a)1.a. entities, and (ff) has been limited to just (3)(a)1.b. entities. There may be a more economical way to draft this but we will leave that up to your drafting.

REVISION 3: In both (f) and (ff), the phrase "from a person who has legal authority to authorize on behalf of the identified health care entity the disclosure of otherwise confidential and privileged records and information" has been replaced with "the employer of the health care entity identified, or a parent organization of the health care entity identified." This change should make it clear exactly who may authorize on behalf of the identified health care entity.

REVISION 4: A sentence has been added to the end of (f) and (ff) to clarify that (f) and (ff) and their authorizations relating to identified health care providers do not apply if the disclosure could be made under (d) or (e) respectively. Laura and I have tried different language to accomplish this purpose and this language still may not do the trick, but the intent is to make sure that (d) always trumps (f) and (e) always trumps (ff). Again, there may be a more economical or proper way to draft this but we will leave that up to your drafting.

INTENT OF (4)(f) AND (4)(ff): The main intent of (4)(f) and the new parallel (4)(ff) is to allow for public reporting and to provide that before a quality improvement report is disclosed in a widespread public report like a CheckPoint report, the individual health care providers specifically identified in the report provide some sort of authorization either personally, or on their behalf as an employer or parent organization, before the report is released.

How would (4)(d) and (f) (or (4)(e) and (ff) for disclosures by directed quality improvement entities) work in practice for hospitals? If a hospital submits information that identifies a physician to CheckPoint but CheckPoint only aggregates and de-identifies the physician identifiable information before releasing to the public the aggregated and physician de-identified information, neither the hospital, nor CheckPoint would have to get authorization from the physicians. Why? CheckPoint's act of collecting quality information and aggregating that information at the direction of the hospital makes CheckPoint a person conducting quality improvement activity pursuant to (3)(a)1.b. As such, the added line in (4)(f) says that (4)(f) does not apply to a disclosure to a (3)(a)1. entity. (4)(d) does apply, so if the hospital will be disclosing its physician identified information from its own quality improvement entity, that hospital's quality improvement entity could disclose the information to CheckPoint pursuant to(4)(d) and thus would not have to get authorization for the physicians identified in the information given to CheckPoint. (Of course, the hospital could also directly report, rather than disclosing through its own quality improvement entity, the physician identifiable information to CheckPoint. In that case, the physician identifiable information held by the hospital would not be a protected record under (3) until it was actually reported to

CheckPoint, and the disclosure provisions under (4) would not apply to the report/disclosure to CheckPoint.)

However, if CheckPoint were to want to publicly report the physician identifiable information, it could disclose the information pursuant to (4)(ff) (CheckPoint would be a (3)(a)1.b. directed quality improvement entity), but that disclosure would require authorization from the physicians identified in the public release or their employers.

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:

SECTION 1. 146.37 of the statutes is repealed.

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.

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.

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

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.

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

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.

(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, collected, reported, aggregated, or organized by any person as part of a quality improvement activity that is conducted by any person, organization, department, single or joint committee, governing body, or committee of a governing body that is any of the following:

a. A person that has responsibility by statute, regulation, condition of accreditation, bylaw, policy, or resolution to conduct the quality improvement activity, except for state agencies.

Deleted: or organization

b. A person that is directed by a health care entity to conduct the quality improvement activity in which the directing health care entity or another health care entity is the subject of the quality improvement 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.

(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, except as provided under subd. (4)(g).

Formatted

(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 created apart from quality improvement activity that are maintained by or for a health care entity for the particular purpose of diagnosing, treating, or documenting care provided to an individual patient.

(aa) Subsection (3) does not apply to the fact of the failure to renew or the reduction, restriction, suspension, denial, or revocation of any of the things described in sub. (3)(a)1.-4.

(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. A record received by a person pursuant to this subparagraph shall not be subject to sub. (3) or (4).

(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) A person conducting a quality improvement activity pursuant to (3)(a)1.a. may disclose the records and information that are confidential and privileged pursuant to (3) to any person conducting quality improvement activity that is described in (3)(a)1. or any health care entity that is identified by name in the records of the quality improvement activity [CAN DISCLOSE REGARDLESS OF WHETHER A PROVIDER IS IDENTIFIED FOR THIS PURPOSE.]

(e) A person conducting a quality improvement activity pursuant to (3)(a)1.b. may disclose the records and information that that are confidential and privileged pursuant to (3). to any person conducting quality improvement activity that is described in (3)(a)1. or any health care entity that is identified by name in the records of the quality improvement activity, *if there is written authorization to make the disclosure from the health care entity that directed the person to conduct the quality improvement activity.* [CAN DISCLOSE REGARDLESS OF WHETHER A PROVIDER IS IDENTIFIED FOR THIS PURPOSE.]

(f) A person conducting a quality improvement activity pursuant to (3)(a)1.a. may disclose the records and information that are confidential and privileged pursuant to (3). and that also identify a health care provider by name if there is written authorization to make the disclosure from the health care entity identified, the employer of the health care entity identified, or a parent organization of the health care entity identified. This subd. (f) does not apply to disclosures to a person conducting quality improvement activity described in (3)(a)1. or a health care entity that is identified by name in the records of the quality improvement activity.

[THIS ALLOWS FOR PUBLIC REPORTING AND PROVIDES THAT THE IDENTIFIED SUBJECTS NEED TO GIVE PERMISSION.

Formatted

Deleted: *disclosing person has*

Formatted

Formatted

Formatted

Formatted

Deleted: disclosing person has

Deleted: or from

Deleted: a person who has legal authority to authorize on behalf of the identified health care entity the disclosure of otherwise confidential and privileged records and information.

redundant

(ff) [all of (ff) is new, but I have only redlined the differences between (f) and (ff)] A person conducting a quality improvement activity pursuant to (3)(a)1.b. may disclose the records and information that are confidential and privileged pursuant to (3). and that also identify a health care provider by name if there is written authorization to make the disclosure from the health care entity identified, the employer of the health care entity identified, or a parent organization of the health care entity identified and *if there is written authorization to make the disclosure from the health care entity that directed the person to conduct the quality improvement activity*. This subd. (ff) does not apply to disclosures to a person conducting quality improvement activity described in (3)(a)1. or a health care entity that is identified by name in the records of the quality improvement activity.

Deleted: a

redundant

THIS ALLOWS FOR PUBLIC REPORTING AND PROVIDES THAT THE IDENTIFIED SUBJECTS NEED TO GIVE PERMISSION

(g) The confidentially and privilege afforded to records and information under par. (3) is waived for records widely disclosed to persons that are not health care entities pursuant to subd. (f) and (ff)

(h) An entity contemplating/planning an activity that would be quality improvement activity under sub. (3)(a)1. may in advance of the activity designate in writing that sub. (3), and sub. (4)(a)-(g) shall not apply to the records and information in records created, collected, reported, aggregated, or organized by any persons as part of the designated activity.

Planning

don't need to except exceptions

(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:

(h) 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.

Ryan, Robin

From: Ryan, Robin
Sent: Tuesday, January 31, 2006 2:17 PM
To: 'Stanford, Matthew'; 'lleitch@wha.org'
Cc: Sweet, Richard
Subject: comments/questions

Matthew and Laura,

Following is proposed statutory language on portions of the confidentiality provisions and exceptions, each followed by a couple comments and questions. This is a work in progress, so their will be changes before it goes to Rep. Underheim (tomorrow or Thursday). Can you give me feedback by tomorrow morning?

Statutory Language:
Sub. (3) (a)
1. Records and information contained in records that are created, collected, reported, aggregated, or organized by any person as part of a quality improvement activity conducted by any of the following:
a. A person, organization, department, single or joint committee, governing body, or committee of a governing body, other than a state agency, that is required by federal or state law to conduct the quality improvement activity, or is required as a condition of accreditation or under the terms of a bylaw, policy, or resolution to conduct the quality improvement activity.
b. A person, organization, department, single or joint committee, governing body, or committee of a governing body that a health care entity directs, authorizes, or requests to conduct the quality improvement activity.

Comments on (3) (a) 1.:
1. When you say "has responsibility" do you mean required?
2. If a statute requires a "hospital" to conduct a quality improvement activity and a committee of the hospital conducts the activity, does 1.a. apply? Should 1.a. also cover a QIA conducted by a designee of the person who is required to conduct the QIA? (i.e. tack on at the end, "or the designee of such person, organization, department, ..."
3. The reference to bylaw, policies, and resolutions is very broad – whose bylaw, policy, resolution? A health care entity's? Similarly, should this specify accreditation of the health care entity, because the person, committee, etc. who conducts the QIA isn't necessarily the one that needs accreditation?
How about: A person, organization, department, committee, governing body, or committee of a governing body, other than a state agency, that is required by federal or state law, required as a condition of a health care entity's accreditation, or required under a health care entity's bylaws, policies, or resolutions to conduct the quality improvement activity.
4. A "joint" committee is a "single" committee – the distinction is not clear.
5. I left off the specification in 1. b. that the subject of the QIA is either the health care entity that directs or authorizes the QIA or any other health care entity, because all QIAs by definition relate to a health care entity so the language regarding the subject doesn't add anything.
6. In 1.b., I added a person whom the health care entity request to conduct the QIA in order to cover the situation where a hospital asks DHFS to conduct a review, because I don't think the hospital is directing or authorizing DHFS to act.
7. Both 1.a. and 1.b. probably cover independent research conducted by a person who happens to be a health care entity.

Exception for treatment records:

Sub. (3) only applies to records created, collected etc. "as part of a QIA," so if you specify treatment records created apart from a QIA the exception doesn't line up with the confidentiality and privilege provision. Also, what if a hospital engaged in a QIA to improve how prescriptions orders are entered in patient charts. Arguably the prescription order is created as part of the QIA, but should still fall under the treatment records exception.

Statutory Language:

Sub. (4)

(d) A person who conducts a quality improvement activity under sub. (3) (a) 1.a. may disclose records related to the quality improvement activity, or information in those records, to any health care entity named in the records.

(d1) A person described under sub. (3) (a) 1. a. may disclose records related to any quality improvement activity conducted under sub. (3) (a) 1., or information in those records, to any other person described under sub. (3) (a) 1. a.

(e) If the health care entity that directs or authorizes [requests] a quality improvement activity described under sub. (3) (a) 1. b. provides written authorization to disclose records related to the quality improvement activity to any health care entity named in the records or to any person described under sub. (3) (a) 1. a., the person who conducted the quality improvement activity may disclose the records as permitted in the written authorization.

(f) If each health care entity named in a record relating to a quality improvement activity described under sub. (3) (a) 1.a., or the employer or parent organization of the health care entity, provides written authorization to disclose the record to any person, the person conducting the quality improvement activity may disclose the record or information in the record, to any person. Records or information that are widely disclosed under this paragraph to persons who are not health care entities are not confidential or privileged under sub. (3).

(ff) If each health care entity named in a record relating to a quality improvement activity described under sub. (3) (a) 1.b., or an employer or parent organization of the health care entity, and the health care entity that directs or authorizes [requests] the quality improvement activity provides written authorization for disclosure of the record to any person, the person conducting the quality improvement activity may disclose the record, or information in the records, to any person. Records or information that are widely disclosed under this paragraph to persons who are not health care entities are not confidential or privileged under sub. (3).

(h) If, before initiating a quality improvement activity described under sub. (3) (a) 1., a health care entity specifies in writing that sub. (3) shall not apply to records relating to the quality improvement activity or information in the records, then sub. (3) does not apply to the records or information.

Comments on Exceptions/Disclosures:

1. I split up (d) because it seemed to cover 2 distinct concepts and I want to be really clear that sharing between review entities is not limited to a specific QIA. (I realize that (e) could also be split under the same reasoning, and may do that)
2. In general, for the exceptions allowing disclosure to a health care entity named in a record, should the exception allow disclosure of all records relating to the QIA, or only those records that name the health care entity?
3. Paragraphs (f) and (ff) require that each health care entity named in a record provide written authorization – is this what you intend?
4. There is no public reporting provision concerning records in which individual health care entities are not named, should there be?

5. Who may make the stipulation under par. (h)?

Ryan, Robin

From: Stanford, Matthew [mstanford@wha.org]
Sent: Wednesday, February 01, 2006 11:02 AM
To: Ryan, Robin
Subject: RE: comments/questions
Attachments: QIARedline 020106.doc

Robin,
Here is the language for (3)(a) and (4). (4)(d) and (f) and (4)(e) and (ff) have been combined for simplicity.
Please call if you have questions.
Matthew

From: Ryan, Robin [mailto:Robin.Ryan@legis.state.wi.us]
Sent: Wednesday, February 01, 2006 9:26 AM
To: Stanford, Matthew
Subject: RE: comments/questions

Sure, I need to get the bill off my desk early this afternoon. If you give me comments (piecemeal or as a whole) later this morning, I will try to incorporate them. If we don't resolve everything this morning, I am assuming that we can do a substitute amendment.

From: Stanford, Matthew [mailto:mstanford@wha.org]
Sent: Wednesday, February 01, 2006 9:16 AM
To: Ryan, Robin
Subject: RE: comments/questions

Will late morning work?

From: Ryan, Robin [mailto:Robin.Ryan@legis.state.wi.us]
Sent: Tuesday, January 31, 2006 2:17 PM
To: Stanford, Matthew; Leitch, Laura
Cc: Sweet, Richard
Subject: comments/questions

Matthew and Laura,

Following is proposed statutory language on portions of the confidentiality provisions and exceptions, each followed by a couple comments and questions. This is a work in progress, so their will be changes before it goes to Rep. Underheim (tomorrow or Thursday). Can you give me feedback by tomorrow morning?

Statutory Language:
Sub. (3) (a)
1. Records and information contained in records that are created, collected, reported, aggregated, or organized by any person as part of a quality improvement activity conducted by any of the following:

a. A person, organization, department, single or joint committee, governing body, or committee of a governing body, other than a state agency, that is required by federal or state law to conduct the quality improvement activity, or is required as a condition of accreditation or under the terms of a bylaw, policy, or resolution to conduct the quality improvement activity.

b. A person, organization, department, single or joint committee, governing body, or committee of a governing body that a health care entity directs, authorizes, or requests to conduct the quality improvement activity.

Comments on (3) (a) 1.:
1. When you say "has responsibility" do you mean required?
2. If a statute requires a "hospital" to conduct a quality improvement activity and a committee of the hospital conducts the activity, does 1.a. apply? Should 1.a. also cover a QIA conducted by a designee of the person who is required to conduct the QIA? (i.e. tack on at the end, "or the designee of such person, organization, department, ..."

3. The reference to bylaw, policies, and resolutions is very broad – whose bylaw, policy, resolution? A health care entity's? Similarly, should this specify accreditation of the health care entity, because the person, committee, etc. who conducts the QIA isn't necessarily the one that needs accreditation?

How about: A person, organization, department, committee, governing body, or committee of a governing body, other than a state agency, that is required by federal or state law, required as a condition of a health care entity's accreditation, or required under a health care entity's bylaws, policies, or resolutions to conduct the quality improvement activity.

4. A "joint" committee is a "single" committee – the distinction is not clear.
5. I left off the specification in 1. b. that the subject of the QIA is either the health care entity that directs or authorizes the QIA or any other health care entity, because all QIAs by definition relate to a health care entity so the language regarding the subject doesn't add anything.

6. In 1.b., I added a person whom the health care entity request to conduct the QIA in order to cover the situation where a hospital asks DHFS to conduct a review, because I don't think the hospital is directing or authorizing DHFS to act.

7. Both 1.a. and 1.b. probably cover independent research conducted by a person who happens to be a health care entity.

Exception for treatment records:
Sub. (3) only applies to records created, collected etc. "as part of a QIA," so if you specify treatment records created apart from a QIA the exception doesn't line up with the confidentiality and privilege provision.

Also, what if a hospital engaged in a QIA to improve how prescriptions orders are entered in patient charts. Arguably the prescription order is created as part of the QIA, but should still fall under the treatment records exception.

Statutory Language:

Sub. (4)
(d) A person who conducts a quality improvement activity under sub. (3) (a) 1.a. may disclose records related to the quality improvement activity, or information in those records, to any health care entity named in the records.

(d1) A person described under sub. (3) (a) 1. a. may disclose records related to any quality improvement activity conducted under sub. (3) (a) 1., or information in those records, to any other person described under sub. (3) (a) 1. a.

(e) If the health care entity that directs or authorizes [requests] a quality improvement activity described under sub. (3) (a) 1. b. provides written authorization to disclose records related to the quality improvement activity to any health care entity named in the records or to any person described under sub. (3) (a) 1. a., the person who conducted the quality improvement activity may disclose the records as permitted in the written authorization.

(f) If each health care entity named in a record relating to a quality improvement activity described under sub. (3) (a) 1.a., or the employer or parent organization of the health care entity, provides written authorization to disclose the record to any person, the person conducting the quality improvement activity may disclose the record or information in the record, to any person. Records or information that are widely disclosed under this paragraph to persons who are not health care entities are not confidential or privileged under sub. (3).

(ff) If each health care entity named in a record relating to a quality improvement activity described under sub. (3) (a) 1.b., or an employer or parent organization of the health care entity, and the health care entity that directs or authorizes [requests] the quality improvement activity provides written authorization for disclosure of the record to any person, the person conducting the quality improvement activity may disclose the record, or information in the records, to any person. Records or information that are widely disclosed under this paragraph to persons who are not health care entities are not confidential or privileged under sub. (3).

(h) If, before initiating a quality improvement activity described under sub. (3) (a) 1., a health care entity specifies in writing that sub. (3) shall not apply to records relating to the quality improvement activity or information in the records, then sub. (3) does not apply to the records or information.

Comments on Exceptions/Disclosures:
1. I split up (d) because it seemed to cover 2 distinct concepts and I want to be really clear that sharing between review entities is not limited to a specific QIA. (I realize that (e) could also be split under the same reasoning, and may do that)

2. In general, for the exceptions allowing disclosure to a health care entity named in a record, should the exception allow disclosure of all records relating to the QIA, or only those records that name the health care entity?

3. Paragraphs (f) and (ff) require that each health care entity named in a record provide written authorization – is this what you intend?

4. There is no public reporting provision concerning records in which individual health care entities are not named, should there be?

5. Who may make the stipulation under par. (h)?