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Chapter 16: Peer Review and Quality Assurance Requirements

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Editors' Notes

This chapter covers legal requirements and accreditation standards for hopsital peer review, quality improvement, and similar programs. For general information on hospitals, see Chapter 10, "Hospital Regulation." For information on licensed professionals, including doctors, see Chapter 9, "Professional Licensure of Individuals." Please consult other resources for required reporting of professional review actions and malpractice payments. These topics are planned for a future chapter.

Chapter Outline

16.1 Chapter Summary

Peer review programs enlist professionals to monitor the quality of patient care provided by their colleagues, identify opportunities to improve the quality of patient care, and educate, restrict, or remove those providers who do not satisfy the applicable standards of knowledge or competence. Quality improvement or quality assurance programs[1] generally share the same goals as peer review. They are designed to monitor the quality of the health care services rendered to patients, identify opportunities to improve patient outcomes, and identify and prevent malpractice. To meet accreditation standards, health care organizations are often required to maintain peer review and quality improvement programs. Under the right circumstances, properly implemented peer review and quality improvement activities will be exempt from discovery in civil litigation and will assist the health care organization in reducing its malpractice exposure.

16.2 The Relevant Statutes

16.2.1 Hospital Coordinated Quality Improvement Programs

Under Washington law, every hospital is required to maintain a coordinated quality improvement program to improve the quality of health care services rendered to patients and to identify and prevent malpractice.[2] In particular, each hospital must establish and maintain one or more quality improvement committees with the responsibility to review the services rendered in the hospital (both prospectively and retrospectively) to improve the quality of medical care furnished to patients.[3] Different quality improvement committees may be established as a part of a quality improvement program to review different health care services. RCW 70.41.200 is intended to encourage hospitals to maintain high standards of care; it includes credentialing requirements and discovery protections, and provides limited immunity for hospital peer review activities.

16.2.1.1 Statutory Credentialing Requirements

RCW 70.41.230(1) sets forth the information a hospital must gather prior to granting or renewing a physician's privileges. Under the statute, a hospital must request: (1) the name of the hospitals or facilities where the physician applicant had or has any association, employment, privileges, or practice during the prior five years;[4] (2) whether the physician has ever been or is in the process of being denied, revoked, terminated, suspended, restricted, reduced, limited, sanctioned, placed on probation, monitored, or not renewed for any of the professional activities specified at RCW 70.41.230(1)(b)(i) – (x) (e.g., professional licensure, board certification, professional socieity); (3) whether the physician has ever voluntarily or involuntarily relinquished, withdrawn, or failed to proceed with an application for any of the professional activities specified at RCW 70.41.230(1)(b)(i) – (x) in order to avoid an adverse action or to preclude an investigation or while under investigation relating to professional competence or conduct; (4) information regarding pending professional misconduct proceedings or professional malpractice actions, including the substance of the allegations and any additional information the physician deems appropriate; (5) the substance of any findings in any medical misconduct or malpractice actions; (6) a waiver by the physician

[1] Some statutes refer to quality improvement programs ("QIP") and some refer to quality assurance programs ("QA" programs). Both terms are used interchangeably throughout this chapter.

[2] RCW 70.41.200.

[3] *Id.*

[4] The hospital may request additional information going back further than five years and the physician must use his or her best efforts to comply with such requests. RCW 70.41.230(1)(a).

of any confidentiality provisions covering information required to be provided to hospitals; and (6) a verification by the physician that the information provided is complete and accurate.[5]

In addition, RCW 70.41.230(2) requires that prior to granting privileges or hiring a physician, the hospital must request the following information from other hospitals where the physician has practiced during the preceding five years: (1) information regarding any pending professional medical misconduct proceedings or malpractice actions; (2) information concerning any judgment or settlement of a medical malpractice action or finding of professional misconduct by a licensing or disciplinary board; and (3) any information that the Medical Quality Assurance Commission requires a hospital to report. A hospital must advise the Medical Quality Assurance Commission of the name of any physician denied privileges, association or employment on the basis of adverse findings within 30 days of the denial.[6]

RCW 70.41.230(6) provides that hospitals will be granted access to information held by the Medical Quality Assurance Commission or the Board of Osteopathic Medicine and Surgery regarding credentialing and recredentialing decisions. It is prudent for a hospital to request information from these organizations as part of its credentialing process.

16.2.1.2 Limited Immunity

RCW 70.41.200(2) provides that any person who, in substantial good faith, either provides information to further the purposes of the quality improvement program, participates in a quality improvement committee, or shares information or documents with other programs, committees or boards, shall not be subject to an action for civil damages or other relief as a result of such activity. With respect to the sharing of information, the statute establishes a rebuttable presumption that the sharing of information is in substantial good faith.[7] This presumption may be rebutted, however, upon a showing of clear, cogent and convincing evidence that the information shared was knowingly false or deliberately misleading.[8]

16.2.1.3 Discovery Protections

RCW 70.41.200(3) prohibits the discovery of information and documents "created specifically for, and collected and maintained by, a quality improvement committee." Except as provided in the statute, such documents and information are not subject to review, disclosure or discovery or introduction to evidence in any civil action.[9] No person who has attended a meeting of such a committee or participated in the creation, collection or maintenance of such information or documents specifically for the committee shall be permitted or required to testify to such matters in any civil action.[10]

The discovery protections of RCW 70.41.200(3), however, do not preclude: (1) discovery of the identity of the persons involved in the care that is the basis of a civil action (whose involvement was independent of any quality improvement activity); (2) testimony of any person concerning the facts that form the basis for the institution of a peer review proceeding if the person has personal knowledge acquired independently from the proceedings; (3) introduction into evidence of information collected and maintained by quality improvement committees regarding a health care provider in an action by such health care provider

[5] RCW 70.41.230(1)(a)-(f).
[6] RCW 70.41.230(3).
[7] RCW 70.41.200(2).
[8] *Id*.
[9] RCW 70.41.230(3).
[10] *Id*.

regarding the restriction or revocation of the individual's clinical or staff privileges; (4) disclosure of the fact that a provider's staff privileges were terminated or restricted including the specific restrictions imposed, if any, and the reasons for the restrictions; or (5) discovery and introduction into evidence of the patient's medical record required by regulation of the Department of Health to be made regarding the care and treatment received.

16.2.1.4 Reporting

RCW 70.41.210(1) requires the chief administrator or executive officer of a hospital to report to the Department of Health ("DOH") when the practice of a health care practitioner is restricted, suspended, limited or terminated based upon a conviction, determination, or finding by the hospital that the health care practitioner has committed an act that may constitute unprofessional conduct.[11]

As defined in the statute, health care practitioners subject to DOH reporting include pharmacists, advanced registered nurse practitioners, dentists, naturopaths, optometrists, osteopathic physicians and surgeons, osteopathic physician assistants, physicians, physician assistants, podiatric physicians and surgeons, and psychologists.[12] The hospital chief administrator or executive officer must also report to the DOH if a health care practitioner voluntarily restricts or terminates his/her privileges or practice while the practitioner is under investigation or the subject of a proceeding regarding unprofessional conduct, or to prevent the hospital from conducting such an investigation or proceeding.[13] Reports must be made within 15 days of the date of a conviction, determination or finding of unprofessional conduct or the voluntary restriction or termination of the practice of the practitioner.[14] A hospital that fails to report as required by the statute may be subject to a civil penalty not to exceed $500.[15] The hospital, chief administrator or executive officer who files a report as required by 70.41.210 is immune from suit in any civil action related to the filing or contents of the report unless the finding, conviction or determination made in the report is proven to not have been made in good faith.[16] The DOH must forward the report to the appropriate disciplining authority and notify the hospital of the disciplining authority's case disposition decision within 15 days after the case disposition.[17]

16.2.1.5 Sharing Information

A hospital quality improvement program *may* share information and documents, including the analysis of complaints and incident reports created specifically for and collected and maintained by a quality improvement committee or peer review committee, with other coordinated quality improvement programs.[18] Other coordinated quality improvement programs include (1) quality improvement programs of other hospitals; (2) coordinated quality improvement programs maintained by health care institutions and medical facilities licensed by DOH, professional societies or organizations, health plans, and provider groups of five or more providers who have a Coordinated Quality Improvement Plan ("CQIP") approved by the DOH as discussed in section 16.2.3 *infra*.; (3) quality assurance committees of nursing facilities (discussed in section 16.2.4 *infra*); (4) quality assurance committees of assisted living facilities (discussed

[11] Unprofessional conduct as defined in RCW 18.130.180.

[12] RCW 70.41.210(2).

[13] RCW 70.41.210(3).

[14] *Id.*

[15] RCW 70.41.210(4).

[16] RCW 70.41.210(5).

[17] RCW 70.41.210(6).

[18] RCW 70.41.200(8).

in section 16.2.5 *infra*); and (5) quality assurance committees of ambulatory surgical faclities (discussed in section 16.2.2 *infra*).[19] The statute does not *require* any sharing of information or documents between or among quality improvement or quality assurance committes. Whether and to what extent such sharing occurs is a matter to be worked out between the individual health care organizations. The privacy protections of Washington's Uniform Health Care Information Act ("UHCIA") and the Health Insurance Portability and Accountability Act ("HIPAA") apply to the sharing of any individually identifiable patient information.[20] Information and documents disclosed by one coordinated quality improvement program to another or to a peer review committee, and any documents created or maintained as a result of the sharing of information and documents are not subject to discovery.[21]

16.2.1.6 Case Law

Several cases have discussed RCW 70.41.200.[22]

Cornu-Labat v. Hospital Dist. No. 2 Grant County. While Dr. Cornu-Labat was employed at Quincy Valley Medical Center, several complaints raised doubts about his competency to practice medicine. Quincy Valley conducted two investigations pursuant to its bylaws that govern corrective and disciplinary action. Each time, the investigative teams—consisting of both physicians and non-physician hospital administrators—determined that the allegations were unsubstantiated. Following the second investigation, the hospital requested that Dr. Cornu-Labat submit to a psychological evaluation. The hospital terminated his employment when he failed to consult the recommended provider.

The doctor subsequently filed several requests pursuant to the Washington Public Records Act for records related to the hospital's investigations. Each time he was rebuffed. Quincy Valley claimed that the documents were exempt from disclosure under the following statutory exemptions:

- RCW 4.24.250 (documents prepared for and maintained by a regularly constituted peer review committee);
- RCW 70.41.200 (documents prepared for and maintained by a regularly constituted quality improvement committee); and
- RCW 70.44.062 (meetings or proceedings of a public hospital district board or its agents concerning the status of a health care provider's clinical privileges).

The trial court held that none of the Public Records Act exemptions invoked by Quincy Valley applied. The court reached the conclusion that the records were not protected by RCW 4.24.250 simply because non-physicians were involved in the investigations.

The Washington Supreme Court disagreed with the trial court in several respects. First, the court held that RCW 4.24.250 allows peer review committees to involve non-physicians. In doing so, the court acknowledged that many Washington hospitals regularly include non-physicians in their peer review

[19] *Id*.; *See* RCW 70.41.200(8).

[20] See Chapter 1 "*Healthcare Information, Confidentiality*" of the Washington Health Law Manual (Third Edition) for a discussion of Washington's UHCIA and HIPAA.

[21] RCW 70.41.200(8).

[22] *Adcox v.Children's Orthopedic Hosp. and Med. Ctr*., 123 Wn. 2d 15, 864 P.2d 921 (1993); *Lafferty v. Stevens Memorial Hosp*., Nos. 56313-1-I, 56382-3-I, 2006 WL 3775848 (Wn. App. Div. 1) (UNPUBLISHED OPINION); *Fellows v. Moynihan*, 175 Wn.2d 641, 285 P.3d 864 (2012); *Lowy v. Peacehealth*, 174 Wn.2d 769, 280 P.3d 1078 (2012); *Cornu-Labat v. Hospital Dist. No. 2 Grant County*, 177 Wn.2d 221, 298 P.3d 741 (2013).

processes. The Supreme Court also clarified that while a hospital may have multiple quality improvement committees that qualify for the exemption provided by RCW 70.41.200, the exemption is limited to those committees that regularly deal with the quality improvement duties delineated in RCW 70.41.200(1)(a). Quincy Valley was ineligible for the exemption because it could not show that its medical staff handled such duties with any degree of regularity.

On an issue of first impression, the court held that RCW 70.44.062 provides public hospital districts with a specific exemption to the Public Records Act. The exemption applies to the *formal* meetings or proceedings of a public hospital district's board of commissioners, its staff and agents, concerning the status of a health care provider's clinical or staff privileges. The court clarified that the exemption covers not only such meetings, but also the *official* written records of such meetings.

The Supreme Court remanded the case to the trial court, noting that issues of material fact remain regarding: (a) whether the group that investigated Dr. Cornu-Labat was a regularly constituted committee, or the agents of such committee, and (b) whether the withheld records constitute the official proceedings of Quincy Valley's board of commissioners or its staff or agents.

Fellows v. Moynihan, et. al.[23] In this case, the Washington Supreme Court held that the quality improvement and peer review privileges under RCW 70.41.200 and RCW 4.24.250 do not apply to records documenting a hospital's initial credentialing and privileging decisions. The court also held that the quality improvement privilege does not prevent discovery of a hospital's reasons for terminating or restricting a staff member's privileges.

The case involved a medical negligence complaint regarding injuries sustained at a hospital. The plaintiff sought discovery of three types of records: privileging and credentialing records for the treating physicians, records created for nonquality improvement committees, and records relating to the hospital's ultimate decision to restrict Dr. Daniel Moynihan's privileges.

The court first determined that the retrospective or prospective nature of a committee's review is not dispositive of the applicability of the peer review privilege. But because the initial credentialing and privileging preceded any peer review, the court held the peer review privilege did not protect the associated records from discovery.

In considering the applicability of the quality improvement privilege the court explained that although "the legislature may have intended protection of the periodic review process, it did not extend this protection to the initial credentialing and privileging process."[24] The court emphasized that the privilege only applies to documents that are "created specifically for, and collected and maintained by, a quality improvement committee."[25] According to the court, the hospital "failed to show how disclosure of records documenting

[23] In 2013, legislature enacted ESB 5666, which strengthened the confidentiality of informaiton gathered by quality improvement committees. The bill was originally intended specifically to reverse the result in *Fellows*, but it faced challenges while in committee. As a result, the version of the bill that was ultimately signed into law did not extend the quality improvement privilege under RCW 70.41.200 to the "initial" credentialing and privileging process. The new law still specifies that quality improvement programs: (a) may include the establishment of "one or more" quality improvement committees to review different health care services; (b) must be conducted in accordance with medical staff bylaws and applicable rules, regulations or policies; and (c) are to review professional conduct. The foregoing revisions further clarify certain points made by the Supreme Court in *Cornu-Labat*.

[24] *Fellows* at 654.

[25] *Id.* at 656.

its staff members' initial credentialing/privileges would hinder the legislative purpose of encouraging candor, open discussions, and constructive criticism."

Lowy v. PeaceHealth. The plaintiff, Dr. Leasa Lowy, brought a malpractice action against PeaceHealth on the theory of corporate negligence. She claimed that she sustained nerve damage due to an improper IV infusion procedure. During discovery, Dr. Lowy sought information relating to instances of IV infusion complications at the hospital during a nine-year period, which the parties agreed was relevant to the corporate negligence claim. The requested information could be obtained through reviewing PeaceHealth's patient records, but the hospital lacked the capability to conduct an electronic search. The parties agreed that a manual, page-by-page search of the medical records would be unduly burdensome.

Dr. Lowy argued PeaceHealth could easily obtain the requested information by consulting its database of incident reports created for quality assurance purposes. Peacehealth acknowledged the existence of the database, but moved for a protective order, claiming it could not be requried to use the database to identify instances of IV infusion injuries because the the database was protected by RCW 70.41.200(3), which states:

> Information and documents, including complaints and incident reports, created spedifically for, and collected and maintained by, a quality improvement committee, are not subject to review or disclosure, except as provided in this section, or discovery or introduction into evidence in any civil action . . . .

The Washington Supreme Court held that the prohibition on "review" refers to external review only; the statute does not prohibit a hospital from reviewing its own records. The court also held "that the consultation of its own privileged database to identify relevant, discoverable files that fall outside of the privilege will not violate the hospital's privilege."[26] The court observed that RCW 70.41.200(3) prevents disclosure of a quality improvement committee's records themselves, but went on to explain that the medical records requested by Dr. Lowy "were not created specifically for the qualify improvement committee and [were] undisputedly relevant and discoverable."[27] PeaceHealth could thus be asked to use a database privileged under RCW 70.41.200(3) to identify the requested unprivileged information.

Lafferty v. Stevens Memorial Hospital. In this case, Division One of the Washington Court of Appeals affirmed a trial court's decision to allow discovery of the contents of an ultrasound technician's personnel file.[28] Stevens Hospital argued that under RCW 70.41.200(3), the documents should have been privileged. Citing conflicting testimony over whether the hospital had a quality assurance committee at all, the court held that there was no evidence to support the hospital's conclusion that the memos and performance evaluations were created specifically for and collected and maintained by a quality improvement committee.

[26] *Lowy* at 772.

[27] *Id.* at 788.

[28] *Lafferty* at *12.

***Adcox v. Children's Orthopedic Hospital and Medical Center*.** Though it cited RCW 70.41.200, the *Adcox* court did not provide much substantive guidance on the statute's application, finding that it did not apply retroactively to protect documents generated before enactment by the legislature in 1986.[29]

16.2.2 Ambulatory Surgical Facility Coordinated Quality Improvement Programs

Washington's coordinated quality improvement progam laws for ambulatory surgical facilties use the same paradigm and feature nearly identical text as the Hospital Quality Improvement statute.[30] Each ambulatory surgical facility must establish and maintain one or more quality improvement committees to coordinate its coordinated quality improvement program ("CQIP"), review the services rendered in the ambulatory surgical facility, both retrospectively and prospectively, and ensure that information gathered pursuant to the program is used to review and revise the policies and procedures of the facility.[31] Different quality improvement committees may be established as a part of the quality improvement program to review different health care services. RCW 70.230.080 is intended to encourage ambulatory surgical faclities to maintain high standards of care; it includes credentialing requirements and discovery protections, provides limited immunity for peer review activities and operates in much the same way as the Hospital Quality Improvement statute (discussed at 16.2.1 *supra*).

16.2.3 Other Coordinated Quality Improvement Programs

Health care institutions and medical facilities (other than hospitals) that are licensed by DOH, professional societies or organizations, health care service contractors, health maintenance organizations, health carriers, and provider groups of five or more providers *may* establish and maintain a CQIP.[32] Unlike hospitals, such institutions and providers are *not required* to engage in quality improvement activities. In general, a CQIP must comply with the essential components of a hospital quality improvement program, modified to reflect the structure of the organization.[33] WAC 246-50-020 sets forth the minimum required components of a CQIP, which must be described in detail within the CQIP plan and submitted to DOH in an application for approval.[34] DOH must approve an organization's CQIP before the limited immunity and discovery protections described below apply.[35] In addition, DOH must approve any modification to the scope, components or operation of an approved CQIP.

16.2.3.1 Limited Immunity

Qualified entities maintaining a CQIP are protected by certain discovery and immunity provisions set forth in RCW 43.70.510(3). This statute provides immunity from civil damages arising out of activities of a CQIP to persons who, in substantial good faith, provide information to further quality improvement and medical malpractice prevention programs or who participate on a quality improvement committee.[36]

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[29] *Adcox* at 30.

[30] RCW 70.230.080.

[31] RCW 70.230.080(1)(a).

[32] RCW 43.70.510(1)(a), (2).

[33] RCW 43.70.510(1)(b).

[34] For more information, visit http://www.doh.wa.gov/ForPublicHealthandHealthcareProviders/HealthcareProfessionsandFacilities/CoordinatedQualityImprovement. The documents an organization submits to DOH in connection with its CQIP application are generally subject to disclosure by DOH under Washington's Public Records Act.

[35] RCW 43.70.510(1)(b), (2).

[36] RCW 43.70.510(3).

16.2.3.2 Discovery Protections

Subject to certain exceptions, the information and documents created specifically for and collected and maintained by a quality improvement committee are not subject to review or disclosure nor are they subject to discovery or introduction into evidence in any civil action.[37] In addition, no person who has attended a committee meeting or participated in the creation, collection or maintenance of such information or documents specifically for the committee may testify in a civil action as to the content of the proceedings or documents.[38] The statute does not, however, preclude the introduction into evidence of information collected and maintained by a coordinated quality improvement committee regarding a health care provider in an action by such health care provider regarding a restriction or revocation of the individual's privileges (or presumably membership in a medical group).

The discovery immunity also does not apply to: (1) discovery of the identity of the persons involved in medical care that is the basis of a civil action (whose involvement was independent of any quality improvement activity); (2) testimony of a person as to facts that form the basis for the institution of the quality improvement activity, if the person has personal knowledge acquired independently from the quality improvement efforts; (3) introduction into evidence of information collected and maintained by quality improvement committees regarding a health care provider in an action by such health care provider regarding the restriction or revocation of the individual's clinical or staff privileges; (4) a civil suit regarding termination of a contract by a state agency with the CQIP entity if the termination was on the basis of quality care concerns; (5) disclosure of the fact that staff privileges were terminated or restricted including the specific restriction imposed and the reasons for such restrictions; or (6) disclosure of patient medical records required by DOH rules to be made regarding the care and treatment received.[39]

In light of the judicial interpretation of the hospital discovery immunity statute (discussed in section 16.2.6.4 *infra*), it is likely that the discovery immunity provided under RCW 43.70.510 would be narrowly construed.[40]

16.2.3.3 Sharing Information

A CQIP *may* share information and documents, including the analysis of complaints and incident reports created specifically for and collected and maintained by a quality improvement committee or peer review committee with other CQIPs, assisted living facility quality assurance committees, nursing facility quality assurance committees, and peer review committees for the purpose of improving the quality of health care services rendered to patients and the identification and prevention of medical malpractice.[41] Other coordinated quality improvement programs include (1) hospital quality improvement programs; (2) CQIPs maintained by health care institutions and medical facilities licensed by DOH, professional socities or organizations, health plans, and provider groups of five or more providers who have a CQIP approved by the DOH; (3) quality assurance committees of nursing facilities (discussed in section 16.2.4 *infra*); (4) quality assurance committees of assisted living facilities (discussed in section 16.2.5 *infra*); and (5) quality assurance committees of ambulatory surgical faclities.[42]

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[37] RCW 43.70.510(4).

[38] *Id*.

[39] RCW 43.70.510(4).

[40] *See Anderson v. Breda*, 103 Wn.2d 901, 700 P.2d 737 (1985), and other cases cited in Section 16.2.6.4.

[41] RCW 43.70.510(6).

[42] *Id*.; RCW 43.70.510(6).

The statute does not *require* any sharing of information or documents between or among quality improvement or quality assurance committees. Whether or not such sharing occurs and the extent of any such sharing is a matter to be worked out between the individual health care organizations. DOH maintains a listing of approved CQIPs, and it may be prudent to confirm that an organization's CQIP has been approved by DOH before sharing any quality improvement information or documents with it. The privacy protections of Washington's Uniform Health Care Information Act and HIPAA apply to the sharing of any individually identifiable patient information.[43] Information and documents disclosed by one CQIP to another or to a peer review committee, and any documents created or maintained as a result of the sharing of information and documents shall not be subject to the discovery process.[44]

16.2.3.4 Regulations

DOH has adopted rules governing the establishment and operation of CQIPs.[45] DOH has also issued regulations pertaining to the sharing of quality improvement information and documents.[46]

16.2.4 Nursing Facility Quality Assurance Committees

Hospital-operated nursing facilities may conduct quality improvement activities for both the hospital and the nursing facility through the hospital's quality improvement committee, subject to the provisions described above in section 16.2.1.[47] The quality improvement activities of all other nursing facilities must meet the requirements of Chapter 74.42 RCW if the nursing facility wishes to avail itself of the discovery and disclosure protections available under the law.[48] The statute does not, however, provide immunity protections for committee participants or for those providing information to a quality improvement committee.[49]

Each nursing facility may maintain a quality assurance committee that includes, at a minimum, the director of nursing services, a physician designated by the facility and three other members from the staff of the facility.[50] The committee, once established, shall meet at least quarterly to identify issues that may adversely affect quality of care and services to residents and to develop and implement plans of action to correct identified quality concerns or deficiencies in the quality of care provided to residents.[51] Notwithstanding any records created for the quality assurance committee, the nursing facility must fully set forth the facts concerning any incident of injury or loss to a resident, the steps taken by the facility to address the resident's needs, and the resident's outcome in the resident's records.[52] The records of such resident must be available to the resident, the Washington State Department of Social and Health Services ("DSHS"), and others as permitted by law.[53]

16.2.4.1 DSHS Disclosures

RCW 74.42.640(3)-(4) protects the information and documents of nursing facility quality assurance committees by limiting the extent to which such information and documents must be disclosed to

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[43] See Chapter 1 "*Healthcare Information, Confidentiality*" of the Washington Health Law Manual (Third Edition) for a discussion of Washington's UHCIA and HIPAA.

[44] RCW 43.70.510(6).

[45] See Ch. 246-50 WAC.

[46] WAC 246-50-060.

[47] RCW 70.41.200(9).

[48] RCW 74.42.640.

[49] *Id*.

[50] RCW 74.42.640(1).

[51] RCW 74.42.640(2).

[52] RCW 74.42.640(10).

[53] *Id*.

regulatory authorities. Specifically, the statute prohibits both DSHS (the State agency that licenses nursing facilities) and the long term care ombudsman from requiring any quality assurance committee records or reports, unless the disclosure is related to the committee's compliance with the quality assurance statute, the records or reports are not maintained pursuant to statutory or regulatory mandate, and the records or reports are created for and collected and maintained by the committee.[54] The only information related to the committee that DSHS may request is information needed to determine whether a facility has a quality assurance committee and whether the committee is operating in compliance with the statute.[55]

If a nursing facility's quality assurance committee makes a good faith attempt to identify and correct quality deficiencies, DSHS cannot use such efforts as the basis for imposing sanctions.[56] If quality assurance committee documents are offered by the facility to DSHS as evidence of compliance with the nursing facility requirements, the documents are protected from public disclosure as quality assurance committee documents under the discovery protections outlined below.[57]

16.2.4.2 Discovery Protections

Subject to certain exceptions, the information and documents, including the analysis of complaints and incident reports, created specifically for and collected and maintained by a nursing facility quality assurance committee are not subject to discovery or introduction into evidence in any civil action, and no person who has attended a committee meeting or who participated in the creation, collection or maintenance of such information or documents specifically for the committee may testify in a civil action as to the content of the proceedings or documents.[58]

The discovery immunity does not apply to: (1) discovery of the identity of the persons involved in medical care that is the basis of a civil action (whose involvement was independent of any quality improvement committee activity); and (2) testimony of a person as to facts that form the basis for the institution of the quality improvement activity, if the person has personal knowledge acquired independently from the quality improvement efforts.[59]

16.2.4.3 Sharing Information

A quality assurance committee *may* share information and documents, including the analysis of complaints and incident reports created specifically for and collected and maintained by the committee with other nursing facility quality asssurance committees, assisted living facility quality assurance committees, other coordinated quality improvement programs, and peer review committees for the purpose of improving the quality of health care and services rendered to nursing facility residents.[60] The statute does not, however, *require* any sharing of quality assurance information or documents. Whether or not such sharing occurs, and the extent of any such sharing, is a matter to be worked out between the nursing facility and other health care organizations. Other coordinated quality improvement programs include hospital quality improvement programs and CQIPs maintained by health care institutions and medical facilities licensed by DOH, professional socities or organizations, health plans, and provider groups of five or more providers

[54] RCW 74.42.640(3).
[55] RCW 74.42.640(4).
[56] RCW 74.42.640(5).
[57] RCW 74.42.640(6), (9).
[58] RCW 74.42.640(7).
[59] *Id*.
[60] RCW 74.42.640(8).

who have a CQIP approved by the DOH.[61] The privacy protections of Washington's Uniform Health Care Information Act and HIPAA apply to the sharing of any individually identifiable patient information.[62] Information and documents disclosed by one quality assurance committee to another or to a peer review or CQIP, and any documents created or maintained as a result of the sharing of information and documents, shall not be subject to the discovery process.[63]

16.2.5 Assisted Living Facility Quality Assurance Committees

Any facility that is licensed as an assisted living facility may maintain a quality assurance committee, and if the committee meets the requirements set forth in RCW 18.20.390, the activities of such committee are entitled to certain disclosure and discovery protections. A licensed assisted living facility is not required, however, to establish a quality assurance committee. The statute requires that an assisted living facility's quality assurance committee include, at a minimum, a licensed registered nurse, the administrator and three other members from the staff of the assisted living facility.[64] Once established, the committee is required to meet at least quarterly to identify issues that may adversely affect quality of care and services to residents and to develop and implement plans of action to correct identified quality concerns or deficiencies in the quality of care provided to residents.[65] Like nursing facilities, assisted living facilities have a statutory obligation to fully set forth in the resident's records, available to the resident, DSHS, and others as permitted by law, the facts concerning any incident of injury or loss to the resident, the steps taken by the facility to address the resident's needs, and the resident outcome.[66]

16.2.5.1 DSHS Disclosures

RCW 18.20.390 protects the information and documents of assisted living facility quality assurance committees by limiting the extent to which such information and documents must be disclosed to regulatory authorities. Specifically, RCW 18.20.390(4) prohibits DSHS (the State agency that licenses assisted living facilities) from requiring any quality assurance committee records or reports, unless the disclosure is related to the committee's compliance with the quality assurance laws, provided that the records or reports are not maintained pursuant to statutory or regulatory mandate and the records or reports are created for and collected and maintained by the committee. The only information DSHS may request is information needed to determine whether a facility has a quality assurance committee and whether that committee is operating in compliance with the statute.[67] The statute also prohibits the long term care ombudsman program from requesting quality assurance committee records or reports under similar circumstances.[68]

If a nursing facility offers documents generated by, or for, the quality assurance committee to DSHS as evidence of compliance with nursing facility requirements, the documents are protected from discovery and exempt from disclosure under Washington's Public Records Act (Ch. 42.56 RCW) as quality assurance

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[61] *Id.*

[62] See Chapter 1 "*Healthcare Information, Confidentiality*" of the Washington Health Law Manual (Third Edition) for a discussion of Washington's UHCIA and HIPAA.

[63] RCW 74.42.640(8).

[64] RCW 18.20.390(1).

[65] RCW 18.20.390(2).

[66] RCW 18.20.390(9).

[67] RCW 18.20.390(4).

[68] RCW 18.20.390(3).

committee documents while they are in the possession of DSHS.[69] In addition, DSHS is prohibited from using a facility's good faith attempts to identify and correct quality deficiencies as the basis for sanctions.[70]

Once quality assurance documents are received by DSHS, it will not be liable to a nursing facility for: (1) any inadvertent disclosure, (2) any disclosure related to a required federal or state audit, or (3) disclosure of documents incorrectly marked as quality assurance committee documents by the facility.[71]

16.2.5.2 Discovery Protections

Subject to certain exceptions, the information and documents (including the analysis of complaints and incident reports), created specifically for and collected and maintained by a assisted living facility quality assurance committee are not subject to discovery or introduction into evidence in any civil action.[72] In addition, no person who attended a assisted living facility quality assurance committee meeting or who participated in the creation, collection or maintenance of such information or documents specifically for the committee may testify in a civil action as to the content of the proceedings or documents.[73]

The discovery immunity does not apply to: (1) discovery of the identity of the persons involved in medical care that is the basis of a civil action (whose involvement was independent of any quality improvement committee activity); and (2) testimony of a person as to facts that form the basis for the institution of the quality improvement activity, if the person has personal knowledge acquired independently from the quality improvement efforts.[74]

16.2.5.3 Sharing Information

A assisted living facility quality assurance committee *may* share information and documents, including the analysis of complaints and incident reports created specifically for and collected and maintained by the committee with other assisted living facility quality asssurance committees, nursing facility quality assurance committees, other coordinated quality improvement programs, and peer review committees for the purpose of improving the quality of health care and services for assisted living facility residents.[75] Other coordianted quality improvement programs include hospital quality improvement programs and CQIPs maintained by health care institutions and medical facilities licensed by DOH, professional socities or organizations, health plans, and provider groups of five or more providers who have a CQIP approved by DOH.[76]

The statute does not, however, *require* any sharing of quality assurance information or documents. The extent of any such sharing is a matter to be worked out between the assisted living facility and other health care organizations. The privacy protections of Washington's Uniform Health Care Information Act and HIPAA apply to the sharing of any individually identifiable patient information.[77] Information and documents disclosed by one assisted living facility quality assurance committee to another or to a peer

[69] 18.20.390(4).

[70] RCW 18.20.390(5).

[71] RCW 18.20.390(4).

[72] RCW 18.20.390(6).

[73] *Id*.

[74] RCW 18.20.390(6)(a)-(b).

[75] RCW 18.20.390(7).

[76] *Id*.

[77] See Chapter 1 "*Healthcare Information, Confidentiality*" of the Washington Health Law Manual (Third Edition) for a discussion of Washington's UHCIA and HIPAA.

review committee or CQIP, and any documents created or maintained as a result of the sharing of information and documents, shall not be subject to the discovery process.[78]

16.2.6 State Immunity Statutes

16.2.6.1 Immunity

Under RCW 4.24.240, certain persons are immune in civil suits from damages arising out of good faith performance of their duties on professional review committees, where the action is brought by the person being evaluated. Persons protected include: (1) the licensed provider; (2) an employee or agent of the licensed provider, acting in the course and scope of his/her employment; or (3) an entity (whether or not incorporated), facility, or institution employing one or more licensed providers, including but not limited to, a hospital, clinic, HMO, or nursing facility or an officer, director, trustee, employee, or agent of the same acting in the course and scope of his or her employment.[79] Note that the immunity provisions are limited to actions for damages. Therefore, even protected persons are subject to civil actions for equitable or injunctive relief.

Under RCW 4.24.250 and .260, any provider who, in good faith, files charges or presents evidence against another member of the profession before a professional board or regularly constituted peer review committee is immune from civil actions for damages.

The Washington State Health Care Peer Review Statute, RCW 7.71.030, provides the exclusive remedy for a health care provider to redress injury caused by the actions of a professional peer review body when those injurious actions are based on matters unrelated to the competence or professional conduct of the health care provider. Under this statute, claims must be brought within a one-year statute of limitations[80] and relief is limited to "appropriate injunctive relief" and damages for lost earnings.[81]

One published decision, *Morgan v. Peace Health Inc.*, references the adoption of the Washington State Health Care Peer Review Statute, but focuses its analysis on the federal Health Care Quality Improvement Act (discussed in section 16.3 *infra*).[82] A more recent case, *Perry v. Rado*, affirms the dismissal of the disgruntled provider's common law claims not authorized by RCW 7.71.030(2).[83]

16.2.6.2 Discovery Protection

Under RCW 4.24.250, the records of a regularly constituted review committee or the board of a professional society or hospital are immune from discovery, except in actions arising out of the recommendations of such committees or boards involving the restriction or revocation of a provider's privileges.[84]

16.2.6.3 Sharing Information

A regularly constituted review committee or board of a professional society or hospital ("peer review committee") may share information and documents, including the analysis of complaints and incident

[78] RCW 18.20.390(7).

[79] RCW 4.24.240(1)(a)-(c).

[80] RCW 7.71.030(4).

[81] RCW 7.71.030(2).

[82] *Morgan v. Peace Health Inc.*, 101 Wn.App. 750, 14 P.3d 773 (2001).

[83] *Perry v. Rado*, 155 Wn.App. 626, 636, 230 P.3d 203 (2010).

[84] RCW 4.24.250(1).

reports created specifically for and collected and maintained by the peer review committee with other peer review committees, nursing facility quality assurance committees, assisted living facility quality assurance committees, and other coordinated quality improvement programs for the purpose of improving the quality of health care services and the identification and prevention of medical malpractice.[85] Other coordinated quality improvement programs include hospital quality improvement programs and CQIP maintained by health care institutions and medical facilities licensed by DOH, professional socities or organizations, health plans, and provider groups of five or more providers who have a CQIP approved by the DOH.[86] The privacy protections of Washington's Uniform Health Care Information Act and HIPAA apply to the sharing of any individually identifiable patient information.[87]

16.2.6.4 Case Law

Illustrative cases interpreting RCW 4.24.240.250 and.260 are summarized below:

In *Coburn v. Seda*,[88] the court found that the RCW 4.24.250 immunity applied to discovery in an action for medical malpractice. The plaintiff sought discovery from a hospital of (1) the existence and name of its quality review committee; (2) the time and place of its review; (3) the names and addresses of committee members; and (4) records of the committee's meetings.

The Washington State Supreme court reversed the trial court, finding that RCW 4.24.250 immunity applied to "any civil action" including medical malpractice actions. The court remanded and instructed the trial court to determine whether the review committee was "regularly constituted" based on the Joint Commission on Accreditation of Health Care Organizations (now called The Joint Commission) guidelines and the hospital's bylaws and regulations.

The court held that if the committee was covered by the statute, then the trial court could only allow discovery of the existence and name of the committee and the time and place of its review; discovery of committee reports and committee members' identities would be prohibited under such a scenario.

In *Anderson v. Breda*,[89] the court found that RCW 4.24.250 did not prohibit discovery of whether privileges were terminated, suspended or restricted. The plaintiff sued physicians and a hospital for medical malpractice. While deposing a defendant physician, the plaintiff asked whether his privileges had been terminated, suspended or restricted. The physician refused to answer and the plaintiff moved to compel him to answer.

The court found the discovery immunity was intended to encourage constructive criticism in quality review committees. Nonetheless, because the statute is in derogation of the common law, the court held it must be strictly construed to prohibit only the discovery of (1) information generated in a regularly constituted hospital committee or board charged with evaluating professional competence and qualifications; and (2) information not available from other sources.

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[85] RCW 4.24.250(2).

[86] *Id*.

[87] See Chapter 1 "*Healthcare Information, Confidentiality*" of the Washington Health Law Manual (Third Edition) for a discussion of Washington's UHCIA and HIPAA.

[88] *Coburn v. Seda*, 101 Wn.2d 270, 677 P.2d 173 (1984).

[89] *Anderson v. Breda*, 103 Wn.2d 901, 700 P.2d 737 (1985).

In *Anderson*, the court found RCW 4.24.250 did not apply because (1) the doctor failed to meet his burden of showing the existence of a regularly constituted quality review committee; and (2) "the fact that a physician's privileges are restricted, suspended, or revoked is not properly subject to the protections of the statute."[90]

In *Ragland v. Lawless*,[91] the court found that RCW 4.24.250 immunized discovery of records from a quality review committee whose findings resulted in the termination of a physician as a Medicaid provider. In one of two lawsuits, the physician sought a declaratory judgment that the quality review organization must respond to discovery requests for records of meetings that resulted in his termination as a Medicaid provider. The physician argued that these records fell within a statutory exception for "actions arising out of committee recommendations which involve restriction or revocation of staff privileges." The *Ragland* court disagreed, finding that the statute only applies to discovery of information about staff privileges. The review did not involve the restriction or revocation of staff privileges, but rather the physician's status as a Medicaid provider. The physician merely lost a source of payment for medical services, not staff privileges or his medical license.

In *Adcox v. Children's Orthopedic Hosp. & Medical Ctr.*,[92] the court found that the RCW 4.24.250 discovery immunity did not apply to records from a hospital's internal investigation. In this case, a medical malpractice plaintiff sought to compel production of documents written by and to a "quality assurance coordinator," the "chairman of the peer review committee," and one of the defendant doctors.

The *Adcox* court held that this informal investigation did not qualify as "regularly constituted" quality review committee. In contrast to the *Coburn* decision where the court remanded to allow evidence on whether a committee was "regularly constituted," the *Adcox* court found remand would be futile and ordered the records produced.

In *Fellows v. Moynihan*[93] (discussed in section 16.2.1.6 *supra*), the Washington Supreme Court held that the quality improvement and peer review privileges under RCW 70.41.200 and RCW 4.24.250 do not apply to records documenting a hospital's initial credentialing and privileging decisions. In the context of a suit for medical negligence, the plaintiff sought discovery of several types of records, including privileging and credentialing records for the treating physicians. The hospital objected to the plaintiff's discovery requests based in part on the peer review privilege.

The Supreme Court applied the two-factor test from *Anderson v. Breda* to determine whether the requested records were protected by RCW 4.24.250. The court first explained that the retrospective or prospective nature of a committee's review is not dispositive of the applicability of the peer review privilege. But the court found no indication in the record to suggest peer review was underway at the time the hospital engaged in its initial credentialing and privileging process. The court clarified that under the *Anderson* test, the peer review privilege does not apply to credentialing and privileging records created before peer review begins, after it ends, or for purposes other than evaluating the quality of patient care or a provider's professional competence and qualifications.

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[90] *Id*. at 907.

[91] *Ragland v. Lawless*, 61 Wn. App. 830, 812 P.2d 872 (1991).

[92] *Id*. *see* fn. 7.

[93] *Fellows v. Moynihan*, 175 Wn.2d 641, 285 P.3d 864 (2012).

In *Cornu-Labat v. Hospital Dist. No. 2 Grant County*[94] (discussed in section 16.2.1.6 *supra*), the Washington Supreme Court held that RCW 4.24.250 allows peer review committees to involve non-physicians. In this case, Quincy Valley Medical Center conducted two investigations in response to complaints that raised doubts regarding Dr. Cornu-Labat's compentency to practice medicine. After the hospital subsequently terminated Dr. Cornu-Labat's employment for failure to submit to a psychological evaluation required in connection with the second investigation, the physician filed several requests pursuant to the Washington Public Records Act for records related to the hospital's investigations. The hospital denied Dr. Cornu-Labat's request, claiming that the documents were exempt from disclosure pursuant to several statutory exemptions, including RCW 4.24.250. In determining whether Quincy Valley's involvement of non-physicians in its investigations of Dr. Cornu-Labat vitiated the protection created by RCW 4.24.250, the court examined the statute's language and ultimately drew on the definition of a "peer review body of health care providers" set forth in chapter 7.71 RCW. The court found it significant that RCW 7.71.030(1) allows such a body to include non-physician officers, directors, employees or agents of a health care provider.

16.3 Federal Law: The Health Care Quality Improvement Act of 1986

Although a discussion of federal law is outside the scope of this Chapter, it is important for health care organizations to be aware of the federal Health Care Quality Improvement Act ("HCQIA"). HCQIA may provide additional protections for an organization's quality improvement activities.[95] In addition, it obligates certain "health care entity"[96] to report certain "professional review actions" to the National Practitioner Data Bank (NPDB) through the state Medical Disciplinary Board.[97] This reporting is mandatory for qualifying entities and actions. HCQIA also may permit a "health care entity" and others participating in "professional review actions" to qualify for immunity from damages for federal and state law claims if the review actions are conducted in accordance with standards set forth in the Act. Additional information regarding the NPDB may be found at http://www.npdb.hrsa.gov.

16.4 Resources

Washington

- *Washington State Department of Health CQIP Program*
  - http://www.doh.wa.gov/ForPublicHealthandHealthcareProviders/HealthcareProfessionsandFacilities/CoordinatedQualityImprovement

- *Washington State Hospital Association*
  - www.wsha.org

American Health Lawyers Publications

- *Immunity for Credentialing Decisions Under Federal and State Law*, Michael A. Cassidy, Esq.
- *Peer Review Guidebook* (Third Ed.), Daniel Mulholland, Esq.
- *The Basics of Representing Physicians*, Michael F. Schaff, Esq.

[94] *Cornu-Labat v. Hospital Dist. No. 2 Grant County*, 177 Wn.2d 221, 298 P.3d 741 (2013).
[95] HCQIA, 42 U.S.C. §§ 11101-11152.
[96] 42 U.S.C. § 11101.
[97] 42 U.S.C. §§ 11133(a), 11134.

Other Resources

Other resources include the following:

- *National Practitioner Data Bank*
  http://www.npdb-hipdb.hrsa.gov

- *National Practitioner Data Bank Guidebook, 2001*, available at
  - http://www.npdb.hrsa.gov/resources/aboutGuidebooks.jsp

- *American Hospital Association*
  - www.aha.org

- *American Medical Association*
  - www.ama-assn.org

- *California Association of Hospitals Publications*
  - *2014 Model Medical Staff Bylaws & Rules*, available at http://www.calhospital.org/model-medical

- *The Joint Commission*, accreditation manuals available at
  - www.jcrinc.com

- *National Committee for Quality Assurance* (NCQA), an accrediting agency for health plans
  - www.ncqa.org

- *National Association of Insurance Commissioners*
  - www.naic.org