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HOUSE BILL NO. 610

Offered January 11, 2006

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A BILL to amend and reenact §§ 8.01-581.13, 8.01-581.16, 8.01-581.17, 8.01-581.19, 32.1-111.3, and 32.1-116.1 of the Code of Virginia, relating to facilitation of the emergency medical services quality of care initiative; civil immunity and privileged communications for members of monitoring entities.

Patron—O'Bannon

Referred to Committee for Courts of Justice

Be it enacted by the General Assembly of Virginia:

1. That §§ 8.01-581.13, 8.01-581.16, 8.01-581.17, 8.01-581.19, 32.1-111.3, and 32.1-116.1 of the Code of Virginia are amended and reenacted as follows:

§ 8.01-581.13. Civil immunity for certain health professionals and health profession students serving as members of certain entities.

A. For the purposes of this subsection, "health professional" means any clinical psychologist, applied psychologist, school psychologist, dentist, *certified emergency medical services personnel,* licensed professional counselor, licensed substance abuse treatment practitioner, certified substance abuse counselor, certified substance abuse counseling assistant, marriage and family therapist, nurse, optometrist, pharmacist, physician, chiropractor, podiatrist, or veterinarian who is actively engaged in the practice of his profession or any member of the Intervention Program Committee pursuant to Chapter 25.1 (§ 54.1-2515 et seq.) of Title 54.1.

Unless such act, decision, or omission resulted from such health professional's bad faith or malicious intent, any health professional, as defined in this subsection, shall be immune from civil liability for any act, decision or omission resulting from his duties as a member or agent of any entity which functions primarily (i) to investigate any complaint that a physical or mental impairment, including alcoholism or drug addiction, has impaired the ability of any such health professional to practice his profession and (ii) to encourage, recommend and arrange for a course of treatment or intervention, if deemed appropriate, or (iii) to review *or monitor* the duration of patient stays in health facilities ~~or~~, delivery of professional services, *or the quality of care delivered in the statewide emergency medical care system* for the purpose of promoting the most efficient use of available health facilities and services, the adequacy and quality of professional services, or the reasonableness or appropriateness of charges made by or on behalf of such health professionals. Such entity shall have been established pursuant to a federal or state law, or by one or more public or licensed private hospitals, or a relevant health professional society, academy or association affiliated with the American Medical Association, the American Dental Association, the American Pharmaceutical Association, the American Psychological Association, the American Podiatric Medical Association, the American Society of Hospitals and Pharmacies, the American Veterinary Medical Association, the American Association for Counseling and Development, the American Optometric Association, International Chiropractic Association, the American Chiropractic Association, the NAADAC: the Association for Addiction Professionals, the American Association for Marriage and Family Therapy or a governmental agency.

B. For the purposes of this subsection, "health profession student" means a student in good standing who is enrolled in an accredited school, program, or curriculum in clinical psychology, counseling, dentistry, medicine, nursing, pharmacy, chiropractic, marriage and family therapy, substance abuse treatment, or veterinary medicine and has received training relating to substance abuse.

Unless such act, decision, or omission resulted from such health profession student's bad faith or malicious intent, any health profession student, as defined in this subsection, shall be immune from civil liability for any act, decision, or omission resulting from his duties as a member of an entity established by the institution of higher education in which he is enrolled or a professional student's organization affiliated with such institution which functions primarily (i) to investigate any complaint of a physical or mental impairment, including alcoholism or drug addiction, of any health profession student and (ii) to encourage, recommend, and arrange for a course of treatment, if deemed appropriate.

C. The immunity provided hereunder shall not extend to any person with respect to actions, decisions or omissions, liability for which is limited under the provisions of the federal Social Security Act or amendments thereto.

§ 8.01-581.16. Civil immunity for members of or consultants to certain boards or committees.

Every member of, or health care professional consultant to, any committee, board, group, commission or other entity shall be immune from civil liability for any act, decision, omission, or utterance done or

made in performance of his duties while serving as a member of or consultant to such committee, board, group, commission or other entity, which functions primarily to review, evaluate, or make recommendations on (i) the duration of patient stays in health care facilities, (ii) the professional services furnished with respect to the medical, dental, psychological, podiatric, chiropractic, veterinary or optometric necessity for such services, (iii) the purpose of promoting the most efficient use *or monitoring the quality of care* of available health care facilities and services, *or of emergency medical services agencies and services,* (iv) the adequacy or quality of professional services, (v) the competency and qualifications for professional staff privileges, (vi) the reasonableness or appropriateness of charges made by or on behalf of health care facilities or (vii) patient safety, including entering into contracts with patient safety organizations; provided that such committee, board, group, commission or other entity has been established pursuant to federal or state law or regulation, or pursuant to Joint Commission on Accreditation of Healthcare Organizations requirements, or established and duly constituted by one or more public or licensed private hospitals, community services boards, or behavioral health authorities, or with a governmental agency and provided further that such act, decision, omission, or utterance is not done or made in bad faith or with malicious intent.

§ 8.01-581.17. Privileged communications of certain committees and entities.

A. For the purposes of this section:

"Centralized credentialing service" means (i) gathering information relating to applications for professional staff privileges at any public or licensed private hospital or for participation as a provider in any health maintenance organization, preferred provider organization or any similar organization and (ii) providing such information to those hospitals and organizations that utilize the service.

"Patient safety data" means reports made to patient safety organizations together with all health care data, interviews, memoranda, analyses, root cause analyses, products of quality assurance or quality improvement processes, corrective action plans or information collected or created by a health care provider as a result of an occurrence related to the provision of health care services.

"Patient safety organization" means any organization, group, or other entity that collects and analyzes patient safety data for the purpose of improving patient safety and health care outcomes and that is independent and not under the control of the entity that reports patient safety data.

B. The proceedings, minutes, records, and reports of any (i) medical staff committee, utilization review committee, or other committee, board, group, commission or other entity as specified in § 8.01-581.16; (ii) nonprofit entity that provides a centralized credentialing service; or (iii) quality assurance, *quality of care,* or peer review committee established pursuant to guidelines approved or adopted by (a) a national or state peer review entity, (b) a national or state accreditation entity, (c) a national professional association of health care providers or Virginia chapter of a national professional association of health care providers, (d) a licensee of a managed care health insurance plan (MCHIP) as defined in § 38.2-5800, ~~or~~ (e) *the Office of Emergency Medical Services or any regional emergency medical services council, or (f)* a statewide or local association representing health care providers licensed in the Commonwealth, together with all communications, both oral and written, originating in or provided to such committees or entities, are privileged communications which may not be disclosed or obtained by legal discovery proceedings unless a circuit court, after a hearing and for good cause arising from extraordinary circumstances being shown, orders the disclosure of such proceedings, minutes, records, reports, or communications. Additionally, for the purposes of this section, accreditation and peer review records of the American College of Radiology and the Medical Society of Virginia are considered privileged communications. Oral communications regarding a specific medical incident involving patient care, made to a quality assurance, *quality of care,* or peer review committee established pursuant to clause (iii), shall be privileged only to the extent made more than 24 hours after the occurrence of the medical incident.

C. Nothing in this section shall be construed as providing any privilege to health care provider, *emergency medical services agency,* community services board, or behavioral health authority medical records kept with respect to any patient in the ordinary course of business of operating a hospital, *emergency medical services agency,* community services board, or behavioral health authority nor to any facts or information contained in such records nor shall this section preclude or affect discovery of or production of evidence relating to hospitalization or treatment of any patient in the ordinary course of hospitalization of such patient.

D. Notwithstanding any other provision of this section, reports or patient safety data in possession of a patient safety organization, together with the identity of the reporter and all related correspondence, documentation, analysis, results or recommendations, shall be privileged and confidential and shall not be subject to a civil, criminal, or administrative subpoena or admitted as evidence in any civil, criminal, or administrative proceeding. Nothing in this subsection shall affect the discoverability or admissibility of facts, information or records referenced in subsection C as related to patient care from a source other than a patient safety organization.

E. Any patient safety organization shall promptly remove all patient-identifying information after

receipt of a complete patient safety data report unless such organization is otherwise permitted by state or federal law to maintain such information. Patient safety organizations shall maintain the confidentiality of all patient-identifying information and shall not disseminate such information except as permitted by state or federal law.

F. Exchange of patient safety data among health care providers or patient safety organizations that does not identify any patient shall not constitute a waiver of any privilege established in this section.

G. Reports of patient safety data to patient safety organizations shall not abrogate obligations to make reports to health regulatory boards or *other* agencies as required by state or federal law.

H. No employer shall take retaliatory action against an employee who in good faith makes a report of patient safety data to a patient safety organization.

§ 8.01-581.19. Civil immunity for physicians, psychologists, podiatrists, optometrists, veterinarians, nursing home administrators, and certified emergency services personnel while members of certain committees.

A. Any physician, chiropractor, psychologist, podiatrist, veterinarian or optometrist licensed to practice in this Commonwealth shall be immune from civil liability for any communication, finding, opinion or conclusion made in performance of his duties while serving as a member of any committee, board, group, commission or other entity that is responsible for resolving questions concerning the admission of any physician, psychologist, podiatrist, veterinarian or optometrist to, or the taking of disciplinary action against any member of, any medical society, academy or association affiliated with the American Medical Association, the Virginia Academy of Clinical Psychologists, the American Psychological Association, the Virginia Applied Psychology Academy, the Virginia Academy of School Psychologists, the American Podiatric Medical Association, the American Veterinary Medical Association, the International Chiropractic Association, the American Chiropractic Association, the Virginia Chiropractic Association, or the American Optometric Association; provided that such communication, finding, opinion or conclusion is not made in bad faith or with malicious intent.

B. Any nursing home administrator licensed under the laws of this Commonwealth shall be immune from civil liability for any communication, finding, opinion, decision or conclusion made in performance of his duties while serving as a member of any committee, board, group, commission or other entity that is responsible for resolving questions concerning the admission of any health care facility to, or the taking of disciplinary action against any member of, the Virginia Health Care Association, provided that such communication, finding, opinion, decision or conclusion is not made in bad faith or with malicious intent.

C. Any emergency medical services personnel certified under the laws of the Commonwealth shall be immune from civil liability for any communication, finding, opinion, decision, or conclusion made in performance of his duties while serving as a member of any regional council, committee, board, group, commission or other entity that is responsible for resolving questions concerning the quality of care, including triage, interfacility transfer, and other components of emergency medical services care, unless such communication, finding, opinion, decision or conclusion is made in bad faith or with malicious intent.

§ 32.1-111.3. Statewide emergency medical care system.

A. The Board of Health shall develop a comprehensive, coordinated, emergency medical care system in the Commonwealth and prepare a Statewide Emergency Medical Services Plan which shall incorporate, but not be limited to, the plans prepared by the regional emergency medical services councils. The Board shall review, update, and publish the Plan triennially, making such revisions as may be necessary to improve the effectiveness and efficiency of the Commonwealth's emergency medical care system. Publishing through electronic means and posting on the Department website shall satisfy the publication requirement. The objectives of such Plan and the system shall include, but not be limited to, the following:

1. Establishing a comprehensive statewide emergency medical care system, incorporating facilities, transportation, manpower, communications, and other components as integral parts of a unified system that will serve to improve the delivery of emergency medical services and thereby decrease morbidity, hospitalization, disability, and mortality;

2. Reducing the time period between the identification of an acutely ill or injured patient and the definitive treatment;

3. Increasing the accessibility of high quality emergency medical services to all citizens of Virginia;

4. Promoting continuing improvement in system components including ground, water and air transportation, communications, hospital emergency departments and other emergency medical care facilities, consumer health information and education, and health manpower and manpower training;

5. Improving the quality of emergency medical care delivered on site, in transit, in hospital emergency departments and within the hospital environment;

6. Working with medical societies, hospitals, and other public and private agencies in developing

approaches whereby the many persons who are presently using the existing emergency department for routine, nonurgent, primary medical care will be served more appropriately and economically;

7. Conducting, promoting, and encouraging programs of education and training designed to upgrade the knowledge and skills of health manpower involved in emergency medical services, including expanding the availability of paramedic and advanced life support training throughout the Commonwealth with particular emphasis on regions underserved by personnel having such skills and training;

8. Consulting with and reviewing, with agencies and organizations, the development of applications to governmental or other sources for grants or other funding to support emergency medical services programs;

9. Establishing a statewide air medical evacuation system which shall be developed by the Department of Health in coordination with the Department of State Police and other appropriate state agencies;

10. Establishing and maintaining a process for designation of appropriate hospitals as trauma centers and specialty care centers based on an applicable national evaluation system;

11. Establishing a comprehensive emergency medical services patient care data collection and evaluation system pursuant to Article 3.1 (§ 32.1-116.1 et seq.) of this chapter;

12. Collecting data and information and preparing reports for the sole purpose of the designation and verification of trauma centers and other specialty care centers pursuant to this section. All data and information collected shall remain confidential and shall be exempt from the provisions of the Virginia Freedom of Information Act (§ 2.2-3700 et seq.);

13. Establishing and maintaining a process for crisis intervention and peer support services for emergency medical services and public safety personnel, including statewide availability and accreditation of critical incident stress management teams;

14. Establishing a statewide emergency medical services for children program to provide coordination and support for emergency pediatric care, availability of pediatric emergency medical care equipment, and pediatric training of medical care providers;

15. Establishing and supporting a statewide system of health and medical emergency response teams, including emergency medical services disaster task forces, coordination teams, disaster medical assistance teams, and other support teams that shall assist local emergency medical services at their request during mass casualty, disaster, or whenever local resources are overwhelmed;

16. Establishing and maintaining a program to improve dispatching of emergency medical services including establishment of and support for emergency medical dispatch training, accreditation of 911 dispatch centers, and public safety answering points; and

17. Identifying and establishing best practices for managing and operating agencies, improving and managing emergency medical response times, and disseminating such information to the appropriate persons and entities.

B. The Board of Health shall also develop and maintain as a component of the Emergency Medical Services Plan a statewide prehospital and interhospital Trauma Triage Plan designed to promote rapid access for pediatric and adult trauma patients to appropriate, organized trauma care through the publication and regular updating of information on resources for trauma care and generally accepted criteria for trauma triage and appropriate transfer. The Trauma Triage Plan shall include:

1. A strategy for implementing the statewide Trauma Triage Plan through formal regional trauma triage plans developed by the regional emergency medical services councils which can incorporate each region's geographic variations and trauma care capabilities and resources, including hospitals designated as trauma centers pursuant to subsection A of this section. The regional trauma triage plans shall be implemented by July 1, 1999, upon the approval of the Commissioner.

2. A uniform set of proposed criteria for prehospital and interhospital triage and transport of trauma patients, consistent with the trauma protocols of the American College of Surgeons' Committee on Trauma, developed by the Emergency Medical Services Advisory Board, in consultation with the Virginia Chapter of the American College of Surgeons, the Virginia College of Emergency Physicians, the Virginia Hospital and Healthcare Association, and prehospital care providers. The Emergency Medical Services Advisory Board may revise such criteria from time to time to incorporate accepted changes in medical practice or to respond to needs indicated by analyses of data on patient outcomes. Such criteria shall be used as a guide and resource for health care providers and are not intended to establish, in and of themselves, standards of care or to abrogate the requirements of § 8.01-581.20. A decision by a health care provider to deviate from the criteria shall not constitute negligence per se.

3. A program for monitoring the quality of care, consistent with other components of the Emergency Medical Services Plan. The program shall provide for collection and analysis of data on emergency medical and trauma services from existing validated sources, including but not limited to the emergency medical services patient care information system, pursuant to Article 3.1 (§ 32.1-116.1 et seq.) of this chapter, the Patient Level Data System, and mortality data. The Emergency Medical Services Advisory

Board shall review and analyze such data on a quarterly basis and report its findings to the Commissioner. The first such report shall be for the quarter beginning on July 1, 1999. The Advisory Board may execute these duties through a committee composed of persons having expertise in critical care issues and representatives of emergency medical services providers. The program for monitoring and reporting the results of emergency medical and trauma services data analysis shall be the sole means of encouraging and promoting compliance with the trauma triage criteria.

The Commissioner shall report aggregate findings of the analysis annually to each regional emergency medical services council, with the first such report representing data submitted for the quarter beginning July 1, 1999, through the quarter ending June 30, 2000. The report shall be available to the public and shall identify, minimally, as defined in the statewide plan, the frequency of (i) incorrect triage in comparison to the total number of trauma patients delivered to a hospital prior to pronouncement of death and (ii) incorrect interfacility transfer for each region.

The Advisory Board shall ensure that each hospital or emergency medical services director is informed of any incorrect interfacility transfer or triage, as defined in the statewide plan, specific to the provider and shall give the provider an opportunity to correct any facts on which such determination is based, if the provider asserts that such facts are inaccurate. The findings of the report shall be used to improve the Trauma Triage Plan, including triage, and transport and trauma center designation criteria.

The Commissioner shall ensure the confidentiality of patient information, in accordance with § 32.1-116.2. Such data or information in the possession of or transmitted to the Commissioner, the Advisory Board, ~~or~~ any committee acting on behalf of the Advisory Board, any hospital or prehospital care provider, *any regional emergency medical services council, permitted emergency medical services agency, or group or committee established to monitor the quality of care pursuant to this subdivision,* or any other person shall be privileged and shall not be disclosed or obtained by legal discovery proceedings, unless a circuit court, after a hearing and for good cause shown arising from extraordinary circumstances, orders disclosure of such data.

C. Whenever any state-owned aircraft, vehicle, or other form of conveyance is utilized under the provisions of this section, an appropriate amount not to exceed the actual costs of operation may be charged by the agency having administrative control of such aircraft, vehicle or other form of conveyance.

§ 32.1-116.1. Prehospital patient care reporting procedure; trauma registry; confidentiality.

A. In order to collect data on the incidence, severity and cause of trauma, integrate the information available from other state agencies on trauma and improve the delivery of prehospital and hospital emergency medical services, there is hereby established the Emergency Medical Services Patient Care Information System. The Emergency Medical Services Patient Care Information System shall include the prehospital patient care reporting procedure and the trauma registry.

All licensed emergency medical services agencies shall participate in the prehospital patient care reporting procedure by making available to the Commissioner or his designees the minimum data set on forms prescribed by the Board or locally developed forms which contain equivalent information. The minimum data set shall include, but not be limited to, type of medical emergency or nature of the call, the response time, the treatment provided and other items as prescribed by the Board.

Each licensed emergency medical services agency shall, upon request, disclose the prehospital care report to law-enforcement officials (i) when the patient is the victim of a crime or (ii) when the patient is in the custody of the law-enforcement officials and has received emergency medical services or has refused emergency medical services.

The Commissioner may delegate the responsibility for collection of this data to the Regional Emergency Medical Services Councils, Department of Health personnel or individuals under contract to the Department. The Advisory Board shall assist in the design, implementation, subsequent revisions and analyses of the data of the prehospital patient care reporting procedures.

B. All licensed hospitals which render emergency medical services shall participate in the trauma registry by making available to the Commissioner or his designees abstracts of the records of all patients admitted to the institutions' trauma and general surgery services with diagnoses related to trauma. The abstracts shall be submitted on forms provided by the Department and shall include the minimum data set prescribed by the Board.

The Commissioner shall seek the advice and assistance of the Advisory Board and the Committee on Trauma of the Virginia Chapter of the American College of Surgeons in the design, implementation, subsequent revisions and analyses of the trauma registry.

C. Patient and other data or information submitted to the trauma registry or transmitted to the Commissioner, the Advisory Board, any committee acting on behalf of the Advisory Board, any hospital or prehospital care provider, any regional emergency medical services council, permitted emergency medical services agency, or other group or committee for the purpose of monitoring and improving the quality of care pursuant to § 32.1-111.3, shall be privileged and shall not be disclosed or obtained by

legal discovery proceedings, unless a circuit court, after a hearing and for good cause shown arising from extraordinary circumstances, orders disclosure of such data.