



Commission on Excellence in Health Care

Report to the Governor and the Legislature

February 1, 2001

Florida Department of
Health



STATE OF FLORIDA

AHCA

AGENCY FOR HEALTH CARE ADMINISTRATION

Florida Commission on Excellence in Health Care Report

*A Comprehensive Statewide Strategy for Improving
the Health Care Delivery System through Meaningful
Reporting Standards, Data Collection and Review,
and Quality Measurement*

*Report Submitted by the
Department of Health and the
Agency for Health Care Administration*

Published Pursuant to Chapters 2000-256 and 2000-367

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February 1, 2001

Dear Governor Bush and Members of the Legislature:

We are pleased to transmit to you a copy of the final report of the Florida Commission on Excellence in Health Care. This report was prepared pursuant to Chapters 2000-256 and 2000-367, Laws of Florida, which directs the commission to develop a comprehensive statewide strategy for improving the health care delivery system through meaningful reporting standards, data collection and review, and quality measurement.

We sincerely thank you for your interest and support of our efforts to enhance patient safety and reduce health care errors. The commission's work product will serve as a catalyst for the realization of a more efficient and effective health care delivery system.

This is an extremely important public policy issue, and we are grateful for the opportunity to work with you to improve the overall quality of life of Floridians.

A handwritten signature in black ink that reads "Robert G. Brooks".

*Robert G. Brooks, M.D., Secretary
Florida Department of Health*

*Ruben J. King-Shaw, Jr., Secretary
Agency for Health Care Administration*

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Foreword

The 2000 Legislature created the Florida Commission on Excellence in Health Care to facilitate the development of a comprehensive statewide strategy for improving the health care delivery system through meaningful reporting standards, data collection and review, and quality measurement.

The Legislature directed the commission to:

- A. Identify existing data sources that evaluate the quality of care in Florida and collect, analyze, and evaluate this data.
- B. Establish guidelines for data sharing and coordination.
- C. Identify core sets of quality measures for standardized reporting by appropriate components of the health care continuum.
- D. Recommend a framework for quality measurement and outcome reporting.
- E. Develop quality measures that enhance and improve the ability to evaluate and improve care.
- F. Make recommendations regarding research and development needed to advance quality measurement and reporting.
- G. Evaluate regulatory issues relating to the pharmacy profession and recommend changes necessary to optimize patient safety.
- H. Facilitate open discussion of a process to ensure that comparative information on health care quality is valid, reliable, comprehensive, understandable, and widely available in the public domain.
- I. Sponsor public hearings to share information and expertise, identify “best practices,” and recommend methods to promote their acceptance.
- J. Evaluate current regulatory programs to determine what changes, if any, need to be made to facilitate patient safety.
- K. Review public and private health care purchasing systems to determine if there are sufficient mandates and incentives to facilitate continuous improvement in patient safety.
- L. Analyze how effective existing regulatory systems are in ensuring continuous competence and knowledge of effective safety practices.
- M. Develop a framework for organizations that license, accredit, or credential health care practitioners and health care providers to more quickly and effectively identify unsafe practitioners and providers and to take action necessary to remove the unsafe practitioner or provider from practice or operation until such time as the practitioner or provider has proven safe to practice or operate.
- N. Recommend procedures for development of a curriculum on patient safety and methods of incorporating such curriculum into training, licensure, and certification requirements.
- O. Develop a framework for regulatory bodies to disseminate information on patient safety to health care practitioners, health care providers, and consumers

- through conferences, journal articles and editorials, newsletters, publications, and Internet websites.
- P. Recommend procedures to incorporate recognized patient safety considerations into practice guidelines and into standards related to the introduction and diffusion of new technologies, therapies, and drugs.
 - Q. Recommend a framework for development of community-based collaborative initiatives for error reporting and analysis and implementation of patient safety improvements.
 - R. Evaluate the role of advertising in promoting or adversely affecting patient safety.
 - S. Evaluate and make recommendations regarding the need for licensure of additional persons who participate in the delivery of health care to Floridians, including, but not limited to, surgical technologists and pharmacy technicians.
 - T. Evaluate the benefits and problems of the current disciplinary systems and make recommendations regarding alternatives and improvements.

The Legislature specified that the commission shall consist of the following membership: the secretary of the Department of Health, the secretary of the Agency for Health Care Administration, one representative each from the Board of Medicine, the Board of Osteopathic Medicine, the Board of Pharmacy, the Board of Dentistry, the Board of Nursing, the Florida Dental Association, the Florida Medical Association, the Florida Osteopathic Medical Association, the Florida Academy of Physician Assistants, the Florida Chiropractic Association, the Florida Chiropractic Society, the Florida Podiatric Medical Association, the Florida Society of Ambulatory Surgical Centers, the Florida Nurses Association, the Florida Organization of Nursing Executives, the Florida Pharmacy Association, the Florida Society of Health System Pharmacists, Inc., the Florida Hospital Association, the Association of Community Hospitals and Health Systems of Florida, Inc., the Florida League of Health Systems, the Florida Health Care Risk Management Advisory Council, the Florida Health Care Association, the Florida Statutory Teaching Hospital Council, Inc., the Florida Statutory Rural Hospital Council, the Florida Association of Homes for the Aging, the Florida Society for Respiratory Care; one licensed clinical laboratory director, two health lawyers, one representative of the medical malpractice professional liability insurance industry, two representatives of the health insurance industry, five consumer advocates, two legislators, and one representative of a Florida medical school.

The Legislature further specified that: (1) the commission membership must reflect the geographic and demographic diversity of the state, (2) the secretaries of the Department of Health and the Agency for Health Care Administration shall jointly chair the commission, (3) subcommittees shall be formed by the joint chairs, as needed, to make recommendations to the full commission, (4) all votes on work products of the commission shall be at the full commission level, and (5) all recommendations to the Governor, the President of the Senate, and the Speaker of the House of Representatives must pass by a two-thirds vote of the full commission.

The Legislature directed that a report be submitted to the Governor, the President of the Senate, and the Speaker of the House of Representatives no later than February 1, 2001.

This report is a summary of the commission's recommendations.

Further information can be found at myflorida.com@doh.state.fl.us.

Copies of this Report are available on line at <http://www.floridahealthstat.com>

Executive Summary

Ensuring the delivery of quality health care is a core mission of the Department of Health and the Agency for Health Care Administration. In spite of diligent efforts, however, errors continue to occur. National studies indicate that this phenomenon is consistent with the experiences of states across the nation. Florida's historical experience with health care errors, coupled with information obtained as a result of major research projects, served as the impetus for the state's in-depth review and analysis of its health care delivery system.

Over the past decade Florida's health care delivery system has made tremendous strides toward addressing the critical issues of access and quality. Millions of Floridians receive high quality health care services. As a result, they are living longer and they are generally healthier than at any time in the history of this state. Florida can also take pride in the fact that it has many of the nation's finest health care professionals, academic health centers, and other medical research institutions.

However, the health care delivery system is under enormous strain, made evident by the number of documented health care errors. At times, the quality of care provided to patients is substandard or patients receive excessive services that undermine the quality of care and needlessly increase costs. At other times, patients do not receive services that have proven to be effective at improving health outcomes and reducing costs. Poor quality care leads to sicker patients, more disabilities, higher costs, and lower consumer confidence in the health care industry. In spite of its good points, there is great potential to improve the quality of Florida's health care delivery system.

Consumers want understandable, meaningful, and readily available, reliable information to help them make critical decisions about their health care. Public and private purchasers want more information about the quality of care they purchase for their employees and their dependents and beneficiaries. Health care practitioners and providers want aggregate data to compare their performance with the industry as a whole. While it is clear that successful strategies have been identified and implemented, there is definitely a need for a statewide, coordinated effort. There are numerous examples of successful efforts to improve health care quality, yet there are many gaps, and in other cases there are far too many redundancies. Moreover, there is no systematic mechanism to share best practices and successful strategies with health care practitioners, providers, and the public.

To address these concerns, the Department of Health and the Agency for Health Care Administration entered into a substantial partnership to improve the overall quality of health care for all Floridians. This partnership resulted in the secretaries of both departments asking the 2000 Legislature to create the Florida Commission on Excellence in Health Care to facilitate development of a comprehensive statewide

strategy for improving the health care delivery system through meaningful standards, data collection and review, and quality measurement. The Legislature and the Governor agreed this level of review and analysis was needed in order to incorporate the necessary incentives and safeguards throughout the various components of the system to reduce health care errors and enhance patient safety.

The state's commitment to the measurement, improvement, and maintenance of high-quality care for all Floridians is evidenced by the proposed development of a statewide plan for quality measurement, data collection, and reporting standards. The Florida Commission on Excellence in Health Care has, through its exhaustive work over the past several months, laid the groundwork for the realization of short-term and long-term goals that will result in the overall improvement of the state's health care delivery system.

Commission members adopted several guiding principles in their attempt to develop a statewide plan. They determined that the plan should be patient-centered, multidimensional, and cost effective. Additionally, the plan should address all aspects of the health care continuum, build on existing models, and must be based on valid, reliable, and accurate data. Essentially, the commission's recommendations call for continued attention to patient safety by the Department of Health and the Agency for Health Care Administration through creation of an Interagency Council for Patient Safety and Excellence in Health Care. The commission also recommended that the Legislature consider creation of a separate, freestanding Center for Patient Safety and Excellence in Health Care.

I. INTERAGENCY COUNCIL FOR PATIENT SAFETY AND EXCELLENCE IN HEALTH CARE

The commission recommended that the Interagency Council for Patient Safety and Excellence in Health Care have the following duties and responsibilities.

A. Provide ongoing leadership in health care quality improvement to:

- 1. Ensure coordination between agencies, to eliminate duplication of efforts, and to close the gaps in data collection.*
- 2. Map current data sources to capture existing data on quality measures.*
- 3. Compile and integrate data on health care errors.*
- 4. Establish guidelines for new reporting requirements.*
- 5. Identify and compile information on quality improvement measures.*
- 6. Prioritize research and develop new initiatives.*
- 7. Identify methods of disseminating information.*
- 8. Determine an appropriate location for the electronic data system.*
- 9. Research and validate best practices recommended to reduce health care errors.*
- 10. Disseminate information on patient safety measures, initiatives, and guidelines via multiple channels of communication – Internet, newsletters, and workshops.*
- 11. Identify statutes that require revisions.*

B. Collaborate and coordinate efforts with:

- 1. Other governmental departments and agencies to develop and implement research plans.*
- 2. Community based initiatives on error reporting, analysis of data, and the implementation of patient safety measures.*
- 3. Accrediting, licensing and professional organizations to investigate educational methods to prevent health care errors through improvements in the analysis and understanding of the results of the data collected.*
- 4. The general public via summits on patient safety and on the directives planned for the future.*
- 5. Other available state and Federal sources to facilitate research.*
- 6. The State Technology Office to develop systems methodologies.*
- 7. Academic institutions (universities, medical schools, pharmacy, nursing and other health care teaching programs) for academic and clinical research in health care error prevention*

C. Develop a mechanism for quality measurement and data analysis and reporting, which includes the following components:

- 1. A quality public report should be developed utilizing a risk-adjusted methodology with protections for confidential health care practitioner, provider, entity, and patient information.*
- 2. Corrective actions taken following adverse incidents should be disseminated in a periodic advisory to reporting entities so loss prevention systems can be implemented that will result in improved patient care.*
- 3. Best practices identified through the collection and analysis of the quality indicators should be shared with reporting entities through a periodic advisory to advance loss prevention activities and improve patient care.*
- 4. Aggregated data should be made available to assigned users on the Internet-based system for tracking and benchmarking.*

D. Work with the Center for Patient Safety and Excellence in Health Care to coordinate the development of community-based collaborative initiatives for error reporting, analysis and implementation of patient safety improvements, including:

- 1. Convening meetings of accrediting, licensing, professional organizations and certifying bodies to propose, investigate, and evaluate educational methods to improve analysis, understanding, and prevention of health care errors.*
- 2. Planning and conducting a summit addressing patient safety and health care error reduction, and producing directives for the future.*
- 3. Applying for and participating in health care quality demonstration projects.*
- 4. Applying to National Institutes of Health (NIH) and Agency for Healthcare Research and Quality (AHRQ), and others, for funding to conduct health care quality research.*

5. *Developing and overseeing the implementation of a plan for research and development regarding health care quality measurement and reporting.*
6. *Meeting quarterly with the Center for Patient Safety and Excellence in Health Care to disseminate information on data analysis results, provide education on safety measures and best practices, and allow input and feedback.*
7. *Developing or purchasing a longitudinal Internet-based system for health care practitioners and providers to track aggregate data through selected quality indicators. The system should:*
 - a. *Build on existing measures established by other quality initiatives, such as the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), the National Committee for Quality Assurance (NCQA), and the Health Care Financing Administration (HCFA). The scope of work should include such areas as morbidity and mortality, and infection rates.*
 - b. *Ensure that data is collected, analyzed, evaluated and reports are disseminated through a centralized collection department.*
 - c. *Allow data to be submitted electronically and stored in a secure, limited access Internet-based system.*

II. CENTER FOR PATIENT SAFETY AND EXCELLENCE IN HEALTH CARE

The commission also recommended that the Legislature create a Center for Patient Safety and Excellence in Health Care, and empower it to:

1. *Collect and establish a statewide database on health care errors, adverse incidents, and near misses, maximizing the use of existing data.*
2. *Analyze statewide data on health care errors in procedures, products and systems and prepare an aggregate report for dissemination.*
3. *Convene multi-disciplinary work groups of representatives from professional organizations, regulatory boards and agencies, accrediting and licensing bodies, educational institutions, health care practitioners and providers, and private industry to review and discuss the information on health care errors and patient safety practices that can be used in developing practice guidelines and standards.*
4. *Disseminate research information on health care errors and patient safety practices to professional societies, hospitals, health plans, and ambulatory surgical centers and encourage them to incorporate patient safety practices into their clinical practice guidelines.*
5. *Serve as the clearinghouse, in conjunction with the regulatory bodies, to disseminate information on patient safety.*
6. *Conduct meetings with professional organizations and regulatory bodies to discuss information on health care errors to determine the types of information and methods for disseminating information on patient safety.*
7. *Conduct meetings with consumer and patient organizations through grassroots informational meetings to determine the types of patient safety information and the most effective methods for disseminating the information to enable consumers to become involved in their care and to be more active participants in the decision-making surrounding their care.*

8. *Develop material on preventing health care errors, patient safety and quality improvement that state regulatory bodies, purchasers, professional associations and societies, health plans, hospitals, and ambulatory surgical centers can disseminate, reprint, or adapt.*
9. *Develop a packet of information to educate consumers on health care errors, improve patient safety, and assist them in taking an active role in making decisions concerning their health care. Health plans, insurance companies, hospitals, health care practitioners, community leaders, retirement centers, etc., should distribute these packets.*
10. *Determine the type and most effective way to present information on patient safety, health care errors and quality improvement to health care practitioners, providers, purchasers and consumers and determine the impact of providing the information.*
11. *Analyze data on health care errors and adverse incidents and other sources to develop a model patient-safety education and training program.*
12. *Encourage medical schools, teaching hospitals, and health care educational programs to incorporate the patient safety-training program into their curriculum.*
13. *Encourage medical and health care teaching facilities to use patient simulators to train and maintain health care practitioner skills.*

Introduction

Building a safer health care system means designing processes of care to ensure that patients are safe from preventable injury. Once agreement has been reached on a particular course of treatment, patients should have the reasonable assurance that it will proceed correctly and safely so they have the best chance possible of achieving the desired outcome. As health care and the system that delivers it become more complex, the opportunity for errors increases. Establishing systems that will promote patient safety and error reduction will require a concerted effort by all components of the health care delivery system, including practitioners and providers, health care entities, purchasers, consumers, regulators, and policy-makers. Traditional clinical boundaries and a culture of blame must be changed so that all members of the health care team are encouraged and supported in reporting and correcting problems. But more importantly, safety systems must be systematically integrated throughout the health care delivery system.

This report describes the efforts of the members of the legislatively appointed Florida Commission on Excellence in Health Care to examine the quality of Florida's health care delivery system. The commission focused its attention on quality of health care issues, patient safety and the reduction of health care errors, as directed by the 2000 Legislature. The Legislature recognized that Florida's health care delivery system is one of the largest and most complex industries in the state, and that additional focus on strengthening it by eliminating avoidable mistakes in the diagnosis and treatment of patients holds tremendous promise to increase the quality of health care services available to residents and visitors.

This report proposes a comprehensive strategy for addressing broad issues of quality health care including reducing health care errors and improving patient safety. The strategy includes market and regulatory initiatives as well as public and private efforts, including enhanced consumer involvement. To address the issue of additional marketplace incentives, the commission proposed that quality performance be recognized and rewarded. Both health care facilities and practitioners would be recognized publicly as quality providers.

Commission members opined that the increased publication of performance data would allow consumers to use the information to make health care decisions based on records of quality. The commission agreed that a basic level of safety should be assured for all health care consumers, and that an efficient and effective regulatory component is critical to accomplishing this goal. However, the commission also recognized that regulation alone would not be sufficient to reduce health care errors and improve patient safety. The commission indicated strongly that in addition to the existing mandatory reporting system, a voluntary, incentive-driven, non-punitive system, for quality improvement purposes should be created to encourage reporting of errors that

could result in injury. Moreover, these records should be redacted of names and used as a learning tool by health care practitioners, providers, and the public.

The commission made an attempt to address all aspects of the health care continuum to ensure that, in the future, health care performance is measured and monitored with a focus on the patient rather than the setting within which treatment occurs. Throughout their deliberations, commission members remained singularly focused on developing a patient-centered health care improvement plan that relies on valid, reliable, and accurate data to establish short-term as well as longer-term goals and objectives. The commission held a total of seven meetings, during which fourteen hours of public testimony was heard. Three subcommittees were formed to address the areas of:

- *Regulation*
- *Education/Best Practices*
- *Quality Measurement/Data Collection and Reporting*

Summary of Recommendations by Program Area

Sections 2000-256 and 2000-367, F.S., established the Florida Commission on Excellence in Health Care to facilitate the development of a comprehensive statewide strategy for improving the health care delivery system through meaningful reporting standards, data collection and review, and quality measurement.

Following is a summary of the recommendations adopted by the Commission. A detailed description of each recommendation is contained in the Subcommittee Recommendations Matrix, which begins on page 17.

I. THE DEPARTMENT OF HEALTH SHOULD:

- A. Identify an internal position to create a customer service liaison to work directly with consumers and assist them with licensure and/or enforcement issues.
- B. Expand the content of periodic regulatory board newsletters to include articles on disciplinary cases resulting from health care errors.
- C. Pursue development of a proposal for registration of surgical technologists.

II. THE DEPARTMENT OF HEALTH AND THE AGENCY FOR HEALTH CARE ADMINISTRATION SHOULD:

- A. Contract with a private consultant to conduct a comprehensive review of the health care practitioner enforcement program. The consultant's work product should be used to determine the changes needed to enhance the system.
- B. Appoint an Interagency Council for Public Safety and Excellence in Health Care. Following is a listing of major duties and responsibilities.
 - 1. Provide ongoing leadership in health care quality improvement to:
 - a. *Ensure coordination between agencies to eliminate duplication of efforts and to close gaps in data collection.*
 - b. *Map current data sources to capture existing data on quality measures.*

- c. Compile and integrate data on health care errors.*
- d. Establish guidelines for new reporting requirements.*
- e. Identify and compile information on quality improvement measures.*
- f. Prioritize research and develop new initiatives.*
- g. Identify methods of disseminating information.*
- h. Determine an appropriate location for the electronic data system.*
- i. Research and validate best practices recommended to reduce health care errors.*
- j. Disseminate information on patient safety measures, initiatives, and guidelines via multiple channels of communication – Internet, newsletters, and workshops.*
- k. Identify statutes that require revisions.*

2. Collaborate and coordinate efforts with:

- a. Other governmental departments and agencies to develop and implement research plans.*
- b. Community based initiatives on error reporting, analysis of data, and the implementation of patient safety measures.*
- c. Accrediting, licensing and professional organizations to investigate educational methods to prevent health care errors through improvements in the analysis and understanding of the results of the data collected.*
- d. The general public via summits on patient safety and on the directives planned for the future.*
- e. Other available state and Federal sources to facilitate research.*
- f. The State Technology Office to develop systems methodologies.*
- g. Academic institutions (universities, medical schools, pharmacy, nursing and other health care programs) for academic and clinical research in health care error prevention.*

3. Develop a mechanism for quality measurement and data analysis and reporting, which includes the following components:

- a. A quality public report should be developed utilizing a risk-adjustment methodology with protections for confidential health care practitioner, provider, entity, and patient information.*
- b. Corrective actions taken following adverse incidents should be disseminated in a periodic advisory to reporting entities so loss prevention systems can be implemented that will result in improved patient care.*
- c. Best practices identified through the collection and analysis of the quality indicators should be shared with reporting entities through a periodic advisory to advance loss prevention activities and improve patient care.*

- d. *Aggregated data should be made available to assigned users on the Internet-based system for tracking and benchmarking.*
 - e. *Work with the Center for Patient Safety and Excellence in Health Care to coordinate the development of community-based collaborative initiatives for error reporting and analysis and implementation of patient safety improvements, including:*
 - 1. *Convening meetings of accrediting, licensing, professional organizations and certifying bodies to propose, investigate, and evaluate educational methods to improve analysis, understanding, and prevention of health care errors.*
 - 2. *Planning and conducting a summit addressing patient safety and health care error reduction, and producing directives for the future.*
 - 3. *Applying for and participating in health care quality demonstration projects.*
 - 4. *Applying to National Institutes of Health and Agency for Healthcare Research and Quality for funding to conduct health care quality research.*
 - 5. *Developing and overseeing the implementation of a plan for research and development regarding health care quality measurement and reporting.*
 - f. *Meet quarterly with appointed representatives from professional organizations and societies, health care practitioners and providers, health plans, and consumers to disseminate information on data analysis results, provide education on safety measures and best practices, and allow input and feedback.*
4. **Develop or purchase a longitudinal, Internet-based system for health care practitioners and providers to track aggregate data through selected quality indicators. The system should:**
- a. *Build on existing measures established by other quality initiatives.*
 - b. *Ensure that data is collected, analyzed, and evaluated and reports and disseminated through a centralized collection department.*
 - c. *Allow data to be submitted electronically and stored in a secure, limited access Internet-based system.*
- C. **Evaluate all sources of data to determine appropriate submission of data and maximize analysis and feedback of analysis from data about health care errors and adverse incidents.**
- D. **Determine and implement strategies to provide quick feedback to individual practitioners and facilities submitting reports of health care errors and adverse incidents, as well as statewide feedback to the medical community. Such feedback should include anecdotal summaries and analysis of prevention strategies.**

- E. Provide timely feedback of effective safety practices to health care practitioners and facilities.
- F. Periodically publish information for the medical community regarding best practices of prevention strategies.
- G. Identify strategies to provide educational consultation to facilities regarding mandatory reporting requirements.
- H. Enhance audit processes and parameters to foster the state's health care quality initiative relating to all practice settings.
- I. Ensure that regulatory rules for any practice setting in which surgical procedures are performed require that the practice setting establish minimum training and education requirements for all operating personnel.
- J. Expand public education strategies to increase patient awareness of safety factors (e.g., checking licensure credentials).
- K. Recommend various revisions to current statutes to:
 1. *Enhance communication with consumers.*
 2. *Improve patient safety.*
 3. *Expand the responsibilities of hospital and ambulatory surgical center risk managers.*
 4. *Provide confidentiality of error reports and immunity from civil liability to risk managers and licensed facilities for reporting adverse incidents.*
 5. *Enhance timely resolution of disciplinary cases.*

III. THE AGENCY FOR HEALTH CARE ADMINISTRATION SHOULD:

- A. Formalize its customer relations function for interaction with complainants, to :
 1. *Expand its consumer resource capability to receive and manage consumer complaints and inquiries and to provide meaningful status updates regarding the investigation and prosecution of the complaint to the person who filed the complaint and/or the patient or the patient's legal representative.*
 2. *Ensure that the complaint brochure is updated timely after any changes in laws and rules and enhancing distribution of the complaint brochure by sending to all physicians and retail establishments that voluntarily want to display it.*
 3. *At the request of the patient, add the patient's name as a co-complainant so that the patient has access to information.*

- B. Establish a system to cross-reference various sources of information with incident reports to ensure that facilities are complying with reporting requirements.**
- C. Publish, no less than quarterly, a summary of adverse incident reports, which shall not include information that would identify the reporting facility or health care practitioner involved. The purpose of the publication of such summaries is to promote the rapid dissemination of information relating to incidents to assist in avoidance of similar incidents and reduce morbidity and mortality. (NOTE: A public records exemption will be necessary, as is currently provided for annual hospital reports). The quarterly report should replace the current annual reporting requirements.**

IV. THE LEGISLATURE SHOULD:

- A. Seek statutory authority to extend the current protections of peer review, relating to quality improvement functions, for institutional pharmacists to community pharmacists.**
- B. Retain certificate of need regulations until after such time as systems for reporting useful clinical outcome data to allow consumers to analyze and choose between existing health care practitioners and providers are implemented.**
- C. Create the Center for Public Safety and Excellence in Health Care, and empower it to:**
 - 1. Collect and establish a statewide database on health care errors, adverse incidents, and near misses.*
 - 2. Analyze statewide data on health care errors in procedures, products and systems and prepare an aggregate report for dissemination.*
 - 3. Convene multi-disciplinary work groups of representatives from professional organizations, regulatory boards and agencies, accrediting and licensing bodies, educational institutions, health care practitioners and providers, and private industry to review and discuss the information on health care errors and patient safety practices that can be used in developing practice guidelines and standards.*
 - 4. Disseminate research information on health care errors and patient safety practices to professional societies, health care practitioners and providers, hospitals, health plans, ambulatory surgical centers and encourage them to incorporate safety practices into their clinical practice guidelines.*
 - 5. Serve as the clearinghouse, in conjunction with the regulatory bodies, to disseminate information on patient safety.*

6. *Conduct meetings with professional organizations and regulatory bodies to discuss information on health care errors to determine the types of information and methods for disseminating information on patient safety.*
7. *Conduct meetings with consumer and patient organizations through grassroots informational meetings to determine the types of patient safety information and the most effective methods for disseminating the information to enable consumers to become involved in their care and to be more active participants in the decision-making surrounding their care.*
8. *Develop material on preventing health care errors, patient safety and quality improvement that state regulatory bodies, purchasers, professional associations and societies, health plans, hospitals, and ambulatory surgical centers can disseminate, reprint, or adapt.*
9. *Develop a packet of information to educate consumers on health care errors, improve patient safety, and assist them in taking an active role in making decisions concerning their health care. Health plans, insurance companies, hospitals, health care practitioners, community leaders, retirement centers, etc, would distribute the packets.*
10. *Determine the type and most effective way to present information on patient safety, health care errors and quality improvement to health care practitioners, providers, purchasers and consumers and determine the impact of providing the information.*
11. *Analyze data on medical errors and adverse incidents and other sources to develop a model patient-safety education and training program.*
12. *Encourage medical schools, teaching hospitals, and health care educational programs to incorporate the patient safety-training program into their curriculum.*
13. *Encourage medical and other health care teaching facilities to use patient simulators to train and maintain health care practitioner skills.*

Subcommittee Recommendations Matrix

Legislative Mandate	Subcommittee Recommendations
Regulation Subcommittee	
<ol style="list-style-type: none"> 1. Evaluate the benefits and problems of the current disciplinary systems and make recommendations regarding alternatives and improvements. 2. Evaluate current regulatory programs to determine what changes, if any, need to be made to facilitate patient safety. 	<ol style="list-style-type: none"> A. AHCA should formalize its "customer relations" function for interaction with complainants by: <ol style="list-style-type: none"> 1. Expanding the consumer resource capability of AHCA to receive and manage consumer complaints and inquiries and to provide meaningful status updates regarding the investigation and prosecution of the complaint to the person who filed the complaint and the patient or the patient's legal representative. <i>(Motion passed unanimously)</i> 2. Ensuring that the complaint brochure is timely updated after any changes in laws and rules and enhancing distribution of the complaint brochure via sending to all doctors and retail establishments that voluntarily wants to display. <i>(Motion passed unanimously)</i> 3. At the request of the patient, adding the patient's name as a co-complainant so that the patient has access to information. <i>(Motion passed unanimously)</i> B. DOH should identify an internal position to create a customer service liaison to work directly with consumers and assist them with licensure and/or enforcement issues. <i>(Motion passed unanimously)</i> C. DOH and AHCA should contract with a private consultant to conduct a comprehensive review of the health care practitioner enforcement program. The consultant's work product should be used to determine the changes needed to enhance the system. <i>(Motion passed unanimously)</i> D. DOH and AHCA should propose legislation to: <ol style="list-style-type: none"> 1. Create in s. 456.073 (9)(a), F.S., new language to allow, upon request, the patient and/or patient's legal representative to receive status information as well as the complainant. <i>(Motion passed by a 2/3 majority)</i> 2. Add language in s. 456.073(9) c, F.S., to allow, upon request, the complainant(s) and defendant/practitioner to receive a copy of the expert report, with the identity of the expert witness redacted, when said report is the basis for closure. <i>(Motion passed by a 2/3 majority)</i> After the first sentence in s. 456.073(9) c, F.S., add the following language: <u>In any disciplinary case for which probable cause is not found, the department shall so inform the person(s) who filed the complaint and notify that (those) person(s) that he or she (they) may, within 60 days, provide additional information to the probable cause panel which may be relevant to the decision. To facilitate the provision of additional information, the person(s) who filed the complaint may receive, upon request, a copy of the agency's expert report that supported the recommendation for closure if a report was relied upon by the agency. In no way does this require the agency to procure an expert opinion or report if none was used. Additionally, the identity of the expert shall remain confidential. The person(s) who filed the complaint shall agree, in writing, to maintain the confidentiality of any information found in the expert report.</u> <i>(Motion passed by a 2/3 majority)</i> 3. Change s. 456.078(1), F.S., by deleting the first sentence in its entirety. Change the word "may" to "shall" in the second sentence. Exclude from mediation allegations of fraud for Medicaid or Medicare but allow some mediation in third party payor claims. Include appropriate Code 15s. <i>(Motion passed unanimously)</i> 4. Change s. 456.078(1)(5), F.S., by deleting "created on or after January 1, 1995". <i>(Motion</i>

Legislative Mandate	Subcommittee Recommendations
	<p><i>passed unanimously</i>)</p> <ol style="list-style-type: none"> 5. Merge 456.072(b), F.S., into section 456.077, F.S., for continuity. <i>(Motion passed unanimously)</i> 6. Change s. 456.072(1) to state that if the subject does not dispute the matter in the citation within 30 days, the citation becomes a final order but <u>not</u> discipline if the violation is the first offense only. <i>(Motion passed unanimously)</i> 7. Change s. 456.072(6), F.S., to delete "created on or after January 1, 1992. <i>(Motion passed unanimously)</i> 8. Repeal s. 456.073(3), F.S. Notices of Non-compliance (provided citation and mediation provisions are adopted). <i>(Motion passed unanimously)</i> 9. Amend s. 395.1072, F.S., to change the Health Care Risk Manager Advisory Council to be a seven (7) member-group. Current statute specifies membership shall include 2 risk managers, 1 hospital administrator, 1 medical malpractice insurer and 1 consumer. The revision to the statute would specify that one of the two risk managers shall be a representative appointed by and a member of the Florida Society of Health Care Risk Managers and two other licensed health care practitioners (allows for flexibility in professions). <i>(Motion passed unanimously)</i> 10. Expand the statutory responsibilities of hospital and ambulatory surgical center risk managers to require that the risk managers notify the appropriate regulatory board of a report of sexual misconduct against a member of the facility's personnel. (Amend s. 395.0197(9)(d), F.S. <u>Report every allegation of sexual misconduct that involves a patient to the Department of Health.</u> <i>(Motion passed unanimously)</i> 11. Revise appropriate statute to specify that: <u>Allegations of sexual misconduct shall be reported to the Department of Health, regardless of the practice setting.</u> <i>(Motion passed unanimously)</i> 12. Expand facility personnel who are required to attend annual training on risk management and prevention. (Amend s. 395.0197(1)(b) 1.b., F.S., to read: At least one hour of such education and training, upon employment or upon obtaining staff privileges, should be required for all personnel of the licensed facility working in clinical areas and providing patient care". Add a requirement that the risk manager annually review and update the training relating to health care errors, adverse incidents, near misses and other quality indicators. <i>(Motion passed by a 2/3 majority)</i> 13. Require the risk manager to review the annual training on risk management and prevention. <i>(Motion passed by a 2/3 majority)</i> 14. Provide confidentiality of 1-day adverse incident reports to AHCA, as provided to Code 15 reports. (Amend s. 395.0197(13), F.S., to amend the subsection to include the reports in subsection 7). <i>(Motion passed unanimously)</i> 15. Create a new statutory section in Chapter 395 to provide immunity from civil liability to risk managers and licensed facilities for reporting only: <u>A privilege against civil liability is hereby granted to any licensed risk manager or licensed facility with regard to information furnished pursuant to Chapter 395, unless the licensed risk manager or facility acted in bad faith or with malice in providing such information.</u> <i>(Motion passed by a 2/3 majority)</i> 16. Amend s. 395.0197(2), F.S., to correct the citation for risk manager requirements to subsection 397.10974 and <u>not</u> Chapter 626, Part IX. <i>(Motion passed unanimously)</i> 17. Amend s. 395.0197(4) to delete the phrase, "after consulting with the Department of Insurance." <i>(Motion passed unanimously)</i> 18. Create a new statutory provision to specify that: <u>It shall be unlawful for any person to coerce, intimidate, or preclude a risk manager from lawfully executing his or her reporting obligations pursuant to Chapter 395, F.S. Such unlawful action shall be subject to civil monetary penalties not to exceed \$10,000 per violation.</u> (Staff should determine the appropriate statutory provision). <i>(Motion passed unanimously)</i>

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	<p>Certificate of Need regulations should not be eliminated or weakened until after such time as the state implements systems for reporting useful clinical outcome data in formats that allow consumers to analyze and choose between existing health care practitioners and providers. The reporting of raw or aggregate data will not meet this requirement. <i>(Motion passed by a 2/3 majority)</i></p>
<p>3. Analyze how effective existing regulatory systems are in ensuring continuous competence and knowledge of effective safety practices.</p>	<p>A. DOH and AHCA should:</p> <ol style="list-style-type: none"> 1. Evaluate all sources of data to determine appropriate submission of data and maximize analysis & feedback of analysis from data about health care errors. <i>(Motion passed by a 2/3 majority)</i> 2. Determine and implement strategies to provide quick feedback to individual facilities submitting reports of health care errors, as well as statewide feedback to the medical community. Such feedback should include anecdotal summaries and analysis of prevention strategies. <i>(Motion passed by a 2/3 majority)</i> 3. Provide timely feedback of effective safety practices to health care practitioners. <i>(Motion passed by a 2/3 majority)</i> 4. Periodically publish information for the medical community regarding best practices of prevention strategies. <i>(Motion passed by a 2/3 majority)</i> 5. Identify strategies to provide educational consultation to facilities regarding mandatory reporting requirements. <i>(Motion passed unanimously)</i> 6. Enhance audit processes and parameters to foster the state's health care quality initiative relating to all practice settings. <i>(Motion passed unanimously)</i> 7. Establish a system to cross reference various sources of information with incident reports to ensure those facilities are complying with reporting requirements. Reports give a broader base to identify avoidable errors and provide feedback for error reduction. <i>(Motion passed by a 2/3 majority)</i> <p>B. AHCA should publish, no less than quarterly, a summary of adverse incident reports, which shall not include information that would identify the reporting facility or health care practitioner involved. The purpose of the publication of such summaries is to promote the rapid dissemination of information relating to incidents to assist in avoidance of similar incidents and reduce morbidity and mortality. (NOTE: A public records exemption will be necessary, as is currently provided for annual hospital reports). Quarterly reports should replace the current annual reporting requirements. <i>(Motion passed by a 2/3 majority)</i></p> <p>C. DOH should expand the content of periodic regulatory board newsletters to include articles on disciplinary cases resulting from health care errors. <i>(Motion passed unanimously)</i></p>
<p>4. Develop a framework for organizations that license, accredit, or credential health care practitioners and health care providers to more quickly and effectively identify unsafe practitioners and providers and to take action necessary to remove the</p>	<p>The commission did not make a formal recommendation regarding this mandate, however, the Department of Health and the Agency for Health Care Administration have contracted with a private consultant to review the health care practitioner enforcement program. The consultant's work product will assist with addressing this mandate.</p>

Legislative Mandate	Subcommittee Recommendations
unsafe practitioner from practice or operation until such time as the practitioner or provider has proven safety to practice or operate.	
5. Evaluate and make recommendations regarding the need for licensure of additional persons who participate in the delivery of health care to Floridians, including, but not limited to, surgical technologists and pharmacy technicians.	<p>A. DOH should pursue development of a proposal for registration of surgical technologists. <i>(Motion passed unanimously)</i></p> <p>B. DOH and AHCA should ensure that regulatory rules for any practice setting in which surgical procedures are performed require that the practice setting establish minimum training and education requirements for all operating personnel. <i>(Motion passed unanimously)</i></p> <p>NOTE: The Subcommittee did not find a need to register pharmacy technicians.</p>
6. Evaluate regulatory issues relating to the pharmacy professions and recommend changes necessary to optimize patient safety.	Seek statutory authority to extend the current protections of peer review, relating to the quality improvement functions, for institutional pharmacists to community pharmacists. <i>(Motion passed by a 2/3 majority)</i>
7. Review public and private health care purchasing systems to determine if there are sufficient mandates and incentives to facilitate continuous improvements in patient safety.	The commission did not make a formal recommendation regarding this mandate, however, the Interagency Council for Patient Safety and Excellence in Health Care staff will coordinate the study of public and private health care purchasing systems to develop recommendations to support continuous improvements in patient safety.
8. Evaluate the role of advertising in promoting or adversely affecting patient safety.	The commission did not make a formal recommendation regarding this mandate, however, the Department of Health and the Agency for Health Care Administration are continuing to aggressively pursue cases involving false advertising. Further, the Interagency Council for Patient Safety and Excellence in Health Care staff will review the role of advertising and its relationship and effect on patient safety.

Legislative Mandate	Subcommittee Recommendations
Education / Best Practices	
	<p>Appoint an Interagency Council for Patient Safety and Excellence in Health Care. The council should consist of representatives of state agencies responsible for the prevention, regulation and study of health care. <i>(Motion passed by a 2/3 majority)</i></p>
	<p>Create a Center for Patient Safety and Excellence in Health Care <i>(Motion passed by a 2/3 majority).</i></p>
<p>1. Recommend procedures to incorporate recognized patient safety considerations into practice guidelines and into standards related to the introduction and diffusion of new technologies, therapies, and drugs.</p>	<p>A. The Center for Patient Safety and Excellence in Health Care should:</p> <ol style="list-style-type: none"> 1. Collect and establish a statewide database on health care errors, adverse incidents, and near misses, maximizing the use of existing data. <i>(Motion passed by a 2/3 majority)</i> 2. Analyze statewide data on health care errors in procedures, products and systems and prepare an aggregate report for dissemination. <i>(Motion passed by a 2/3 majority)</i> 3. Convene multi-disciplinary work groups of representatives from professional organizations, regulatory boards and agencies, accrediting and licensing bodies, educational institutions, health care practitioners and providers, and private industry to review and discuss the information on health care errors and patient safety practices that can be used in developing practice guidelines and standards. <i>(Motion passed by a 2/3 majority)</i> 4. Disseminate research information on health care errors and patient safety practices to health care practitioners, professional societies, hospitals, health plans, and ambulatory surgical centers and encourage them to incorporate patient safety practices into their clinical practice guidelines. <i>(Motion passed by a 2/3 majority)</i> <p>B. The Interagency Council on Patient Safety and Excellence in Health Care should coordinate the dissemination of information with professional organizations and societies; health maintenance organizations; health care practitioners, providers and purchasers, to educate practitioners on practice guidelines and encourage their use. <i>(Motion passed by a 2/3 majority)</i></p>
<p>2. Develop a framework for regulatory bodies to disseminate information on patient safety to health care practitioners, health care providers, and consumers through conferences, journal articles and editorials, newsletters, publications, and Internet web sites.</p>	<p>The Center for Patient Safety and Excellence in Health Care should:</p> <ol style="list-style-type: none"> A. Serve as the clearinghouse, in conjunction with the regulatory bodies, to disseminate information on patient safety. <i>(Motion passed unanimously)</i> B. Conduct meetings with professional organizations and regulatory bodies to discuss information on health care errors to determine the types of information and methods for disseminating information on patient safety. <i>(Motion passed unanimously)</i> C. Conduct meetings with consumer and patient organizations through grassroots informational meetings to determine the types of patient safety information and the most effective methods for disseminating the information

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	<p>to enable consumers to become involved in their care and to be more active participants in the decision-making surrounding their care. <i>(Motion passed unanimously)</i></p> <p>D. Develop material on preventing health care errors, patient safety and quality improvement that state regulatory bodies, purchasers, professional associations and societies, health plans, hospitals, and ambulatory surgical centers and can disseminate, reprint, or adapt. <i>(Motion passed unanimously)</i></p> <p>E. Develop a packet of information to educate consumers on health care errors, improve patient safety and assist them in taking an active role in making decisions concerning their health care. Health plans, insurance companies, hospitals, health care practitioners, community leaders, retirement centers, etc., would distribute the packets. <i>(Motion passed unanimously)</i></p> <p>F. Determine the type and most effective way to present information on patient safety, health care errors and quality improvement to health care practitioners, providers, purchasers and consumers and determine the impact of providing the information. <i>(Motion passed unanimously)</i></p>
<p>3. Recommend procedures for the development of an education and training program on patient safety and methods of incorporating such training into licensure and certification requirements.</p>	<p>A. The Center for Patient Safety and Excellence in Health Care should:</p> <ol style="list-style-type: none"> 1. Analyze data on health care errors and adverse incidents and other sources to develop a model patient- safety education and training program. <i>(Motion passed unanimously)</i> 2. Encourage medical schools, teaching hospitals, and health care educational programs to incorporate the patient safety-training program into their curriculum. <i>(Motion passed unanimously)</i> 3. Encourage medical and health care teaching facilities to use patient simulators to train and maintain health care practitioner skills. <i>(Motion passed unanimously)</i> <p>B. Legislation should be proposed requiring a course in medical errors and patient safety, including root cause analysis, error reduction, error prevention and patient safety practices as a requirement for initial and re-licensing of appropriate health care professionals. The course will be included in the existing number of required hours. <i>(Motion passed unanimously)</i></p>
<p>4. Recommend a framework for development of community based collaborative initiatives for error reporting and analysis and implementation of patient safety improvements.</p>	<p>The Interagency Council for Patient Safety and Excellence in Health Care and the Center for Patient Safety and Excellence in Health Care should coordinate the development of community-based collaborative initiatives for error reporting and analysis and implementation of patient safety improvements including:</p> <p>A. Convening meetings of accrediting, licensing, professional organizations and certifying bodies to propose, investigate, and evaluate educational methods to improve analysis, understanding, and prevention of health care errors. <i>(Motion passed unanimously)</i></p> <p>B. Planning and conducting a summit addressing patient safety and health care error reduction, and producing directives for the future. <i>(Motion passed unanimously)</i></p>

Legislative Mandate	Subcommittee Recommendations
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***Quality Measurement / Data Collection and Reporting
Subcommittee***

<p>1. Facilitate open discussion of a process to ensure that comparative information on health care quality is valid, reliable, comprehensive, understandable, and widely available in the public domain.</p>	<p>The secretaries of DOH and AHCA should appoint an Interagency Council for Patient Safety and Excellence in Health Care. The responsibilities of the council should include, but not be limited to:</p> <p>A. Providing ongoing leadership in health care quality improvement by:</p> <ol style="list-style-type: none"> 1. Ensuring coordination between agencies to eliminate duplication of efforts and to close gaps in data collection. 2. Mapping current data sources of existing quality measures. 3. Compiling and integrating health care errors data. 4. Establishing guidelines for new reporting requirements. 5. Identifying and compiling information on quality improvement measures. 6. Prioritizing research and developing new initiatives. 7. Identifying methods of disseminating information. 8. Determining an appropriate location for the electronic data system. 9. Researching and validating best practices recommended to reduce health care errors. 10. Disseminating information on patient safety measures, initiatives, and guidelines via multiple channels of communication - Internet, newsletters, and workshops. 11. Identifying statutes that require revisions. <p>B. Collaborating and coordinating efforts with:</p> <ol style="list-style-type: none"> 1. Other governmental departments and agencies to develop and implement research plans. 2. Community based initiatives on error reporting, analysis of data, and the implementation of patient safety measures. 3. Accrediting, licensing and professional organizations to investigate educational methods to prevent medical errors through improvements in the analysis and understanding of the results of the data collected. 4. The general public via summits on patient safety and on the directives planned for the future. 5. Other available state and Federal sources to facilitate research plans. 6. The State Technology Office to develop systems methodologies. 7. Academic institutions (universities, medical schools, pharmacy, nursing and other health care teaching programs) for academic and clinical research in health care error prevention. <i>(Motion passed unanimously)</i> <p>The secretaries of DOH and AHCA should appoint representatives from the following entities: Professional organizations and societies, health care practitioners and providers, health plans, and consumers.</p> <p>Representatives should meet quarterly with the Interagency Council for Patient Safety and Excellence in Health Care to:</p> <ol style="list-style-type: none"> 1. Disseminate information on data analysis results 2. Provide education on safety measures and best practices learned. 3. Allow input and feedback. <p><i>(Motion passed unanimously)</i></p>
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<i>Legislative Mandate</i>	<i>Subcommittee Recommendations</i>
<p>2. Identify existing data sources that evaluate quality of care in Florida and collect, analyze, and evaluate this data.</p> <p>3. Establish guidelines for data sharing and coordination.</p>	<p>The Interagency Council for Patient Safety and Excellence in Health Care should develop or purchase a longitudinal Internet-based system for health care practitioners and providers to track aggregate data through selected quality indicators. The system should:</p> <p>A. Build on existing measures established by other quality initiatives, such as the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), the National Committee for Quality Assurance (NCQA), and the Health Care Financing Administration (HCFA). The scope of work should include such areas as morbidity and mortality, and infection rates.</p> <p>B. Ensure that data is collected, analyzed, evaluated and reports are disseminated through a centralized collection department.</p> <p>C. Allow data to be submitted electronically and stored in a secure, limited access Internet-based system.</p> <p><i>(Motion passed by a 2/3 majority)</i></p> <p>NOTE: Data integrity checks should provide for data to be validated.</p>
<p>4. Identify core sets of quality measures for standardized reporting by appropriate components of the health care continuum.</p>	<p>Incentivize implementation of voluntary efforts to prevent adverse incidents and improve quality of care with the following components:</p> <p>A. In addition to mandatory reporting, a voluntary, incentive-based, non-punitive system should be created to encourage reporting of near misses defined as circumstances or events that have the capacity to result in injury or death. These records should be exempted from discovery and disclosure pursuant to Chapter 119, Florida Statutes and the Florida Constitution.</p> <p>B. Facilities and providers should be recognized publicly as quality facilities/providers. Indicators for recognition may include, but not be limited to:</p> <ol style="list-style-type: none"> 1. Entities/providers who have implemented a system for 48-hour turnaround time to provide feedback to providers on near miss and adverse outcome issues. 2. Entities/providers who have implemented a 24-hour acknowledgement to patients when a quality of care complaint has been received. 3. Entities/providers who have participated in an Institute for Safe Medication Practices (ISMP) self-assessment of the facility. 4. Facilities that have received American Nurses Credentialing Center (ANCC) Magnet Recognition, participated in the Governor's Sterling Council (FSA), or the Malcolm Baldrige Award for Performance Excellence. <p>C. The Interagency Council for Patient Safety and Excellence in Health Care should have the authority to approve additional indicators for recognition, including implementation of a meaningful risk reduction and quality improvement program as a mitigating factor in relevant disciplinary action.</p> <p><i>(Motion passed unanimously)</i></p>
<p>5. Recommend a framework for quality measurement and outcome reporting.</p>	<p>The Interagency Council for Patient Safety and Excellence in Health Care should develop a mechanism for quality measurement and data analysis and reporting,</p>

<i>Legislative Mandate</i>	<i>Subcommittee Recommendations</i>
	<p>which includes the following components:</p> <ul style="list-style-type: none"> A. A quality public report should be developed utilizing a risk-adjustment methodology with protections for confidential health care practitioner, provider, entity, and patient information. B. Corrective actions taken following adverse incidents should be disseminated in a periodic advisory to reporting entities so loss prevention systems can be implemented that will result in improved patient care. C. Best practices identified through the collection and analysis of the quality indicators should be shared with reporting entities through a periodic advisory to advance loss prevention activities and improvement of patient care. D. Aggregated data should be made available to assigned users on the Internet-based system for tracking and benchmarking. <i>(Motion passed unanimously)</i>
<p>6. Develop quality measures that enhance and improve the ability to evaluate and improve care.</p>	<p>The Center for Patient Safety and Excellence in Health Care should develop and oversee the implementation of a plan for research and development regarding health care quality measurement and reporting, with the following functions:</p> <ul style="list-style-type: none"> A. At a minimum, the plan should be reviewed and updated annually, and should identify state and federal resources available to facilitate the work of the research and development plan. B. Prioritize research and development initiatives. C. Develop partnerships with faculty at public and private state universities who are experts in health care quality measurement, health services research, and outcomes research. (These experts might be in schools of medicine, public health, nursing and health services). D. Report the health care quality research and development findings and best practices for the distribution, as appropriate, to health care practitioners and providers and consumers, using multi-media approaches. <i>(Motion passed unanimously)</i>
<p>7. Make recommendations regarding research and development needed to advance quality measurement and reporting.</p>	<p>The Center for Patient Safety and Excellence in Health Care and its partners should:</p> <ul style="list-style-type: none"> A. Apply for and participate in health care quality demonstration projects. B. Apply to National Institutes of Health (NIH) and Agency for Healthcare Research and Quality (AHRQ), and others for funding to conduct health care quality research. C. Pursue other sources of funding, as appropriate. <i>(Motion passed unanimously)</i>

In addition to the proposals presented by the subcommittees, the commission decided to discuss several recommendations not formally brought forth by either subcommittee. The Florida Association of Homes for the Aging submitted the following proposals that were considered by the commission:

1. **Require each nursing home to implement a quality assurance program directed by an interdisciplinary team that meets at least every other month. (*Motion passed unanimously*)**
2. **Require the Agency for Health Care Administration to implement a continuous quality improvement educational program that consists of training modules for specific topics. (*Motion passed unanimously*)**
3. **Require the Agency for Health Care Administration to create a list-serve that members of quality assurance committees can use to ask and respond to questions about best practices and quality of care issues. (*Motion passed unanimously*)**

Glossary

- I. Adverse Incident (as defined in s. 395.0197(5), F.S.) – An event over which health care personnel could exercise control and which is associated in whole or in part with medical intervention, rather than the condition for which such intervention occurred, and**
- A. Results in one of the following injuries:**
 - 1. Death.**
 - 2. Brain or spinal damage.**
 - 3. Permanent disfigurement.**
 - 4. Fracture or dislocation of bones or joints.**
 - 5. A resulting limitation of neurological, physical, or sensory function, which continues after discharge from the facility.**
 - 6. Any condition that required specialized medical attention or surgical intervention resulting from non-emergency medical intervention, other than an emergency medical condition, to which the patient has not given his or her informed consent.**
 - 7. Any condition that required the transfer of the patient, within or outside the facility, to a unit providing a more acute level of care due to the adverse incident, rather than the patient's condition prior to the adverse incident.**
 - B. Was the performance of a surgical procedure on the wrong patient, a wrong surgical procedure, a wrong-site surgical procedure, or a surgical procedure otherwise unrelated to the patient's diagnosis or medical condition?**
 - C. Required surgical repair of damage resulting to a patient from a planned surgical procedure, where the damage was not a recognized specific risk, as disclosed to the patient and documented through the informed-consent process.**
 - D. Was a procedure to remove unplanned foreign objects remaining from a surgical procedure?**
- II. Adverse Incident (as defined in ss. 458.351 and 459.026, F.S.) - An event over which the physician or licensee could exercise control and which is associated in whole or in part with a medical intervention, rather than the condition for which such intervention occurred, and which results in the following patient injuries:**
- A. The death of a patient.**
 - B. Brain or spinal damage to a patient.**
 - C. The performance of a surgical procedure on the wrong patient.**
 - 1. The performance of a wrong-site surgical procedure.**
 - 2. The performance of a wrong surgical procedure.**
 - 3. The surgical repair of damage to a patient resulting from a planned s**

4. **Surgical procedure where the damage is not a recognized specific risk as disclosed to the patient and documented through the informed consent process, if it results in death, brain or spinal damage; permanent disfigurement not to include the incision scar; fracture or dislocation of bones or joints; a limitation of neurological, physical, or sensory function; or any condition that required the transfer of the patient.**
 - D. **A procedure to remove unplanned foreign objects remaining from a surgical procedure.**
 - E. **Any condition that required the transfer of a patient to a hospital licensed under chapter 395 from an ambulatory surgical center licensed under chapter 395 or any facility or any office maintained by a physician for the practice of medicine, which is not licensed under chapter 395.**
- III. **Code 15 - A comprehensive report filed by a facility or a physician on an adverse incident that must be reported within a certain time frame.**
- IV. **Commission – Florida Commission on Excellence in Health Care.**
- V. **Health Care Error (as defined in the Institute of Medicine Report entitled, "To Err is Human") – An unintended act, by omission or commission.**
- VI. **Health Care Practitioner – Any person licensed under chapter 457, chapter 458, chapter 459; chapter 460; chapter 461; chapter 462; chapter 463; chapter 464; chapter 465; chapter 466; chapter 467; part I, part II, part III, part V, part X, part XIII, or part XIV of chapter 468; chapter 478; chapter 480; part III or part IV of chapter 483; chapter 484; chapter 486; chapter 490; or chapter 491, Florida Statutes.**
- VII. **Health Care Provider – Any health care facility or other health care organization licensed or certified to provide approved medical and allied health services in Florida.**

Appendices

Appendix 1: Enacting Legislation

Appendix 2: Commission Membership List

Appendix 3: Summary of Meeting Minutes

Appendix I

Enacting Legislation

Chapter 2000-256

Section 33. Florida Commission on Excellence in Health Care. —

(1) LEGISLATIVE FINDINGS AND INTENT. —The Legislature finds that the health care delivery industry is one of the largest and most complex industries in Florida. The Legislature finds that the current system of regulating health care practitioners and health care providers is one of blame and punishment and does not encourage voluntary admission of errors and immediate corrective action on a large scale. The Legislature finds that previous attempts to identify and address areas that impact the quality of care provided by the health care industry have suffered from a lack of coordination among the industry’s stakeholders and regulators. The Legislature finds that additional focus on strengthening health care delivery systems by eliminating avoidable mistakes in the diagnosis and treatment of Floridians holds tremendous promise to increase the quality of health care services available to Floridians, thereby reducing the costs associated with medical mistakes and malpractice and in turn increasing access to health care in the state. To achieve this enhanced focus, it is the intent of the Legislature to create the Florida Commission on Excellence in Health Care To facilitate the development of a comprehensive statewide strategy for improving health care delivery systems through meaningful reporting standards, data collection and review, and quality measurement.

(2) DEFINITIONS. —As used in this act, the term:

- (a) “Agency”** means the Agency for Health Care Administration.
- (b) “Commission”** means the Florida Commission on Excellence in Health Care.
- (c) “Department”** means the Department of Health.
- (d) “Error,”** with respect to health care, means an unintended act, by omission or commission.
- (e) “Health care practitioner”** means any person licensed under chapter 457; chapter 458; chapter 459; chapter 460; chapter 461; chapter 462; chapter 463; chapter 464; chapter 465; chapter 466; chapter 467; part I, part II, part III, part V, part X, part XIII, or part XIV of chapter 468; chapter 478; chapter 480; part III or part IV of chapter 483; chapter 484; chapter 486;

chapter 490; or chapter 491, Florida Statutes.

(f) “Health care provider” means any health care facility or other health care organization licensed or certified to provide approved medical and allied health services in this state.

(3) COMMISSION; DUTIES AND RESPONSIBILITIES.—There is hereby created the Florida Commission on Excellence in Health Care. The commission shall:

- (a) Identify existing data sources that evaluate quality of care in Florida and collect, analyze, and evaluate this data.**
- (b) Establish guidelines for data sharing and coordination.**
- (c) Identify core sets of quality measures for standardized reporting by appropriate components of the health care continuum.**
- (d) Recommend a framework for quality measurement and outcome reporting.**
- (e) Develop quality measures that enhance and improve the ability to evaluate and improve care.**
- (f) Make recommendations regarding research and development needed to advance quality measurement and reporting.**
- (g) Evaluate regulatory issues relating to the pharmacy profession and recommend changes necessary to optimize patient safety.**
- (h) Facilitate open discussion of a process to ensure that comparative information on health care quality is valid, reliable, comprehensive, understandable, and widely available in the public domain.**
- (i) Sponsor public hearings to share information and expertise, identify “best practices,” and recommend methods to promote their acceptance.**
- (j) Evaluate current regulatory programs to determine what changes, if any, need to be made to facilitate patient safety.**
- (k) Review public and private health care purchasing systems to determine if there are sufficient mandates and incentives to facilitate continuous improvement in patient safety.**
- (l) Analyze how effective existing regulatory systems are in ensuring continuous competence and knowledge of effective safety practices.**
- (m) Develop a framework for organizations that license, accredit, or credential health care practitioners and health care providers to more quickly and effectively identify unsafe providers and practitioners and to take action necessary to remove the unsafe provider or practitioner from practice or operation until such time as the practitioner or provider has proven safe to practice or operate.**
- (n) Recommend procedures for development of a curriculum on patient safety and methods of incorporating such curriculum into training, licensure, and certification requirements.**
- (o) Develop a framework for regulatory bodies to disseminate information on patient safety to health care practitioners, health care providers, and consumers through conferences, journal articles and editorials, newsletters, publications, and Internet websites.**
- (p) Recommend procedures to incorporate recognized patient safety considerations**

into practice guidelines and into standards related to the introduction and diffusion of new technologies, therapies, and drugs.

(q) Recommend a framework for development of community-based collaborative initiatives for error reporting and analysis and implementation of patient safety improvements.

(r) Evaluate the role of advertising in promoting or adversely affecting patient safety.

(s) Evaluate and make recommendations regarding the need for licensure of additional persons who participate in the delivery of health care to Floridians, including, but not limited to, surgical technologists and pharmacy technicians.

(t) Evaluate the benefits and problems of the current disciplinary systems and make recommendations regarding alternatives and improvements.

(4) MEMBERSHIP, ORGANIZATION, MEETINGS, PROCEDURES, STAFF.—

(a) The commission shall consist of:

1. The Secretary of Health and the Executive Director of the Agency for Health Care Administration.

2. One representative each from the following agencies or organizations: the Board of Medicine, the Board of Osteopathic Medicine, the Board of Pharmacy, the Board of Nursing, the Board of Dentistry, the Florida Dental Association, the Florida Medical Association, the Florida Osteopathic Medical Association, the Florida Academy of Physician Assistants, the Florida Chiropractic Society, the Florida Chiropractic Association, the Florida Podiatric Medical Association, the Florida Society of Ambulatory Surgical Centers, the Florida Statutory Teaching Hospital Council, Inc., the Florida Statutory Rural Hospital Council, the Florida Nurses Association, the Florida Organization of Nursing Executives, the Florida Pharmacy Association, the Florida Society of Health System Pharmacists, Inc., the Florida Hospital Association, the Association of Community Hospitals and Health Systems of Florida, Inc., the Florida League of Health Care Systems, the Florida Health Care Risk Management Advisory Council, the Florida Health Care Association, and the Florida Association of Homes for the Aging;

3. One licensed clinical laboratory director, appointed by the Secretary of Health;

4. Two health lawyers, appointed by the Secretary of Health, one of who shall be a member of The Florida Bar Health Law Section who defends physicians and one of whom shall be a member of the Florida Academy of Trial Lawyers;

5. One representative of the medical malpractice professional liability insurance industry, appointed by the Secretary of Health;

6. One representative of a Florida medical school appointed by the Secretary of Health;

7. Two representatives of the health insurance industry, appointed by

the Executive Director of the Agency for Health Care Administration, one of who shall represent indemnity plans and one of who shall represent managed care;

8. Five consumer advocates, consisting of one from the Association for Responsible Medicine, two appointed by the Governor, one appointed by the President of the Senate, and one appointed by the Speaker of the House of Representatives; and

9. Two legislators, one appointed by the President of the Senate and one appointed by the Speaker of the House of Representatives.

Commission membership shall reflect the geographic and demographic diversity of the state.

(b) The Secretary of Health and the Executive Director of the Agency for Health Care Administration shall jointly chair the commission. Subcommittees shall be formed by the joint chairs, as needed, to make recommendations to the full commission on the subjects assigned. However, all votes on work products of the commission shall be at the full commission level, and all recommendations to the Governor, the President of the Senate, and the Speaker of the House of Representatives must pass by a two-thirds vote of the full commission. Sponsoring agencies and organizations may designate an alternative member who may attend and vote on behalf of the sponsoring agency or organization in the event the appointed member is unable to attend a meeting of the commission or any subcommittee. The commission shall be staffed by employees of the Department of Health and the Agency for Health Care Administration. Sponsoring agencies or organizations must fund the travel and related expenses of their appointed members on the commission. Travel and related expenses for the consumer members of the commission shall be reimbursed by the state pursuant to s. 112.061, Florida Statutes. The commission shall hold its first meeting no later than July 15, 2000.

(5) EVIDENTIARY PROHIBITIONS.—

(a) The findings, recommendations, evaluations, opinions, investigations, proceedings, records, reports, minutes, testimony, correspondence, work product, and actions of the commission shall be available to the public, but may not be introduced into evidence at any civil, criminal, special, or administrative proceeding against a health care practitioner or health care provider arising out of the matters, which are the subject of the findings of the commission. Moreover, no member of the commission shall be examined in any civil, criminal, special, or administrative proceeding against a health care practitioner or health care provider as to any evidence or other matters produced or presented during the proceedings of this commission or as to any findings, recommendations, evaluations, opinions, investigations, proceedings, records, reports, minutes, testimony, correspondence, work product, or other actions of the commission or any members thereof. However, nothing in this section shall be construed to mean that information, documents, or records otherwise available and obtained from original sources are

immune from discovery or use in any civil, criminal, special, or administrative proceeding merely because they were presented during proceedings of the commission. Nor shall any person who testifies before the commission or who is a member of the commission be prevented from testifying as to matters within his or her knowledge in a subsequent civil, criminal, special, or administrative proceeding merely because such person testified in front of the commission.

(b) The findings, recommendations, evaluations, opinions, investigations, proceedings, records, reports, minutes, testimony, correspondence, work product, and actions of the commission shall be used as a guide and resource and shall not be construed as establishing or advocating the standard of care for health care practitioners or health care providers unless subsequently enacted into law or adopted in rule. Nor shall any findings, recommendations, evaluations, opinions, investigations, proceedings, records, reports, minutes, testimony, correspondence, work product, or actions of the commission be admissible as evidence in any way, directly or indirectly, by introduction of documents or as a basis of an expert opinion as to the standard of care applicable to health care practitioners or health care providers in any civil, criminal, special, or administrative proceeding unless subsequently enacted into law or adopted in rule.

(c) No person who testifies before the commission or who is a member of the commission may specifically identify any patient, health care practitioner, or health care provider by name. Moreover, the findings, recommendations, evaluations, opinions, investigations, proceedings, records, reports, minutes, testimony, correspondence, work product, and actions of the commission may not specifically identify any patient, health care practitioner, or health care provider by name.

(6) REPORT; TERMINATION.—The commission shall provide a report of its findings and recommendations to the Governor, the President of the Senate, and the Speaker of the House of Representatives no later than February 1, 2001. After submission of the report, the commission shall continue to exist for the purpose of assisting the Department of Health, the Agency for Health Care Administration, and the regulatory boards in their drafting of proposed legislation and rules to implement its recommendations and for the purpose of providing information to the health care industry on its recommendations. The commission shall be terminated June 1, 2001.

Chapter 2000-367

Section 33. Florida Commission on Excellence in Health Care.

(1) LEGISLATIVE FINDINGS AND INTENT.—The Legislature finds that the health care delivery industry is one of the largest and most complex industries in Florida. The Legislature finds that additional focus on strengthening health care delivery systems by eliminating avoidable mistakes in the diagnosis and treatment of Floridians holds tremendous promise to increase the quality of health care services available to Floridians. To achieve this enhanced focus, it is the intent of the Legislature to create the Florida Commission on Excellence in Health Care to facilitate the development of a comprehensive statewide strategy for improving health care delivery systems through meaningful reporting standards, data collection and review, and quality measurement.

(2) DEFINITIONS.—As used in this act, the term:

(a) “Agency” means the Agency for Health Care Administration.

(b) “Commission” means the Florida Commission on Excellence in Health Care.

(c) “Department” means the Department of Health.

(d) “Error,” with respect to health care, means an unintended act, by omission or commission.

(e) “Health care practitioner” means any person licensed under chapter 457; chapter 458; chapter 459; chapter 460; chapter 461; chapter 462; chapter 463; chapter 464; chapter 465; chapter 466; chapter 467; part I, part II, part III, part V, part X, part XIII, or part XIV of chapter 468; chapter 478; chapter 480; part III or part IV of chapter 483; chapter 484; chapter 486; chapter 490; or chapter 491, Florida Statutes.

(f) “Health care provider” means any health care facility or other health care organization licensed or certified to provide approved medical and allied health services in this state.

(3) COMMISSION; DUTIES AND RESPONSIBILITIES.—There is created the Florida Commission on Excellence in Health Care. The commission shall:

(a) Identify existing data sources that evaluate quality of care in Florida and collect, analyze, and evaluate this data.

(b) Establish guidelines for data sharing and coordination.

(c) Identify core sets of quality measures for standardized reporting by appropriate components of the health care continuum.

(d) Recommend a framework for quality measurement and outcome reporting.

(e) Develop quality measures that enhance and improve the ability to evaluate and improve care.

- (f) Make recommendations regarding research and development needed to advance quality measurement and reporting.**
- (g) Evaluate regulatory issues relating to the pharmacy profession and recommend changes necessary to optimize patient safety.**
- (h) Facilitate open discussion of a process to ensure that comparative information on health care quality is valid, reliable, comprehensive, understandable, and widely available in the public domain.**
- (i) Sponsor public hearings to share information and expertise, identify “best practices,” and recommend methods to promote their acceptance.**
- (j) Evaluate current regulatory programs to determine what changes, if any, need to be made to facilitate patient safety.**
- (k) Review public and private health care purchasing systems to determine if there are sufficient mandates and incentives to facilitate continuous improvement in patient safety.**
- (l) Analyze how effective existing regulatory systems are in ensuring continuous competence and knowledge of effective safety practices.**
- (m) Develop a framework for organizations that license, accredit, or credential health care practitioners and health care providers to more quickly and effectively identify unsafe providers and practitioners and to take action necessary to remove the unsafe provider or practitioner from practice or operation until such time as the practitioner or provider has proven safe to practice or operate.**
- (n) Recommend procedures for development of a curriculum on patient safety and methods of incorporating such curriculum into training, licensure, and certification requirements.**
- (o) Develop a framework for regulatory bodies to disseminate information on patient safety to health care practitioners, health care providers, and consumers through conferences, journal articles and editorials, newsletters, publications, and Internet websites.**
- (p) Recommend procedures to incorporate recognized patient safety considerations into practice guidelines and into standards related to the introduction and diffusion of new technologies, therapies, and drugs.**
- (q) Recommend a framework for development of community-based collaborative initiatives for error reporting and analysis and implementation of patient safety improvements.**
- (r) Evaluate the role of advertising in promoting or adversely affecting patient safety.**

(4) MEMBERSHIP, ORGANIZATION, MEETINGS, PROCEDURES, STAFF.—

(a) The commission shall consist of:

- 1. The Secretary of Health and the Director of Health Care Administration;**
- 2. One representative each from the following agencies or organizations: the Board of Medicine, the Board of Osteopathic Medicine, the Board of Pharmacy, the Board of Dentistry, the Board of Nursing, the Florida Dental Association, the Florida Medical Association, the Florida Osteopathic**

Medical Association, the Florida Chiropractic Association, the Florida Chiropractic Society, the Florida Podiatric Medical Association, the Florida Nurses Association, the Florida Organization of Nursing Executives, the Florida Pharmacy Association, the Florida Society of Health System Pharmacists, Inc., the Florida Hospital Association, the Association of Community Hospitals and Health Systems of Florida, Inc., the Florida League of Health Systems, the Florida Health Care Risk Management Advisory Council, the Florida Health Care Association, the Florida Statutory Teaching Hospital Council, Inc., the Florida Statutory Rural Hospital Council, the Florida Association of Homes for the Aging, and the Florida Society for Respiratory Care;

3. Two health lawyers, appointed by the Secretary of Health, one of whom must be a member of the Health Law Section of The Florida Bar who defends physicians and one of whom must be a member of the Academy of Florida Trial Lawyers;

4. Two representatives of the health insurance industry, appointed by the Director of Health Care Administration, one of whom shall represent indemnity plans and one of whom shall represent managed care;

5. Five consumer advocates, consisting of one from the Association for Responsible Medicine, two appointed by the Governor, one appointed by the President of the Senate, and one appointed by the Speaker of the House of Representatives;

6. Two legislators, one appointed by the President of the Senate and one appointed by the Speaker of the House of Representatives; and

7. One representative of a Florida medical school appointed by the Secretary of Health.

Commission membership shall reflect the geographic and demographic diversity of the state.

(b) The Secretary of Health and the Director of Health Care Administration shall jointly chair the commission. Subcommittees shall be formed by the joint chairs, as needed, to make recommendations to the full commission on the subjects assigned. However, all votes on work products of the commission shall be at the full commission level, and all recommendations to the Governor, the President of the Senate, and the Speaker of the House of Representatives must pass by a two-thirds vote of the full commission.

Sponsoring agencies and organizations may designate an alternative member who may attend and vote on behalf of the sponsoring agency or organization in the event the appointed member is unable to attend a meeting of the commission or any subcommittee. The commission shall be staffed by employees of the Department of Health and the Agency for Health Care Administration. Sponsoring agencies or organizations must fund the travel and

related expenses of their appointed members on the commission. Travel and related expenses for the consumer members of the commission shall be reimbursed by the state pursuant to section 112.061, Florida Statutes. The commission shall hold its first meeting no later than July 15, 2000.

(5) EVIDENTIARY PROHIBITIONS.—

(a) The findings, recommendations, evaluations, opinions, investigations, proceedings, records, reports, minutes, testimony, correspondence, work product, and actions of the commission shall be available to the public, but may not be introduced into evidence at any civil, criminal, special, or administrative proceeding against a health care practitioner or health care provider arising out of the matters, which are the subject of the findings of the commission. Moreover, no member of the commission shall be examined in any civil, criminal, special, or administrative proceeding against a health care practitioner or health care provider as to any evidence or other matters produced or presented during the proceedings of this commission or as to any findings, recommendations, evaluations, opinions, investigations, proceedings, records, reports, minutes, testimony, correspondence, work product, or other actions of the commission or any members thereof. However, nothing in this section shall be construed to mean that information, documents, or records otherwise available and obtained from original sources are immune from discovery or use in any civil, criminal, special, or administrative proceeding merely because they were presented during proceedings of the commission. Nor shall any person who testifies before the commission or who is a member of the commission be prevented from testifying as to matters within his or her knowledge in a subsequent civil, criminal, special, or administrative proceeding merely because such person testified in front of the commission.

(b) The findings, recommendations, evaluations, opinions, investigations, proceedings, records, reports, minutes, testimony, correspondence, work product, and actions of the commission shall be used as a guide and resource and shall not be construed as establishing or advocating the standard of care for health care practitioners or health care providers unless subsequently enacted into law or adopted in rule. Nor shall any findings, recommendations, evaluations, opinions, investigations, proceedings, records, reports, minutes, testimony, correspondence, work product, or actions of the commission be admissible as evidence in any way, directly or indirectly, by introduction of documents or as a basis of an expert opinion as to the standard of care applicable to health care practitioners or health care providers in any civil, criminal, special, or administrative proceeding unless subsequently enacted into law or adopted in rule.

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(6) REPORT; TERMINATION.—The commission shall provide a report of its findings and recommendations to the Governor, the President of the

Senate, and the Speaker of the House of Representatives no later than February 1, 2001. After submission of the report, the commission shall continue to exist for the purpose of assisting the Department of Health, the Agency for Health Care Administration, and the regulatory boards in their drafting of proposed legislation and rules to implement its recommendations and for the purpose of providing information to the health care industry on its recommendations. The commission shall be terminated June 1, 2001.

Appendix II

Florida Commission on Excellence in Health Care Membership List

Organization Represented	Members
<i>Department of Health</i>	<i>Robert G. Brooks, M.D., Secretary</i>
<i>Agency for Health Care Administration</i>	<i>Ruben J. King-Shaw, Jr., Secretary</i>
<i>Board of Medicine</i>	<i>Georges El-Bahri, M.D.</i>
<i>Board of Osteopathic Medicine</i>	<i>Robert Panzer, D.O.</i>
<i>Board of Pharmacy</i>	<i>Leonard Inge, RPh.</i>
<i>Board of Dentistry</i>	<i>Charles Ross, D.D.S.</i>
<i>Board of Nursing</i>	<i>Cathy Oles, LPN</i>
<i>Florida Dental Association</i>	<i>Lee Cohen, D.D.S., M.S.</i>
<i>Florida Medical Association</i>	<i>Arthur Palamara, M.D.</i>
<i>Florida Academy of Physician Assistants</i>	<i>Mary P. Ettari, MPH, PA-C</i>
<i>Florida Osteopathic Medical Association</i>	<i>Dianne Pappachristou, D.O.</i>
<i>Florida Chiropractic Association</i>	<i>Greg Hollstrom, D.C.</i>
<i>Florida Chiropractic Society</i>	<i>Kevin Fogarty, D.C.</i>
<i>Florida Podiatric Medical Association</i>	<i>Robert Frimmel, D.P.M.</i>
<i>Florida Nurses Association</i>	<i>Jacqueline Byers, PhD., RN</i>
<i>Florida Organization of Nursing Executives</i>	<i>Alice Lanford</i>
<i>Florida Pharmacy Association</i>	<i>Michael Jackson, R.Ph.</i>
<i>Florida Society of Health System Pharmacists, Inc.</i>	<i>Alan Knudsen, R.Ph.</i>
<i>Florida Hospital Association</i>	<i>Susie White, Ph.D.</i>
<i>Association of Community Hospitals and Health Systems of Florida, Inc.</i>	<i>Karen Peterson, Esquire</i>
<i>Florida League of Health Systems</i>	<i>Alan Levine</i>
<i>Florida Health Care Risk Management Advisory Council</i>	<i>Sherrie Manulak</i>
<i>Florida Health Care Association</i>	<i>Terry Goodman</i>
<i>Florida Society of Ambulatory Surgical Centers</i>	<i>David Shapiro, M.D.</i>
<i>Florida Statutory Teaching Hospital Council, Inc.</i>	<i>Michael Pinnell, M.D.</i>
<i>Florida Statutory Rural Hospital Council</i>	<i>Robert Snyder</i>
<i>Florida Association of Homes for the Aging</i>	<i>Theresa Mortimer Bertram</i>
<i>Florida Society for Respiratory Care</i>	<i>Earnestine Thompson, MS, RRT</i>
<i>Licensed Clinical Laboratory Director</i>	<i>Roger Donahue, Ph.D.</i>
<i>Health Lawyer (Representing the Health Law Section of the Florida Bar)</i>	<i>Bruce Lamb, Esquire</i>
<i>Health Lawyer (Representing the Academy of Florida Trial Lawyers)</i>	<i>Neal Roth, Esquire</i>
<i>Medical Malpractice Professional Liability Insurance Industry Representative</i>	<i>Beth Rominger</i>
<i>Health Insurance Industry Representative (Indemnity)</i>	<i>Rhonda Medows, M.D.</i>

***Florida Commission on Excellence in Health Care
Membership List (cont'd)***

<i>Health Insurance Industry Representative (Managed Care)</i>	<i>Ted Nichols, Esquire</i>
<i>Consumer Advocate</i>	<i>Ray McEachern</i>
<i>Consumer Advocate</i>	<i>Lena Juarez</i>
<i>Consumer Advocate</i>	<i>May Wong-Chou, Esquire</i>
<i>Consumer Advocate</i>	<i>Violet Nikolici</i>
<i>Legislator (Representing the Florida Senate)</i>	<i>Senator Ronald Silver, District 38</i>
<i>Legislator (Representing the Florida House of Representatives)</i>	<i>Carole Green, District 75</i>
<i>Florida Medical School Representative (University of Florida)</i>	<i>Timothy Flynn, M.D.</i>

Appendix III

Summary of Meeting Minutes

Florida Commission on Excellence in Health Care

Organizational Meeting

Friday, July 14, 2000

Hyatt Hotel, Orlando International Airport

Rooms 5 & 6, Intercontinental Room -- 10:00 a.m. - 4:00 p.m.

MINUTES

(Meeting Facilitator: Secretary Ruben J. King-Shaw, Jr.)

Members Present

Robert G. Brooks, M.D.	Secretary, DOH
Ruben King-Shaw	Secretary, AHCA
Georges El-Bahri, M.D.	Board of Medicine
Robert Panzer, D.O.	FOMA (Substituting for Dr. Moran)
Leonard Inge, RPh.	Board of Pharmacy
Cathy Oles, LPN	Board of Nursing
Charles Ross, D.D.S.	Board of Dentistry
Betty Hughes	Florida Dental Association
Arthur Palamara, M.D.	Florida Medical Association
Dianne Pappachristou, D.O.	Florida Osteopathic Medical Association
Mary Ettari, MPH, PA-C	Florida Academy of Physician Assistants
Kevin Fogarty, D.C.	Florida Chiropractic Society
Greg Hollstrom, D.C.	Florida Chiropractic Association
Robert Frimmel, D.P.M.	Florida Podiatric Association
Robert Snyder	Florida Statutory Rural Hospital Council
Jacqueline Byers, PhD, RN	Florida Nurses Association
Alice Lanford	Florida Organization of Nurses Executives
Susie White, PhD.	Florida Hospital Association
Karen Peterson	Association of Community Hospitals & Health Systems of FL
Sherry Manulak	Florida Health Care Risk Mgmt Advisory Council
Terry Goodman	Florida Health Care Association
Theresa Mortimer Bertram	Florida Association of Homes for the Aging
Earnestine "Mikki" Thompson	Florida Society for Respiratory Care
Roger Donahue, Ph.D	Licensed Clinical Laboratory Director
Bruce Lamb, Esquire	Health Lawyer
Neal Roth, Esquire	Health Lawyer
Beth Rominger	Medical Malpractice Profession Liability Insurance Industry

Timothy Flynn, M.D.	Florida Medical School Representative
Rhonda Medows, M.D.	Health Insurance Industry (Indemnity)
Ted Nichols	Health Insurance Industry (Managed Care)
Ray McEachern	Consumer Advocate (Association for Responsible Medicine)
Elena Juarez	Consumer Advocate (Appointed by Senate President)
Senator Ronald Silver	Legislator (Appointed by the Senate President)
Absent:	
Michael Pinell, M.D., M.H.A.	Florida Statutory Teaching Hospital
David Shapiro, M.D.	Florida Society of Ambulatory Surgical Centers
Michael Jackson, R.P.h.	Florida Pharmacy Association
Alan Knudsen	Florida Society of Health System Pharmacists
Ralph Glatfelter	Florida League of Health Care Systems
Representative Carole Green	Legislator (Appointed by the House Speaker)

- I. Welcome Secretary Ruben King-Shaw
Secretary Robert G. Brooks, M.D.
- II. Introduction of Commission Members
- III. General Comments by Joint Chairpersons Secretary Robert G. Brooks, M.D.
Secretary Ruben King-Shaw
- IV. Overview of Commission Duties and Responsibilities Gloria C. Henderson
(Legislative Mandate)

Ms. Henderson gave an overview of the Legislation that passed in the 2000 Legislative Session creating the Florida Commission on Excellence in Health Care and its purpose. Following are suggested sub-committees:

- Quality Measurement/Data Collection and Reporting
- Regulation
- Education/Best Practices

- V. Discussion of Administrative Issues Secretary Ruben King-Shaw

Secretary King-Shaw discussed the following administrative issues;

- Parliamentary Procedures – The Commission adopted Robert’s Rules of Order.
- Travel and Reimbursement – Packets were given to the Commission consumer members to submit for travel reimbursement.
- Evidentiary Prohibitions - William Large, attorney for the Department of Health, discussed Florida’s Government in the Sunshine law. The Commission will function in the same way boards do in that discussions between members concerning Commission business must be noticed in the Florida Administrative Weekly. All full Commission and sub-committee meetings will be noticed. Minutes of those meetings will be posted on the MQA Web-site, www.doh.state.fl.us/mqa/. Additionally, Mr. Large explained that all findings and recommendations of the

Commission are public record and nothing discussed by the Commission can be used as evidentiary findings. Senator Silver suggested inviting the Commission on Ethics to attend the next meeting to give an overview of Sunshine issues..

VI. *Discussion of Organizational Issues*

Secretary Ruben King-Shaw

- Sub-committees - The Commission discussed attendance at sub-committee and full Commission meetings. The Commission requested the attendance policy be left open. Staff will get the name of an alternate from each organization represented. If the member and/or the alternate miss a meeting, whoever is going to attend the next meeting must ensure they are educated about the issues enabling them to cast an informed vote.
The Commission requested they be provided with a list of all members and alternates names, mailing addresses, telephone and fax numbers, and email address if available.
- Sub-committee Membership and Assignments – Secretary King-Shaw requested members complete the sub-committee sign-up sheet prioritizing their preference of the sub-committees for which their expertise would be most beneficial to the Commission.
- Report of Findings and Recommendations – The law specifies the Commission shall provide a report of its findings and recommendations to the Governor, the President of the Senate, and the Speaker of the House of Representatives no later than February 1, 2001.
 - Commission Tenure – Pursuant to CS/HB 2339 and CS/SB 2034, the Commission shall continue to exist for the purpose of assisting the Department of Health, the Agency for Health Care Administration, and the regulatory boards in their drafting of proposed legislation and rules to implement its recommendations, and for the purpose of providing information to the health care industry on its recommendations. The Commission shall be terminated June 1, 2001.

LUNCH

There was some clarification needed by the members regarding their role in analyzing the quality of health care. Did this apply to all health care practitioners and all levels of health care? Dr. Brooks suggested the commission might consider inviting a representative from the Institute of Medicine to discuss the report issued this past year, "To Err is Human," which may help to clarify their task. All members agreed this would be beneficial.

At the suggestion of Dr. Brooks, members were asked to share knowledge of what types of "Quality Initiatives" they are aware of or working with in the health care industry. Following is a list of organizations mentioned by the members:

- Institute of Medicine
- National Safety Foundation (NPSF)
- Patient Safety Steering Committee
- Beyond Blame - Video
- National Resource Collecting Data for VA
- Florida Board of Pharmacy's Peer Review Committee
- Florida Health Care Risk Management Advisory Council
- Chiropractic Association
- Association for Responsible Medicine

- Blind Eye - Book

On-going Quality Initiatives discussed by the members included the Florida Board of Medicine's initiatives concerning Alternative Medicine in Chelation Therapy and Office Based Surgery. The Florida Board of Dentistry has recommended their anesthesiologists report any adverse incidents. The Florida Nurses Association, together with the Florida Organization of Nurse Executives and the Agency for Health Care Administration, is working on a three-year pilot project looking at the nursing shortage and how it is impacting the quality of health care. The Florida Hospital Association and the Agency for Health Care Administration is currently working on several quality initiatives such as current reporting and evaluation of the data reported. The Florida Health Care Risk Management Advisory Council and the Agency for Health Care Administration are currently studying data collection, surveying process, handling of code 15s, and Risk Management and Continuing Education programs. The Chiropractic Association has been tracking quality issues for the past five years, and the Florida Board of Nursing has been part of a Task Force mandated by the 1997 Legislature, analyzing continued competency. The members involved in these initiatives agreed to share information with the Commission at future meetings.

VII. Presentations on Regulatory Data Currently Collected

- A. Agency for Health Care Administration Scott Hopes

Mr. Hopes gave the Commission an overview of current data collection by the Agency for Health Care Administration, which included:

- Data on Quality of Care/Measurement/Outcome Reporting
Hospital Inpatient Discharge Data & Ambulatory Surgery Outpatient Visit Data
Identifying, demographic, and visit data elements are collected
 - HMO Quality Indicators
Quality indicators will be collected on Florida commercial, Medicaid & Medicare provider plans
 - Florida Medicaid Management Information System
Comprehensive data on claims submitted to Medicaid, data on services, prescribed drugs and diagnosis
 - Medicaid/PRO Contracts
Utilization – Medical Necessity Reviews
 - Managed Care & Health Quality
Statewide Provider and Subscriber Assistance Program – Unresolved subscriber grievances against Health Maintenance Organizations.
 - HMO Hotline
Complaints/inquiries regarding Health Maintenance Organizations
 - Managed Care & Health Quality/Consumer Services/ISU
Enforcement & Statistics Performance Measurements
 - Managed Care & Health Quality/Long Term Care
Administrative Actions Tracking
Aspen – Facility Characteristics and Certification Survey Results
- FRAES – Florida Regulatory Administration and Enforcement System

- Licensing; Complaints; Inspections and others
- Managed Care & Health Quality/HSQU
Informal Dispute Resolution Tracking

Minimum Data Set – Nursing Home and Resident Characteristics; Quality Indicators

- Oasis – Outcome and Assessment Information Set; Home Health Agency Characteristics, Patient Characteristics and Quality Indicators.
- Oscar – Online Survey and Certification Reporting System; Facility Characteristics, Certification Survey Results and Owner
- *Managed Care & Health Quality/Health Standards & Quality Unit*
Quality of Care Monitoring Program Facility Visits
- Managed Care & Health Quality Managed Health Care/Medicaid HMO Contracts and Oversight Unit
Medicaid HMO Quality of Care Measures
- Managed Care & Health Quality/Consumer Services/ISU
New and Change of Location Reports
Pending Inspection Reports
- Managed Care and Health Quality/Risk Management
Adverse Incidents and Malpractice Actions
- Managed Care & Health Quality/Consumer Services/ISU
Monthly Critical Business Measures
Hospital Discipline Reports
Quarterly Probation Monitoring Reports
- Managed Care & Health Quality/CON & Financial Analysis
Utilization data on Florida Hospital Beds and Transplants, Open Heart Surgery and Cardiac Catheterization Program, Community Nursing Homes, Hospital-Based Skilled Nursing and Hospice Admissions
- Managed Care & Health Quality/Managed Care/Healthcare & Facility Regulation
Hospital Financial Data and Utilization Statistics
Nursing Home Financial Data Utilization Statistics
- Managed Care & Health Quality/Managed Health Care/Commercial HMO Compliance
Accreditation Organization HMO Survey Criteria
Comprehensive HMO Provider Network Data

VII. Presentations on Regulatory Data Currently Collected

B. Department of Health

Meade Grigg

Meade Grigg gave an overview of the data the Department of Health currently collects and maintains in three broad categories:

- Health Client Service Data
- Community Health Assessment & Disease Surveillance Data
- Licensure, Certification & Regulatory Data
- Health Client Service Data is collected to assist in the management of local clinic operations, patient case management, and local management reporting. The data are

collected through the Client Services Data System (CMS) and the County Health Department Client Information and Clinic Management System.

- Community Health Assessment & Disease Surveillance Data are collected to assess the health status of Florida communities through the monitoring of diseases, risk factors and behaviors. Additionally, this data provide the basis for epidemiological investigations, program policy development, program implementation and evaluation. This type of data collection includes cause of death; morbidity by disease type; mortality by cause of death; risk factor information.
- Licensure, Certification & Regulatory Data are collected to assist in administration and management of the licensing, certification, and regulatory functions associated with health care practitioners, facilities, and equipment. Data collected include license history, education/training, board certification, specialties, complaint and investigation and disciplinary history.

Included in the agenda books was a Health Client Service Data Systems Matrix (attachment #1), which defines data collection by the Department, indicating whether or not the data collected are mandated or voluntary, confidential or public and whether there is Legislative change needed to collect or provide the data. Additionally, the chart shows if there is future enhancements scheduled, whether the public has access to the data, and if so, how the data are made available and disseminated?

VIII. Discussion of Efforts to Streamline Data Collection Requirements

Diane Orcutt

Ms. Orcutt gave an overview of the Practitioner Regulatory Administration and Enforcement System utilizing a slide of conceptual design (attachment #2), which follows the regulatory process from conception to completion. Next, Ms. Orcutt gave an overview of Data Collection and Reporting: Present Situation and Future Initiatives. She discussed issues of concern with the Commission relating to reporting, public pressure for information, adequate resources, funding, expertise, remediation methods, security of data, cost/burden on reporting entities, and training. She shared examples of existing national databases/reporting systems which included CDC, DOD, FDA, HCFA, HHS, HRSA, JCAHO, U.S. Pharmacopoeia and the VA, as well as, what the Federal Government and the Private Sector is currently doing.

- The Federal Government is currently requiring entities to report data to the National Practitioner Data Bank (NPDB), which was established in 1986 and implemented in 1990. Data required to be reported includes adverse licensure actions, adverse clinical privilege actions, adverse professional society membership actions and medical malpractice payments. Only adverse actions against allopathic and osteopathic physicians, and dentists are required to be reported. Access to information maintained in the NPDB is limited to hospitals; other health care entities that conduct peer review and provide or arrange for care, state licensing boards, and individual practitioners may self-query.
- The Health Insurance Portability and Accountability Act of 1996 created the Healthcare Integrity and Protection Data Bank (HIPDB), to help combat health care fraud and abuse by maintaining a data base of adverse actions to include

civil judgments related to the delivery of a health care item or service (excludes malpractice), Federal or State criminal convictions related to the delivery of a health care item or service, actions by Federal or State licensing or certification agencies, and exclusion from participation in Federal or State health care programs. Reporting is required of health care providers, suppliers and practitioners. Data are accessible to federal and state government agencies and health plans. Providers, suppliers and practitioners may self-query.

- President Clinton established the Quality Interagency Coordination Task Force (QuIC) in response to the final report of the President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry. The Task Force seeks to provide people with information to assist them in making choices about their care, improve the care delivered by Federal providers and purchased on behalf of Federal beneficiaries, as well as develop the infrastructure needed to improve the health care system.
- The National Quality Forum for Health Care Quality Measurement and Reporting is a not-for-profit organization created to develop and implement a national strategy for health care quality measurement and reporting. The Quality Forum has broad participation from all parts of the health care system, including national, state, regional, and local groups representing consumers, public and private purchasers, employers, health care professionals, provider organizations, health plans, accrediting bodies, labor unions, supporting industries, and organizations involved in health care research or quality improvement.

IX. Discussion of Future Meetings

The Commission agreed to meet in various locations throughout the State of Florida ensuring public testimony opportunities. The August meeting will be scheduled in either Jacksonville or Ft. Lauderdale. The September meeting will be held on the 26th in conjunction with "Capital for a Day" to be held in Panama City. Additional meetings will be scheduled at future meetings.

Some closing remarks and suggestions from Ms. Henderson of topics the sub-committees might consider include: duplication of data collection, regulatory agencies sharing data, disciplinary actions taken and their outcomes, data collection relevance, and electronic prescribing.

X. Closing Remarks

Secretary Brooks and Secretary King-Shaw thanked the members for their dedication to public safety and quality health care and reminded the Commission our goal is quality; reducing errors is how we reach that goal.

Staff Assignments:

- Obtain names of alternate members from each organization
- Provide members with names, phone/fax numbers and e-mail address of all members
- Invite representative from the Institute of Medicine to the next Commission meeting

- Invite representative from the Ethics Commission to speak about the Sunshine law.

The meeting was adjourned at 3:40 p.m.

The Commission as written at their August 16, 2000 meeting approved the minutes.

Florida Commission on Excellence in Health Care

Meeting

August 16, 2000

Sheraton Airport Hotel – 1825 Griffin Road, Dania, Florida
Salons 1 & 2- 10:00 a.m. - 5:00 p.m.

MINUTES

(Meeting Facilitator: Secretary Robert G. Brooks, M.D.)

Members Present

Robert G. Brooks, M.D.	Secretary, DOH
Ruben King-Shaw	Secretary, AHCA
Robert Panzer, D.O.	Board of Osteopathic Medicine
Leonard Inge, RPh.	Board of Pharmacy
Betty Taylor, RN (Alternate Member)	Board of Nursing
Charles Ross, D.D.S.	Board of Dentistry
Lee Cohen, D.D.S. (Alternate Member)	Florida Dental Association
Arthur Palamara, M.D.	Florida Medical Association
	Florida Osteopathic Medical Association
James Cary (Alternate Member)	Florida Academy of Physician Assistants
Kevin Fogarty, D.C.	Florida Chiropractic Society
Greg Hollstrom, D.C.	Florida Chiropractic Association
Robert Snyder	Florida Statutory Rural Hospital Council
Jacqueline Byers, PhD, RN	Florida Nurses Association
Alice Lanford	Florida Organization of Nurses Executives
Susie White, PhD.	Florida Hospital Association
Karen Peterson	Association of Community Hospitals & Health Systems of FL
	Florida Health Care Risk Mgmt Advisory Council
Sherrie Manulak	Florida Health Care Association
Bernard Roos, M.D. (Alternate Member)	Florida Association of Homes for the Aging
Theresa Mortimer Bertram	Florida Society for Respiratory Care
Earnestine "Mikki" Thompson	Licensed Clinical Laboratory Director
Roger Donahue, Ph.D	Health Lawyer
Bruce Lamb, Esquire	Health Lawyer
Jay Cohen, Esquire (Alternate Member)	Medical Malpractice Profession Liability Insurance Industry
Beth Rominger	Health Insurance Industry (Indemnity)
	Health Insurance Industry (Managed Care)
Rhonda Medows, M.D.	Consumer Advocate (Association for Responsible Medicine)
Ted Nichols	Consumer Advocate (Appointed by Senate)
Ray McEachern	
Lena Juarez President)	
Kelly Millet for Senator Ronald Silver Legislator (Appointed by the Senate President)	
Michael Pinell, M.D., M.H.A.	Florida Statutory Teaching Hospital
David Shapiro, M.D.	Florida Society of Ambulatory Surgical Centers
Michael Jackson, R.P.h.	Florida Pharmacy Association
Alan Knudsen	Florida Society of Health System Pharmacists

Alan Levine
Violet Nikolici
Governor)
May Wong-Chou
Governor)
Representative Carole Green

Florida League of Health Care Systems
Consumer Advocate (Appointed by the
Consumer Advocate (Appointed by the
Legislator (Appointed by the House Speaker)

Absent:
Georges El-Bahri, M.D.
Timothy Flynn, M.D.
Robert Frimmel, D.P.M.

Board of Medicine
Florida Medical School Representative
Florida Podiatric Association

I. Welcome

Secretary Ruben King-Shaw
Secretary Robert G. Brooks, M.D.

Commission members introduced themselves. Dr. Brooks reminded the members of the Commission's adoption of Roberts Rules of Order.

II. July 14, 2000 meeting minutes.

The minutes were approved as written.

III. Briefing of the Sunshine Law

William Large, General Counsel, DOH
Mr. Large gave the members a hand out of an overview of the Sunshine Law.

IV. Presentations of Current Quality Improvement/Error Reduction Initiatives

- Susie White, Ph.D., Florida Hospital Association

Dr. White gave a brief presentation of the Florida Hospital Association's Patient Safety Initiatives, which included:
Web; Newsletters; Professional Membership Groups; and Patient Safety Steering Committee.

The Patient Safety Steering Committee's goals are to identify education/conferences; encourage use of self-assessment tools; strategies for distribution of information; association wide comments on legislation; shift culture; clearinghouse on patient safety issues; work with media and others to reduce duplication. The Steering Committee's membership consists of several health care organization representatives.

- Ray McEachern, Executive Director, Association for Responsible Medicine

Mr. McEachern spoke about the Association for Responsible Medicine. He created this association because of an adverse incident that occurred to his wife several years ago that has left her physically handicapped. He shared his ideas of improving the error reduction rate in health care. Admitting there is a problem is the first step,

which obviously has been taken as a result of the Institute of Medicine's report released last year regarding adverse medical incidents . Mr. McEachern feels there should be more of an effort from state Government to educate consumers. The industry should use mistakes to prevent them from occurring again. His desired outcome of this Commission is education and legislation.

- Leonard Inge, RPh., Florida Board of Pharmacy

Mr. Inge spoke to the Commission about the Board of Pharmacy's standard of practice quality improvement initiatives concerning mail order prescriptions and prescriptions available via the Internet.

VI. Public Testimony

The Commission heard public testimony from 11 consumers that have either been affected, or have had a family member adversely affected by health care. The message heard repeatedly was that health care practitioners do not listen to their patients, and HMO's should not be determining whether a patient needs medical care; a health care practitioner should make this decision.

VII. Committee Break-out Sessions

The subcommittee members adjourned to meet separately.

VIII. Committee Briefings to the Commission

- Quality Measurement/Data Collection and Reporting:

Mr. Stivers, Co-coordinator of the Quality Measurement/Data Collection and Reporting subcommittee gave a briefing to the Commission. This subcommittee is going to research the data currently being collected; determine what entity is collecting the data; whether or not the data is shared between agencies; how the data is being utilized; is the data beneficial. They will be looking at the code 15's and corrective action plans that are submitted to the Agency for Health Care Administration from facilities. Staff will compile the data currently being collected by the Department of Health and the Agency for Health Care Administration and submit to the subcommittee at its next meeting.

- Regulation:

Mr. Sharp, Co-coordinator of the Regulation Subcommittee gave a briefing to the Commission. They will be reviewing and evaluating data currently being collected in Code 15s, as well as purchasing and payment methodology.

- Education/Best Practices:

Ms. Wilson, Co-Coordinator of the Education/Best Practices gave a briefing to the Commission. This subcommittee determined their first action would be to define patient

safety. They will additionally research “Best Practices” already being implemented in the health care industry.

IX. Discussion of Future Meetings

The Commission will meet September 26, 2000 in Panama City in conjunction with “Capital for a Day”. The subcommittees will meet on the 25th and 26th. Staff will attempt to schedule the October and November meeting as soon as possible.

X. Closing Remarks

The meeting was adjourned at 5:00 p.m.

Florida Commission on Excellence in Health Care

Meeting

September 26, 2000

Bay Point Marriott

4200 Marriott Drive, Panama City, Florida

10:00 a.m. - 12:00 p.m.

MINUTES

(Meeting Facilitator: Secretary Ruben J.-King-Shaw, Jr.)

Members Present

Robert G. Brooks, M.D.	Secretary, DOH
Ruben King-Shaw	Secretary, AHCA
Robert Panzer, D.O.	Board of Osteopathic Medicine
Georges El-Bahri, M.D.	Board of Medicine
Leonard Inge, RPh.	Board of Pharmacy
Cathy Oles, LPN	Board of Nursing
Charles Ross, D.D.S.	Board of Dentistry
Lee Cohen, D.D.S.	Florida Dental Association
Arthur Palamara, M.D.	Florida Medical Association
Dianne Pappachristou, D.O.	Florida Osteopathic Medical Association
Mary Ettari	Florida Academy of Physician Assistants
Kevin Fogarty, D.C.	Florida Chiropractic Society
John Gentile, D.C.	Florida Chiropractic Association
Robert Snyder	Florida Statutory Rural Hospital Council
Jacqueuline Byers, PhD, RN	Florida Nurses Association
Alice Lanford	Florida Organization of Nurses Executives
Susie White, PhD.	Florida Hospital Association
Karen Peterson	Association of Community Hospitals & Health Systems of FL
Sherrie Manulak	Florida Health Care Risk Mgmt Advisory Council
Terry Goodman	Florida Health Care Association
Theresa Mortimer Bertram	Florida Association of Homes for the Aging
Earnestine "Mikki" Thompson	Florida Society for Respiratory Care
Roger Donahue, Ph.D	Licensed Clinical Laboratory Director
Bruce Lamb, Esquire	Health Lawyer
Neal Roth, Esquire	Health Lawyer
Beth Rominger	Medical Malpractice Profession Liability Insurance Industry
Rhonda Medows, M.D.	Health Insurance Industry (Indemnity)
Ted Nichols	Health Insurance Industry (Managed Care)
Ray McEachern	Consumer Advocate (Association for Responsible Medicine)
Lena Juarez President)	Consumer Advocate (Appointed by Senate)
Michael Pinell, M.D., M.H.A.	Florida Statutory Teaching Hospital
David Shapiro, M.D.	Florida Society of Ambulatory Surgical Centers
Michael Jackson, R.P.h.	Florida Pharmacy Association

Alan Knudsen
Alan Levine
May Wong-Chou
Governor)
Representative Carole Green
Timothy Flynn, M.D.
Robert Frimmel, D.P.M.

Florida Society of Health System Pharmacists
Florida League of Health Care Systems
Consumer Advocate (Appointed by the
Legislator (Appointed by the House Speaker)
Florida Medical School Representative
Florida Podiatric Association

Absent:

Violet Nikolici
Governor)
Senator Ronald Silver

Consumer Advocate (Appointed by the
Legislator (Appointed by the Senate President)

I. Welcome

Secretary Ruben King-Shaw
Secretary Robert G. Brooks, M.D.

Commission members introduced themselves.

II. Discussion of Administrative/Logistical Issues

Secretary King-Shaw reminded the members of the Commission's goal to reduce medical errors. In reaching that goal, Secretary King-Shaw asked that individual and facility names not be used.

III. Review August 16, 2000 Meeting Minutes

Mr. McEachern made a motion to discuss the minutes. Mr. Cohen seconded the motion.

Mr. McEachern requested the public testimony be appended to the minutes. Discussion ensued regarding whether or not the minutes should reflect a summary of the meeting or include testimony. A motion was made and seconded to append the minutes with transcription of the public testimony, the motion failed.

A motion was made, seconded and carried, approving the minutes as written; however, staff will add to the Commission web site, "Click here for transcribed public testimony." Staff will provide the transcriptions when requested once the testimony has been redacted removing information that would identify persons or facilities.

IV. Public Testimony

Public testimony was given by the following individuals:

1. Linda Barefoot
2. Beverly Dufrechou
3. Stephen Shiflett

4. Gary Blankenship
5. Patricia McEachern
6. Cheryl Williams

Transcripts once transcribed will be available upon request by contacting the Department of Health, Division of Medical Quality Assurance.

V. Committee Break-out Sessions

Meeting adjourned for sub-committee breakout sessions.

Florida Commission on Excellence in Health Care

Meeting

October 24, 2000

Wyndham Westshore Hotel

4860 West Kennedy Blvd., Tampa, Florida

10:00 a.m. - 5:00 p.m.

MINUTES

(Meeting Facilitator: Secretary Robert G. Brooks, M.D.)

Members Present

Robert G. Brooks, M.D.	Secretary, DOH
Ruben King-Shaw	Secretary, AHCA
Robert Panzer, D.O.	Board of Osteopathic Medicine
Leonard Inge, RPh.	Board of Pharmacy
Cathy Oles, LPN	Board of Nursing
Charles Ross, D.D.S.	Board of Dentistry
Lee Cohen, D.D.S.	Florida Dental Association
Arthur Palamara, M.D.	Florida Medical Association
Dianne Pappachristou, D.O.	Florida Osteopathic Medical Association
Mary Ettari	Florida Academy of Physician Assistants
Craig Berko, D.C.(Alternate)	Florida Chiropractic Society
John Gentile, D.C.	Florida Chiropractic Association
Robert Snyder	Florida Statutory Rural Hospital Council
Jacqueuline Byers, PhD, RN	Florida Nurses Association
Alice Lanford	Florida Organization of Nurses Executives
Susie White, PhD.	Florida Hospital Association
Karen Peterson	Association of Community Hospitals & Health Systems of FL
Sherrie Manulak	Florida Health Care Risk Mgmt Advisory Council
Earnestine "Mikki" Thompson	Florida Society for Respiratory Care
Roger Donahue, Ph.D	Licensed Clinical Laboratory Director
Bruce Lamb, Esquire	Health Lawyer
Jay Cohen, Esquire (Alternate)	Health Lawyer
Beth Rominger	Medical Malpractice Profession Liability Insurance Industry
Ted Nichols	Health Insurance Industry (Managed Care)
Ray McEachern	Consumer Advocate (Association for Responsible Medicine)
Lena Juarez President)	Consumer Advocate (Appointed by Senate)
Michael Pinell, M.D., M.H.A.	Florida Statutory Teaching Hospital
David Shapiro, M.D.	Florida Society of Ambulatory Surgical Centers
Michael Jackson, R.P.h.	Florida Pharmacy Association
Alan Knudsen	Florida Society of Health System Pharmacists
Bill Bell (Alternate)	Florida League of Health Care Systems
Robert Frimmel, D.P.M.	Florida Podiatric Association

Violet Nikolici
Governor)
Timothy Flynn, M.D.
May Wong-Chou
Governor)
Theresa Mortimer Bertram
Terry Goodman

Consumer Advocate (Appointed by the
Florida Medical School Representative
Consumer Advocate (Appointed by the
Florida Association of Homes for the Aging
Florida Health Care Association

Absent:
Rhonda Medows, M.D.
Senator Ronald Silver
Representative Carole Green
Georges El-Bahri, M.D.

Health Insurance Industry (Indemnity)
Legislator (Appointed by the Senate President)
Legislator (Appointed by the House Speaker)
Florida Board of Medicine

I. Welcome

Secretary Robert G. Brooks, M.D.
Secretary Ruben J. King-Shaw, Jr.

Dr. Brooks welcomed the members and audience and took a few minutes to review the goals and objectives of the Commission. Dr. Brooks reminded members that Florida is one of several states that have responded to the Institute of Medicine's *To Err is Human* report released last year by creating a Commission. Additionally, Florida is one of the states that now require mandatory reporting of adverse incidents. The IOM report recommended a four tiered attempt at reducing the medical errors by 50% by creating a forum on safety issues, identifying and learning from medical errors, raising the standards of expectations and implementing safe practices at the delivery level.

Dr. Brooks advised members that beginning with the November meeting, the Commission would begin the process of developing the report due to the Legislature February 1, 2001. He reminded all in attendance that the purpose of the Commission is to learn from errors and develop systems to improve health care, not lay blame. He reiterated again the importance of not naming identifiers of practitioners as well as facilities in documents and testimony presented to the Commission.

II. Review September 26, 2000 Meeting Minutes

There was a motion made to approve the minutes as written, the motion was seconded and carried unanimously.

III. Overview of Subcommittees

- Quality Measurement/Data Collection

Jacqueline Byers, PhD, RN, a member representing the Florida Nurse's Association gave the report for this subcommittee. (Please see Committee's meeting records for details of the committee's findings and recommendations.

- Education/Best Practices

Lorene Wilson, Co-coordinator of this subcommittee gave the report. (Please see Committee's meeting records for details of the committee's findings and recommendations.

- Regulation

Bruce Lamb, Esquire, a member representing the Florida Bar Health Law Section gave the report for this subcommittee. (Please see Committee's meeting records for details of the committee's findings and recommendations.

IV. Overview of the Health Care Practitioner Enforcement Process

Nancy Snurkowski, attorney for AHCA gave a presentation of the health practitioner enforcement process that included the following:

- How a complaint becomes a case
- Most common types of investigations
- What constitutes Legal sufficiency
- Contact with consumers
- Statistics relating to complaints/discipline

V. Overview of Managed Care

Pamela Thomas, Chief, Bureau of Managed Health Care, AHCA and Walter Hollinger, Corporate Medical Director for Blue Cross Blue Shield of Florida gave a presentation of the managed care process.

VI. Video—"Beyond Blame"

Members watched a video dealing with how a particular hospital handled a medical mistake resulting in the death of a boy.

VII. Public Testimony

The following individuals gave public testimony:

1. Willie King and his attorney Peter Brudny
2. Darleen Kunkle
3. Dayle Zeigler
4. Patricia Quigley, Department of Veterans Affairs
5. Bonnie Strickland
6. Carolyn Hattaway
7. Ruth Piquette
8. George Parker
9. Rod Nail, HT Medical Simulator
10. Ira Mandel, MD, Quality Partners
11. Bridget Cross
12. Terry Dayton
13. Mike McGee, St. Joseph Hospital
14. Patti Hart O'Regan

15. Jannis Chisholm

Transcripts will be available upon request by contacting the Department of Health, Division Medical Quality Assurance.

Meeting adjourned at 5:20 p.m.

Florida Commission on Excellence in Health Care

Meeting

November 6, 2000
Hilton Jacksonville Riverfront
Jacksonville, Florida
10:00 a.m. - 5:00 p.m.

MINUTES

(Meeting Facilitator: Secretary Ruben J. King-Shaw, Jr.)

Members Present

Ruben King-Shaw	Secretary, AHCA
Robert G. Brooks, M.D	Secretary, DOH
Robert Panzer, D.O.	Board of Osteopathic Medicine
Leonard Inge, RPh.	Board of Pharmacy
Cathy Oles, LPN	Board of Nursing
Charles Ross, D.D.S.	Board of Dentistry
Lee Cohen, D.D.S.	Florida Dental Association
Arthur Palamara, M.D.	Florida Medical Association
Dianne Pappachristou, D.O.	Florida Osteopathic Medical Association
Mary Ettari	Florida Academy of Physician Assistants
Craig Berko, D.C.(Alternate)	Florida Chiropractic Society
John Gentile, D.C.	Florida Chiropractic Association
Robert Snyder	Florida Statutory Rural Hospital Council
Jacqueuline Byers, PhD, RN	Florida Nurses Association
Alice Lanford	Florida Organization of Nurses Executives
Susie White, PhD.	Florida Hospital Association
Karen Peterson	Association of Community Hospitals & Health Systems of FL
Sherrie Manulak	Florida Health Care Risk Mgmt Advisory Council
Earnestine "Mikki" Thompson	Florida Society for Respiratory Care
Roger Donahue, Ph.D	Licensed Clinical Laboratory Director
Bruce Lamb, Esquire	Health Lawyer
Jay Cohen, Esquire (Alternate)	Health Lawyer
Beth Rominger	Medical Malpractice Profession Liability Insurance Industry
Ted Nichols	Health Insurance Industry (Managed Care)
Ray McEachern	Consumer Advocate (Association for Responsible Medicine)
Lena Juarez President)	Consumer Advocate (Appointed by Senate)
David Shapiro, M.D.	Florida Society of Ambulatory Surgical Centers
Robert Wilson, R.P.h.(Alternate)	Florida Pharmacy Association
Alan Knudsen	Florida Society of Health System Pharmacists
Bill Bell (Alternate)	Florida League of Health Care Systems
Tim Tillo, D.P.M.(Alternate)	Florida Podiatric Association

Violet Nikolici Governor)	Consumer Advocate (Appointed by the
Timothy Flynn, M.D. May Wong-Chou Governor)	Florida Medical School Representative Consumer Advocate (Appointed by the
Theresa Mortimer Bertram	Florida Association of Homes for the Aging

Absent:	
Rhonda Medows, M.D. Senator Ronald Silver Representative Carole Green Georges El-Bahri, M.D. Michael Pinell, M.D., M.H.A. Terry Goodman	Health Insurance Industry (Indemnity) Legislator (Appointed by the Senate President) Legislator (Appointed by the House Speaker) Florida Board of Medicine Florida Statutory Teaching Hospital Florida Health Care Association

I. Welcome Secretary Ruben King-Shaw, Jr.

Secretary King-Shaw welcomed the members and audience and took a few minutes to review the goals and objectives of the Commission.

Secretary King-Shaw advised members that beginning with this meeting, the Commission would begin the process of developing the report due to the Legislature February 1, 2001. He reminded all in attendance that the purpose of the Commission is to learn from errors and develop systems to improve health care, not lay blame. He reiterated again the importance of not naming identifiers of practitioners as well as facilities in documents and testimony presented to the Commission.

III. Review October 24, 2000 Meeting Minutes

There was a motion made to approve the minutes as written, the motion was seconded and carried unanimously.

IV. Presentation on Board of Nursing's Quality Improvement Initiatives

Cathy Oles, Chairperson of the Florida Board of Nursing gave a presentation of the Board of Nursing's Quality Improvement initiatives. The Board of Nursing has taken a proactive approach to patient safety by:

- Implementation of Tracking Database for Disciplined Nurses
Board staff has developed a database by which all nurses whose cases are considered by a probable cause panel are tracked. At any given time, data regarding disciplined nurses can be provided to the Board. The data includes type of violations, fines and costs assessed, discipline imposed and the number of cases considered by probable cause panels. This data can be manipulated in many ways.
- Audit for Compliance with Continuing Education Requirements

Board staff conducted a pre-renewal audit versus the “norm” post-renewal conducted by other allied professions. They were able to determine that noncompliance in meeting the HIV/AIDS and domestic violence requirement, as well as taking courses outside the biennium were a problem.

- Participation in a study conducted by the National Council of State Boards of Nursing to identify performance indicators by which boards can determine their effectiveness.

Indicators were established for both the Board as well as Board staff. Indicators for boards include, but are not limited to, consistency of discipline, occurrence of repeat offenders, and perception of fairness of board action by affected parties.

Indicators for staff are timeliness of application processing and quality of customer service. The Department of Health through the Division of Medical Quality Assurance has made customer service a major priority. Board staff continuously looks for ways to speed the process without jeopardizing safety of patients.

Additionally, an ombudsman will be hired soon to help applicants seeking licensure as well as our “consumer friendly” web-site.

- The previous Board Chair appointed a Task Force to look at the issue of continued competency.

Since continued competency is an issue directly related to patient safety, the task force will gather data from nurses they have randomly selected for a continuing education audit. A questionnaire will be sent to determine the number of hours nurses work as well as the number of employers nurses may have at one time. Also, information will be gathered about areas of practice and job responsibility. The Board would like to determine if nurses are taking continuing education directly related to their areas of job responsibility.

- The assumption of regulatory responsibility for Certified Nursing Assistants.

For several years there has been concern about the regulation of CNAs. The Board was asked to assume the regulatory responsibility for CNAs in the 2000 Legislative Session. They are currently in the process of promulgating rules, which establish disciplinary guidelines for CNAs.

VIII. Public Testimony

The following individuals gave public testimony:

16. Ava Bell
17. Stephen Shiffit
18. Gary Blankenship

Transcripts will be available upon request by contacting the Department of Health, Division Medical Quality Assurance.

V. Discussion of Subcommittee Work Product

Education/Best Practices Subcommittee:

Jay Cohen, representing the Health Lawyers gave a summary of the Education/Best Practice Subcommittee’s recommendations:

1. Recommendation:

Create an Interagency Council on Patient Safety to provide ongoing state leadership in health care quality improvement in Florida. The council should consist of representatives of state agencies responsible for the provision, regulation and study of health care. The council shall focus on developing policy and proposed legislation on medical errors and patient safety to ensure coordination between agencies and eliminate duplication of efforts.

2. Recommendation:

Create a Center on Excellence in Health Care to serve as a (1) clearinghouse for research, information, and preventive tools with respect to patient safety risk factors; (2) serve as an educational forum for building awareness among providers, practitioners, and consumers about patient safety, errors in health care, and preventive strategies; and (3) conduct research designed to analyze risk factors in health care and provide practical tools and solutions.

Additionally, this Center would integrate statewide data on medical errors and adverse incidents, conduct analysis to identify errors in procedures, products and systems and prepare an aggregate report on medical errors for dissemination. Convene a multi-disciplinary workgroup of representatives from professional organizations, regulatory, accrediting and licensing bodies; educational institutions; and private industry to review the information on medical errors and propose core patient safety practices.

The Center shall disseminate the research information on medical errors and patient safety practices to professional societies, hospitals, health plans, ambulatory surgical centers and encourage them to incorporate the patient safety practices in their clinical practice guidelines.

Aggregate information on medical errors relating to drugs, medical devices and equipment should be provided to the Food and Drug Administration (FDA) and the FDA shall be encouraged to use the data to develop safety standards that relate to the problems.

The Center for Excellence in Health Care should analyze data on medical errors and adverse incidents from state agencies and other sources to develop model patient safety education and training programs. Medical schools, teaching hospitals and health care educational programs should be utilized to pilot the patient safety-training program. Research and validate techniques for improving patient safety. Information on patient safety “best practices” should be disseminated to practitioners, hospitals, health plans, and ambulatory surgical centers.

Lastly, the Center should investigate the need for an independent ombudsmen for hospitals.

Regulatory bodies for health care practitioners should propose legislation requiring a course in medical errors and patient safety including root cause analysis, error reduction, error prevention, and patient safety practices as a requirement for initial licensure and re-licensing.

- **Quality Measurement/Data Collection Subcommittee:**
Jacqueline Byers, PhD, RN, representing the Florida Nurse’s Association gave the following summary of the Quality Measurement/Data Collection Subcommittee’s recommendations:

1. Recommendation:

Create an External Leadership Body empowered by the Legislature to oversee the functions of the State’s centralized collection department and monitor quality of care.

Membership:

Gubernatorial appointees from the public representing consumers, providers, hospitals, and healthcare facilities, etc. Ex-officio members from State Agencies, i.e. DOH, AHCA, DOI.

Functions:

- Continue the work of the QM/Data Collection subcommittee.
- Identify, assess and integrate current health quality data sources.
- Identify areas in which measures do not exist; identify initiatives under development; and either incorporate these measures or develop ones appropriate for the setting.
- Develop a plan so that all aspects of the health care continuum have performance measures to indicate care delivered.
- Develop a centralized data repository for core quality measurement data.
- Ensure ongoing data validity.
- Report data and analyses to providers and public.
- Oversee research and development in the areas of quality measurement, quality improvement and error prevention.

2. Recommendation:

The State of Florida should develop or purchase a longitudinal web-based system for health care providers to track aggregate data through selected quality indicators, near misses and currently reported adverse outcome events.

Components:

- Build on existing measures established by other quality initiatives, i.e. morbidity & mortality; infection rates.
- Guidelines should be established for the creation of new reporting requirements.
- Eliminate duplication of data reporting.
- Identify gaps in measurement and make recommendations.
- Ensure efficient, cost-effective, continuum-based approach.
- Base measures on a priority matrix for conditions, populations, and settings.
- Performance measures should reflect “quality of care/performance” measures and sentinel/adverse events so multiple aspects of care are reviewed and improved.
- The data should be collected, analyzed, evaluated and reports disseminated through a centralized collection department.

- Data will be submitted electronically and stored in a secure, limited web-based system.
- Data integrity checks will be in place, and data will be validated during the survey process, i.e. complaint investigations and annual risk management surveys.

3. Recommendation:

Revise the current required adverse event reporting system.

Components:

- In addition to mandatory reporting, a voluntary, incentivized, non-punitive system should be created to encourage reporting of near misses. Facilities/Providers will be recognized publicly as a quality provider. Indicators may include, but are not limited to:
 - a.) Entities/Providers who have implemented a system for 48 hour turnaround time to provide feedback to providers on near miss and adverse outcome issues.
 - b.) Entities/Providers who have implemented a system for 24 hour acknowledgement to patients when a quality of care complaint has been received.
 - c.) Entities/Providers who have participated in an ISMP self-assessment of the facility.
- Reporting entities must include a root cause analysis when reporting near misses and adverse outcome events.
- Definitions must be developed to ensure consistency in reporting.
- Reports submitted in compliance with the adverse events and near miss reporting will be confidential and individuals and entities making the reports will be protected from civil lawsuits and monetary damages.

4. Recommendation:

Develop a mechanism for Quality Measurement Data Analysis and Reporting.

Components:

- A quality public report should be developed utilizing a risk-adjustment methodology with protections for confidential provider, entity location and patient information. All reports will be disseminated through a variety of media made available to all populations. Corrective actions taken should be disseminated in a monthly advisory so loss prevention systems can be implemented that will result in improved patient care.
- Best practices identified and disseminated through the collection of the advance loss prevention activities and improvement of patient care.
- Aggregate data should be made available to assigned users on the web-based system for tracking and benchmarking.

5. Recommendation:

Establish a subcommittee of the External Leadership Body to develop and oversee implementation of a plan for research and development regarding health care quality measurement and reporting.

Function:

- At a minimum, the plan shall identify state and federal resources available to facilitate the work of the research and development plan.
- Prioritize research and develop initiatives needs.
- Be reviewed and updated by the subcommittee annually.

Membership:

Senior state employees responsible for Florida’s quality measurement and reporting. Experts from the academic and health care fields. The maximum membership shall be two each from AHCA & DOH, 10 from academic & health care fields and 4 consumer members.

6. Recommendation:

The State of Florida should develop academic partnerships with faculty at state universities who are experts in health care quality measurement, health services research, and outcomes research. (These experts might be in schools of medicine, public health, nursing and health services.)

Projects: The State of Florida and their academic partners should apply for and participate in health care quality demonstration projects that are deemed high priority by the Research and Development Subcommittee of the External Leadership Body.

Funding: The State of Florida and their academic partners should apply for National Institutes of Health (NIH) and Agency for Healthcare Research and Quality (AHRQ) funding for health care quality research in areas that are deemed high priority by the Research and Development Subcommittee of the External Leadership Body. Other funding sources should be pursued.

Reporting: The State of Florida and its research partners shall report the health care quality research and development findings and best practices to the External Leadership Body for distribution, as appropriate, to both health care providers and consumers, using multi-media approaches.

- **Regulation Subcommittee:**

Beth Rominger representing the Medical Malpractice Profession Liability Insurance Industry gave the following summary of the Regulation Subcommittee’s recommendations:

The Consumer/complainant Experience

The Regulation Subcommittee determined the consumer/complainant interaction with the practitioner regulatory process is unsatisfactory. The “customer relations” function needs improvement.

1. RECOMMENDATION:

- The regulatory agency should establish a formalized “customer relations” function for interaction with complainants, that maximizes the complainant’s opportunity for information and updates on the status of investigations.
- Consider developing a brochure to advise complainants about the investigation process and timeframes.

- The role of regulators in consumer education should be strengthened.
- The subcommittee has had preliminary discussion about methods of facilitating customer relations, including “ombudsman” models of assistance, and response to complainant dissatisfaction with the complaint investigation process and results. Recommendations have not been fully formulated.

1.1 Specific recommendation:

- If a patient is not the primary complainant, the patient should be added to the complaint as a co-complainant if the patient requests. This procedure will ensure that the patient has access to all information that is available to the original complainant. AHCA chief attorney Nancy Snurkowski has advised that she can and will implement this procedural change without requiring any legislation. NOTE: The committee has not formulated any recommendations as yet regarding expansion of complainant access to investigation materials and information.

Quality Improvement and Risk Management Programs

2. RECOMMENDATION:

- The AHCA should determine and implement strategies to provide quick feedback to individual facilities submitting reports of medical errors, as well as statewide feedback to the medical community. Such feedback should include anecdotal summaries and analysis of prevention strategies. This recommendation will impact avoidable errors.
- A system should be established within the regulatory agency to cross reference various sources of information with incident reports to ensure that facilities are complying with reporting requirements. More reports give a broader base to identify avoidable errors and provide feedback for error reduction.
- The AHCA should periodically publish information for the medical community regarding best practices of prevention strategies.
- The AHCA should identify strategies to provide educational consultation to facilities regarding mandatory reporting requirements, and to conduct audits of facilities with apparent minimal reporting compliance.

Meeting adjourned at 5:20 p.m.

Florida Commission on Excellence in Health Care

Meeting

December 15, 2000

Hyatt Regency Orlando Airport

Orlando, Florida

10:00 a.m. - 5:00 p.m.

MINUTES

(Meeting Facilitator: Secretary Robert G. Brooks, M.D.)

Members Present

Robert G. Brooks, M.D.
Ruben King-Shaw
Leonard Inge, RPh.
Arthur Palamara, M.D.
Mary Ettari
Kevin Fogarty, DC
Jacqueuline Byers, PhD, RN
Alice Lanford
Susie White, PhD.
Karen Peterson

Earnestine "Mikki" Thompson
Roger Donahue, Ph.D
Bruce Lamb, Esquire
Jay Cohen, Esquire (Alternate)
Ray McEachern

Lena Juarez
President)
Alan Knudsen
Robert Frimmel, DPM
Violet Nikolici
Governor)
Timothy Flynn, M.D.
Theresa Mortimer Bertram
Michael Pinell, M.D., M.H.A.
Cathy Oles, LPN
Alan Levine
Rhonda Medows, MD

Secretary, DOH
Secretary, AHCA
Board of Pharmacy
Florida Medical Association
Florida Academy of Physician Assistants
Florida Chiropractic Society
Florida Nurses Association
Florida Organization of Nurses Executives
Florida Hospital Association
Association of Community Hospitals & Health
Systems of FL
Florida Society for Respiratory Care
Licensed Clinical Laboratory Director
Health Lawyer
Health Lawyer
Consumer Advocate (Association for
Responsible Medicine)
Consumer Advocate (Appointed by Senate

Florida Society of Health System Pharmacists
Florida Podiatric Association
Consumer Advocate (Appointed by the

Florida Medical School Representative
Florida Association of Homes for the Aging
Florida Statutory Teaching Hospital
Board of Nursing
Florida League of Health Care Systems
Representative of Health Insurance Industry
(Indemnity)

Absent:

Michael Jackson, R.Ph
May Wong-Chou (Resigned)
Governor)
Charles Ross, D.D.S.

Florida Pharmacy Association
Consumer Advocate (Appointed by the

Board of Dentistry

Dianne Pappachristou, D.O.
John Gentile, D.C.
Sherrie Manulak

Beth Rominger

Ted Nichols
David Shapiro, M.D.
Senator Ronald Silver
Representative Carole Green
Georges El-Bahri, M.D.
Terry Goodman
Robert Panzer, D.O.
Lee Cohen, D.D.S.
Robert Snyder

Florida Osteopathic Medical Association
Florida Chiropractic Association
Florida Health Care Risk Mgmt Advisory
Council
Medical Malpractice Profession Liability
Insurance Industry
Health Insurance Industry (Managed Care)
Florida Society of Ambulatory Surgical Centers
Legislator (Appointed by the Senate President)
Legislator (Appointed by the House Speaker)
Florida Board of Medicine
Florida Health Care Association
Board of Osteopathic Medicine
Florida Dental Association
Florida Statutory Rural Hospital Council

I. Welcome

Secretary Robert Brooks, M.D.

Secretary Brooks welcomed the members and audience and took a few minutes to review the goals and objectives of the Commission.

Secretary Brooks advised members that beginning with this meeting, the Commission would begin voting on recommendations submitted to them by the Subcommittees for the purpose of developing the report due to the Legislature February 1, 2001. He reminded all in attendance that the purpose of the Commission is to learn from errors and develop systems to improve health care, not lay blame. He reiterated again the importance of not naming identifiers of practitioners as well as facilities in documents and testimony presented to the Commission.

V. Review November 6, 2000 Meeting Minutes

There was a motion made to approve the minutes as written, the motion was seconded and carried unanimously.

VI. Recommendations From the Regulation Subcommittee

Following are the recommended motions presented to the Full Commission and unanimously approved:

Motion #1

- AHCA shall formalize the “customer relations” function for interaction with complainants.
- DOH shall identify an internal position to create a customer service liaison to work directly with consumers and assist them with licensure and/or enforcement issues.
- Expand the consumer resource capability of AHCA to receive and manage consumer complaints and inquiries and to provide meaningful status updates regarding the investigation and prosecution of the complaint to the person who filed the complaint and/or the patient or the patient’s legal representative.

- DOH and AHCA shall contract with a private consultant to conduct a comprehensive review of the health care practitioner disciplinary program. The consultant's work product will be used to determine what changes need to be made to enhance the system.

Motion #2

- AHCA will enhance distribution of the complaint brochure via sending to all doctors and retail establishments that voluntarily what to display.

Motion #3 (Opposed – Jay Cohen)

- Create in s. 456.073(9)(c), F.S., new language to allow upon request the patient and/or patient's legal representative to receive status information as well as the complainant.
- Add language in s. 456.073(9)(c), F.S., to allow upon request the ~~patient complainant(s)~~ and defendant/practitioner to receive a copy of the expert report with the identity of the expert witness redacted, when said report is the basis for closure.
Add language to s. 456.073(9)(c), F.S., In any disciplinary case for which probable cause is not found, the department shall so inform the person(s) who filed the complaint ~~or the patient's legal representative~~ and notify that person(s) that he or she may, within 60 days, provide additional information to the probable cause panel which may be relevant to the decision. To facilitate the provision of additional information, the person(s) who filed the complaint or the patient or patient's legal representative may receive upon request a copy of the agency's expert report that supported the recommendation for closure if a report was relied upon by the agency. In no way does this require the agency to procure an expert opinion or report if none were used. Additionally, the identity of the expert shall remain confidential. The person(s) who filed the complaint or the patient or the patient's legal representative shall agree, in writing, to maintain the confidentiality of any information found in the expert report.

Motion #4

- Section 456.078, F.S., Mediation__
- (1) ~~Notwithstanding the provisions of s. 456.073, F.S., the board, or the department when there is no board, shall adopt rules to designate which violations of the applicable professional practice act are appropriate for mediation. The board, or the department when there is no board, may shall~~ designate as mediation offenses those complaints where harm caused by the licensee is economic in nature or can be remedied by the licensee.
- (2) – (4) No changes
- (5) Any board ~~created on or after January 1, 1995,~~ shall have 6 months to adopt rules designating which violations are appropriate for mediation, after which time the department shall have exclusive authority to adopt rules pursuant to this section. A board shall have continuing authority to amend its rules adopted pursuant to this section.

Exclude from mediation allegations of fraud of Medicaid or Medicare but allow some mediation in third party payor claims. Include appropriate Code 15s.

Motion #5

- Section 456.077, F.S., Citation__
- Merge 456.072(b) into section 456.077, F.S., for continuity.

- Change s. 456.072(1) to state that if the subject does not dispute the matter in the citation within 30 days, the citation becomes a final order but not discipline if the violation is the first offense only.

Motion #6

- Change subsection (6) to delete “created on or after January 1, 1992.”
- Repeal s456.073(3), F.S., notices of Non-compliance, if expanded citation and mediation provisions are adopted.

Motion #7 (Withdrawn)

Motion #8

- Provide confidentiality of 1-day incident reports to AHCA, as provided in Code 15 reports. (Amend s.395.0197(13), F.S., to amend the subsection to include the reports in subsection 7.)

Motion #9

- Amend s. 395.0197(2), F.S., to correct the citation for risk manager requirements to subsection 397.1074 and not Chapter 626, Part IX.

Motion #10 (Opposed – Ray McEachern)

- AHCA and DOH shall evaluate all sources of data to determine appropriate submission of data and maximize analysis & feedback of analysis from data about medical errors.
- Determine and implement strategies to provide quick feedback to individual facilities submitting reports of medical errors, as well as statewide feedback to the medical community. Such feedback should include anecdotal summaries and analysis of prevention strategies.
- Require feedback of effective safety practices to health care practitioners.
- Establish a system within AHCA and DOH to cross reference various sources of information with incident reports to ensure those facilities are complying with reporting requirements. More reports give a broader base to identify avoidable errors and provide feedback for error reduction.
- Periodically publish information for the medical community regarding best practices of prevention strategies.

Motion #11

- Identify strategies to provide educational consultation to facilities regarding mandatory reporting requirements. AHCA and DOH shall enhance audit processing and parameters to foster the state’s health care quality initiative relating to all practice settings.

Motion #12

- DOH will expand the content of periodic Board newsletters to include articles on disciplinary cases resulting from medical errors.

Motion #13 and Substitute #13 withdrawn.

III. Recommendations From the Education/Best Practice Subcommittee

Motion #14 (Opposed Karen Peterson)

- Create an Interagency Council on Patient Safety and Excellence. The Council shall consist of representatives of state agencies responsible for the prevention, regulation and study of health care, and shall provide ongoing leadership in health care quality improvement in Florida.
- Focus on quality improvement of patient safety, ensure coordination between agencies and eliminate duplication of efforts.

Motion #15

- Create a Center on Patient Safety and Excellence. The Center shall serve as a clearinghouse for research, information, and preventive tools with respect to patient safety risk factors.
- Serve as an educational forum for building awareness among providers, practitioners, and consumers about patient safety, errors in health care, and preventive strategies.
- Conduct research designed to analyze risk factors in health care and provide practical tools and solutions.

IX. Presentation by Mr. Ray McEachern Association for Responsible Medicine & Commission Member

Mr. McEachern made the following recommendations for the Commission to consider:

- Revise the Florida Medical Consent Law and place it in the section on Civil Rights rather than Tort law.
- Select the 10 most common non-elective and 10 most common elective procedures and require hospitals and ambulatory surgical centers to report the number of complications that occurred from a list of specific complications.
- Require all adverse incidents to be reported quarterly.
- Provide a quarterly report to the public by hospital and ambulatory surgical centers of the total number of adverse incidents and the number of procedures and the percentage of complications by procedure.
- Amend the Florida Wrongful Death Law to remove the exemption allowed for medical malpractice.
- Create a revolving fund from fines levied for medical negligence to reimburse the cost of legal representation or investigation by experts for the complainant if probable cause is found.
- Consolidate all field investigators under one division and establish a hospital patient Ombudsman program using volunteers to gather information and assist with complaint investigation.
- Require that Risk Managers, Field Investigators, Medical Providers, Doctors and Nurses in training receive training in the causes and prevention of medical injury utilizing victims of medical injury in the presentation of material.
- Create incentives from hospitals to purchase patient simulators to train and maintain skills of medical staff.
- Establish a point system for medical providers similar to the system of assigning points against the license of motor vehicle operators.
- Documents included in Mr. McEachern's presentation:
 - The Florida Medical Consent Law, a Tribune Times article from November 2000 titled *Surgical Study Finds Experience Doesn't Always Mean Success*; a list of possible complications of selected procedures; a copy of a brochure from Dun & Bradstreet Healthcare Information regarding Orlando Area Hospitals 1994 Consumer Hospital Guide; statistics concerning Code 15s; Florida Law on Disclosure of Adverse Incidents; The Florida Wrongful Death Law; excerpts from the medical record of a DNR patient and information regarding Patient Simulators.

The meeting was adjourned.

Florida Commission on Excellence in Health Care

Meeting

January 12, 2001
Tallahassee Civic Center
Tallahassee, Florida
10:00 a.m. - 5:00 p.m.

MINUTES

(Meeting Facilitator: Secretary Ruben J King-Shaw, Jr.)

Members Present

Ruben King-Shaw	Secretary, AHCA
Robert G. Brooks, M.D	Secretary, DOH
Leonard Inge, RPh.	Board of Pharmacy
Arthur Palamara, M.D.	Florida Medical Association
Mary Ettari	Florida Academy of Physician Assistants
Alice Lanford	Florida Organization of Nurses Executives
Susie White, PhD.	Florida Hospital Association
Karen Peterson	Association of Community Hospitals & Health Systems of FL
Earnestine "Mikki" Thompson	Florida Society for Respiratory Care
Bruce Lamb, Esquire	Health Lawyer
Jay Cohen, Esquire (Alternate)	Health Lawyer
Ray McEachern	Consumer Advocate (Association for Responsible Medicine)
Lena Juarez (President)	Consumer Advocate (Appointed by Senate)
Alan Knudsen	Florida Society of Health System Pharmacists
Timothy Flynn, M.D.	Florida Medical School Representative
Theresa Mortimer Bertram	Florida Association of Homes for the Aging
Cathy Oles, LPN	Board of Nursing
Rhonda Medows, MD	Representative of Health Insurance Industry (Indemnity)
Linda Brainard (Alternate)	Florida Statutory Rural Hospital Council
Bill Bell (Alternate)	Florida League of Health Care Systems
Michael Jackson, R.Ph	Florida Pharmacy Association
Dianne Pappachristou, D.O.	Florida Osteopathic Medical Association
Beth Rominger	Medical Malpractice Profession Liability Insurance Industry
Ted Nichols	Health Insurance Industry (Managed Care)
David Shapiro, M.D.	Florida Society of Ambulatory Surgical Centers
Senator Ronald Silver (Came in Late)	Legislator (Appointed by the Senate President)
Denise McMillin, M.D. (Alternate)	Florida Board of Medicine
Judy Greenwald (Alternate)	Florida Health Care Association
Craig Berko, DC (Alternate)	Florida Chiropractic Society

Absent:

Roger Donahue, Ph.D
Robert Frimmel, DPM
Violet Nikolici
Governor)

Michael Pinell, M.D., M.H.A.
May Wong-Chou (Resigned)
Governor)

Charles Ross, D.D.S.
John Gentile, D.C.
Sherrie Manulak

Representative Carole Green
Glenn Moran, D.O. (Alternate)
Lee Cohen, D.D.S.
Jacqueuline Byers, PhD, RN

Licensed Clinical Laboratory Director
Florida Podiatric Association
Consumer Advocate (Appointed by the

Florida Statutory Teaching Hospital
Consumer Advocate (Appointed by the

Board of Dentistry
Florida Chiropractic Association
Florida Health Care Risk Mgmt Advisory
Council
Legislator (Appointed by the House Speaker)
Board of Osteopathic Medicine
Florida Dental Association
Florida Nurses Association

I. Welcome

Secretary Ruben King-Shaw, Jr.

Secretary King-Shaw welcomed the members and audience and took a few minutes to review the goals and objectives of the Commission.

Secretary King-Shaw advised members that the Commission would be voting on recommendations submitted to them by the Subcommittees for the purpose of developing the report due to the Legislature February 1, 2001. He reiterated again the importance of not naming identifiers of practitioners as well as facilities in documents and testimony presented to the Commission.

VII. Review December 15, 2000 Meeting Minutes

There was a motion made to approve the minutes as written, the motion was seconded and carried unanimously.

VIII. Recommendations From the Education/Best Practices Subcommittee

Following are the recommended motions presented to the Full Commission:

Motion #1 (Legislative mandate #1, page 12 of Findings & Recommendations matrix)
(*Passed Unanimously*)

- The Center for Patient Safety shall collect and establish a statewide database on quality indicators, patient safety and near misses, maximizing the use of existing data.
- Analyze statewide data on medical errors in the procedures, products and systems and prepare an aggregate report for dissemination.
- Convene multi-disciplinary work groups of representatives from professional organizations, regulatory boards and agencies, accrediting and licensing bodies, educational institutions, health care practitioners and providers, and private industry to review and discuss the information on medical errors and patient safety practices that can be used in developing practice guidelines and standards.

- Disseminate research information on medical errors and patient safety practices to professional societies, hospitals, health plans, ambulatory surgical centers and encourage them to incorporate patient safety practices into their clinical practice guidelines.
- The Interagency Council on Patient Safety and Excellence shall coordinate with professional organizations and societies; health maintenance organizations; insurers; health care practitioners, providers and purchasers to disseminate information, educate practitioners on practice guidelines and encourage their use.

Motion #2 (Legislative mandate #2, page 13 of Findings & Recommendations matrix)
(*Passed unanimously*)

- The Center for Patient Safety and Excellence shall serve as the clearinghouse in conjunction with the regulatory bodies to disseminate information on patient safety.
- Conduct meetings with professional organizations and regulatory bodies to discuss information on medical errors to determine the types of information and methods for disseminating information on patient safety.
- Conduct meetings with consumer and patient organizations through grassroots information meetings to determine the types of patient safety information and the most effective methods of disseminating the information to enable consumers to become involved in their care and to be more active participants in the decision making surrounding their care.
- Develop material on preventing medical errors, patient safety and quality improvement that state regulatory bodies, purchasers, professional associations and societies, health plans, hospitals, ambulatory surgical centers can disseminate, reprint or adapt.
- Develop a packet of information to educate consumers on medical errors, improve patient safety and assist them in taking an active role in making decisions concerning their health care. Health plans, insurance companies, hospitals, health care practitioners, community leaders, retirement centers, etc., would distribute the packets.
- Determine the type and most effective way to present information on patient safety, medical errors and quality improvements to health care practitioners, providers, purchasers and consumers and determine the impact of providing the information.

Motion #3 (Legislative mandate #3, page 14 of Findings & Recommendations matrix)
(*Passed unanimously*)

- The Center for Excellence in Health Care shall analyze data on medical errors and adverse incidents and other sources to develop a model patient safety education and training program.
- Encourage medical schools, teaching hospitals, and health care educational programs to incorporate the patient safety-training program into their curriculum.
- Medical teaching facilities and health care institutions are encouraged to use patient simulators to train and maintain health care provider skills.
- Legislation should require a course in medical errors and patient safety, including root cause analysis, error reduction, error prevention and patient safety practices as a requirement for initial and re-licensing of appropriate health care profession and included in the existing number of required hours.

Motion #4 (Legislative mandate #4, page 14-15 of Findings & Recommendations matrix)
(*Passed unanimously*)

- The Center and the Interagency Council on Patient Safety and Excellence will coordinate the development of community-based collaborative initiatives for error reporting and analysis and implementation of patient safety improvements including;
 - b. Convening meetings of accrediting, licensing, professional organizations and certifying bodies to propose, investigate, and evaluate educational methods to improve analysis, understanding, and prevention of medical errors.
 - b. Planning and conducting a summit addressing patient safety and medical error reduction, and producing directives for the future.

Motion #5 (Legislative mandate #7, page 14 of Findings & Recommendations matrix)
(Passed unanimously)

- Last month's minutes reflected a task directed to the Center on Patient Safety and Excellence which was inaccurate, therefore, this motion was passed unanimously to remove the following language from Legislative Mandate #7 of the Quality Measurement/Data Collection subcommittee, "Investigate the need for an independent ombudsman for hospitals."

IX. Recommendations From the Regulation Subcommittee

Motion #6 (Legislative Mandate # 1 & 2, letters K & L, page 2 of Findings & Recommendations matrix)
(Passed unanimously)

- Amend s. 395.10972, F.S., to change the Health Care Risk Manager Advisory Council to be a seven (7) member group comprised of the following;
 - Current statutory members include 2 risk managers, 1 hospital administrator, 1 medical malpractice insurer and 1 consumer member. This legislation will add a requirement that 1 of the 2 risk managers shall be a representative appointed by and a member of the Florida Society of Health Care Risk managers and 2 other licensed health care practitioners (flexibility in professions.)

Motion #7 (Legislative mandates #1 & 2, letter M, page 2 of Findings & Recommendations matrix)
(Passed unanimously)

- Expand the statutory responsibilities of hospital and ASC risk managers to require that the risk manager notify the appropriate regulatory board of a report of sexual misconduct against a member of the facility's personnel as follows:
 - s. 395.0197(9)(d), F.S., Report every allegation of sexual misconduct, which involves a patient to the Department of Health.
 - Further, the subcommittee recommends that allegations of sexual misconduct shall be reported to the Department of Health regardless of the practice setting. The subcommittee directed staff to determine the appropriate statutory placement of this requirement.

Motion #8 (Legislative mandates #1 & 2, letter N, page 2 of Findings & Recommendations matrix)
(Passed 2/3 Vote)

- Expand facility personnel who are required to attend annual training on risk management and prevention. (Amend s. 395.0197(1)(b)1.b., F.S., to read: At least 1 hour of such

education and training upon employment, or obtaining staff privileges for annually all ~~non-physician~~ personnel of the licensed facility working in clinical areas and providing patient care.

- Add a requirement that the risk manager annually review and update the training that includes medical errors, adverse incidents, near misses and other quality indicators.
- Delete the current requirement for annual retraining of personnel.

Motion #9 (Legislative mandates #1 & 2, letter P, page 2 of Findings & Recommendations matrix)

(Passed 2/3 Vote)

- Create a new statutory section in Chapter 395 to provide immunity from civil liability to risk managers and licensed facilities for reporting only under the following provisions:
A privilege against civil liability is hereby granted to any licensed risk manager or licensed facility with regard to information furnished pursuant to Chapter 395, unless the licensed risk manager or facility acted in bad faith or with malice in providing such information.

- **Motion #10** (Legislative mandates #1 & 2, page 3 of Findings & Recommendations matrix)

(Passed unanimously)

Amend s. 395.0197(4), F.S., as follows: phrase, ~~“after consulting with the Department of Insurance.~~

Motion #11 (Legislative mandates #1 & 2, page 3 column 2 of Findings & Recommendations matrix)

(Passed unanimously)

Create a new statutory provision that is shall be unlawful for any person to coerce, intimidate, or preclude a risk manager from lawfully executing his or her reporting obligations pursuant to Chapter 395, F.S. Such unlawful action shall be subject to civil monetary penalties not to exceed \$10,000 per violation. Staff should determine the appropriate statutory placement for this provision.

Motion #12 (Legislative mandate # 3, page 3 & 4, column 3 letter B & page 4 middle column letter g of Findings & Recommendations matrix)

(Passed 2/3 Vote)

- Certificate of Need regulations should not be eliminated or weakened until after such time as the state implements systems for reporting useful clinical outcome data in formats that allow consumers to analyze and choose between existing health care practitioners and providers. The reporting of raw or aggregate data will not meet this requirement.

Motion #13 (Legislative mandate #5, page 5 middle column matrix)

(Passed unanimously)

- AHCA and DOH will publish no less than quarterly a summary of adverse incident reports, which shall not include information that would identify the reporting facility or health care practitioner(s) involved. The purpose of the publication of such summaries is to promote the rapid dissemination of information relating to incidents to assist in avoidance of similar incidents and reduce morbidity and mortality. A public records

exemption will be necessary, as is currently provided for annual hospital reports. This quarterly publication should be established in lieu of annual reporting requirements in current law.

Motion #14 (Legislative mandate #6, page 5 middle column, letters a & b of Findings & Recommendations matrix)

(Passed 2/3 Vote)

- The Department of Health shall pursue development of a proposal for registration of surgical technologists.
- AHCA and DOH shall ensure that regulatory rules for any practice setting in which surgical procedures are performed require that the practice setting establish minimum training and education requirements for all operating personnel.

Motion #15 (Legislative mandate #6, page 5 middle column, letters a & b of Findings & Recommendations matrix)

(Passed 2/3 Vote)

- Seek statutory authority to extend current protections of peer review relating to the quality improvement functions to include community pharmacies.
- The Committee reported that meeting time expired before the committee could conclude its consideration of other issues and proposals, including:
 - Association of Responsible Medicine proposals
 - Florida Health Care Association proposals
 - Board of Medicine proposals
 - Other staff proposals

The committee asked if there would be another opportunity to meet before the commission report was submitted to the Legislature. Mr. King-Shaw advised that it did not appear that a quorum could be obtained for another meeting prior to the deadline for the submission of the commission report. He noted, however, that the commission could continue to meet and submit a supplemental report if desired.

X. Recommendations From the Quality Measurement/Data Collection Subcommittee

Motion #16 (Legislative mandates # 1 & 2, page 6 of Findings & Recommendations matrix) (MOTION FAILED)

- The State of Florida should develop or purchase a longitudinal Internet-based system for health care practitioners and providers to track aggregate data through selected quality indicators, near misses and currently reported adverse outcome events.

Motion #17 (Legislative mandate #7, page 11 of Findings & Recommendations matrix & Dr. Meadow's 1 page handout)

(Passed unanimously)

- The Secretaries of DOH and AHCA will appoint an Interagency Council on Patient Safety and Excellence in Health Care and directed staff to ensure there is no duplication made by the previous sub-committee. The responsibilities of this Council are to include, but not be limited to the following:
 - A. Providing ongoing leadership in health care quality improvement by:

- Ensuring coordination between agencies to eliminate duplication of efforts and to close gaps in data collection.
 - Mapping current data sources of existing quality measures.
 - Compiling and integrating medical errors data.
 - Establishing guidelines for new reporting requirements.
 - Identifying and compiling information on quality improvement measures.
 - Prioritizing research and developing new initiatives.
 - Identifying methods of disseminating information e.g. the proposed central clearinghouse of data and Internet based system for the submission of data and the reporting out of findings and recommendations.
 - Determining an appropriate location for the electronic data system.
 - Researching and validating best practices recommended to reduce medical errors.
 - Disseminating information on patient safety measures, initiatives, and guidelines via multiple channels of communication – Internet, newsletters, and workshops.
 - Identifying statutes that require revisions. (Commission directed staff to do this)
- B. Collaborating and Coordinating efforts with:
- Other governmental departments and agencies to develop and implement research plans.
 - Community based initiatives on error reporting, analysis of data, and the implementation of patient safety measures.
 - Accrediting, licensing and professional organizations to investigate educational methods to prevent medical errors through improvements in the analysis and understanding of the results of the data collected.
 - The general public via summits on patient safety and on the directives planned for the future.
 - State and Federal resources available to facilitate research plans.
 - The Governors Office of Technology to develop systems methodologies.
 - Academic Institutions (universities, medical schools, pharmacy and nursing programs) for academic and clinic research in medical error prevention.

Motion #18 (*Legislative mandate # 7, page 11 of Findings & Recommendation matrix & Dr. Meadow's 1 page handout*)

(Passed unanimously)

Representatives from the following entities appointed by the Secretaries of DOH and AHCA: Professional Organizations and Societies, Health Care Providers, Health Plans and Consumer Representatives shall meet quarterly with the Interagency Council to:

- Disseminate information re: data analysis results.
- Provide education on safety measures and best practices learned.
- Allow input and feedback.

Motion #19 (*Legislative mandate # 2, page 4 of Quality Measurement/Data Collection Subcommittee's matrix*)

(Passed 2/3 Vote)

The Interagency Council should develop or purchase a longitudinal web-based system for health care providers to track aggregate data through selected quality indicators with the following components:

- Build on existing measures established by other quality initiatives, such as JCAHO, NCQA, HCFA – 6th Scope of Work, Health Care Finance & Administration, i.e. morbidity & mortality; infection rates.
- Ensure that the data are collected, analyzed, evaluated and reports disseminated through a centralized collection department.
- Allow data to be submitted electronically and stored in a secure, limited access web-based system.
- Data integrity checks shall provide for data to be validated.

Motion #20 (Motion Withdrawn) (Legislative mandate # 3, page 5 of Quality Measurement/Data Collection Subcommittee’s Matrix)

Revise the current required adverse event reporting system with the following components:

- Expand the time frame for reporting adverse events and to require reporting entities to include a root cause analysis.
 Immediate reporting for adverse incidents remains the same.
 A subsequent report on root cause analysis is submitted within 45 days.
 An investigation by AHCA will commence after 45 days.
- Reports submitted in compliance with the adverse events and near miss reporting will be confidential and individuals and entities making the reports will be protected from civil lawsuits and monetary damages.

Motion #21 (Legislative mandate # 3, page 6 of Quality Measurement/Data Collection Subcommittee’s matrix)

(Passed unanimously)

Incentivize implementation of voluntary efforts to prevent adverse incidents and improve quality of care with the following components:

- In addition to mandatory reporting, a voluntary, incentivized, non-punitive system should be created to encourage reporting of near misses defined as circumstances or events, which have the capacity to result in injury or death. THESE RECORDS SHALL BE EXEMPTED FROM DISCOVERY AND DISCLOSURE PURSUANT TO CHAPTER 119, FLORIDA STATUTES AND THE FLORIDA CONSTITUTION.

Motion #22 (Legislative mandate # 3, page 6 of Quality Measurement/Data Collection Subcommittee’s matrix)

(Passed unanimously)

Facilities/Providers will be recognized publicly as a quality provider. Indicators for recognition may include, but are not limited to:

- Entities/Providers who have implemented a system for 48 hour turn around time to provide feedback to providers on near miss and adverse outcome issues.
- Entities/Providers who have implemented a 24-hour acknowledgement to patients when a quality of care complaint has been received.
- Entities/Providers who have participated in an ISMP self-assessment of the facility.
- Facilities who have received ANCC Magnet Recognition, participated in the Governor’s Sterling Council GSA or the Malcolm Baldrige Award for Performance Excellence.

- The Council shall have the authority to approve additional indicators for recognition.
- Includes implementation of a meaningful risk reduction and quality improvement program as a mitigating factor in relevant disciplinary action.

Motion #23 (Legislative mandate # 4, page 7 of Quality Measurement/Data Collection Subcommittee's matrix)

(Passed unanimously) The Council shall develop a mechanism for Quality Measurement Data Analysis and Reporting with the following components:

- A quality public report should be developed utilizing a risk-adjustment methodology with protections for confidential provider, entity location and patient information.
- All reports will be disseminated through a variety of media made available to all populations.
- Corrective actions taken following adverse (injury) events should be disseminated in a periodic advisory to reporting entities so loss prevention systems can be implemented that will result in improved patient care.
- Best practices identified through the collection and analysis of the quality indicators should be shared with reporting entities through a periodic advisory to advance loss prevention activities and improvement of patient care.
- Aggregated data should be made available to assigned users on the web-based system for tracking and benchmarking.

Motion #24 (Legislative mandate # 5, page 7 of Quality Measurement/Data Collection Subcommittee's matrix)

(Passed 2/3 Vote)

The Center shall develop and oversee the implementation of a plan for research and development regarding health care quality measurement and reporting with the following functions:

- At a minimum, the plan shall: Identify state and federal resources available to facilitate the work of the research and development plan.
- Prioritize research and development initiatives needs and be reviewed and updated annually.

Motion #25 (Legislative mandate # 6, page 8 of Quality Measurement/Data Collection Subcommittee's matrix)

(Passed unanimously)

The Center should develop partnerships with faculty at public and private state universities who are experts in health care quality measurement, health services research, and outcomes research. (These experts might be in schools of medicine, public health, nursing and health services.)

- The Center and its partners should apply for and participate in health care quality demonstration projects.
- The Center and its partners should apply for National Institutes of Health (NIH) and Agency for Healthcare Research and Quality (AHRQ) funding for health care quality research. Other funding sources should be pursued as well.

- The Center shall report the health care quality research and development findings and best practices for the distribution, as appropriate, to both health care providers and consumers, using multi-media approaches.

Memo from the Cathedral Foundation

A memorandum from the Cathedral Foundation was distributed to Commission members indicating the Florida Association of Homes for the Aging has submitted a proposal to the Task Force on Availability and Affordability of Long Term Care addressing “The Long Term Care Litigation and Liability Insurance Crisis.”

The following are recommendations of the Florida Association of Homes for the Aging:

Motion #26 (Memo hand-out from the Cathedral Foundation)

(Passed unanimously)

Require each nursing home to implement a quality assurance program directed by an interdisciplinary team that meets at least every other month. Federal law now requires quarterly meetings.)

Motion #27 (Memo hand-out from the Cathedral Foundation)

(Passed unanimously)

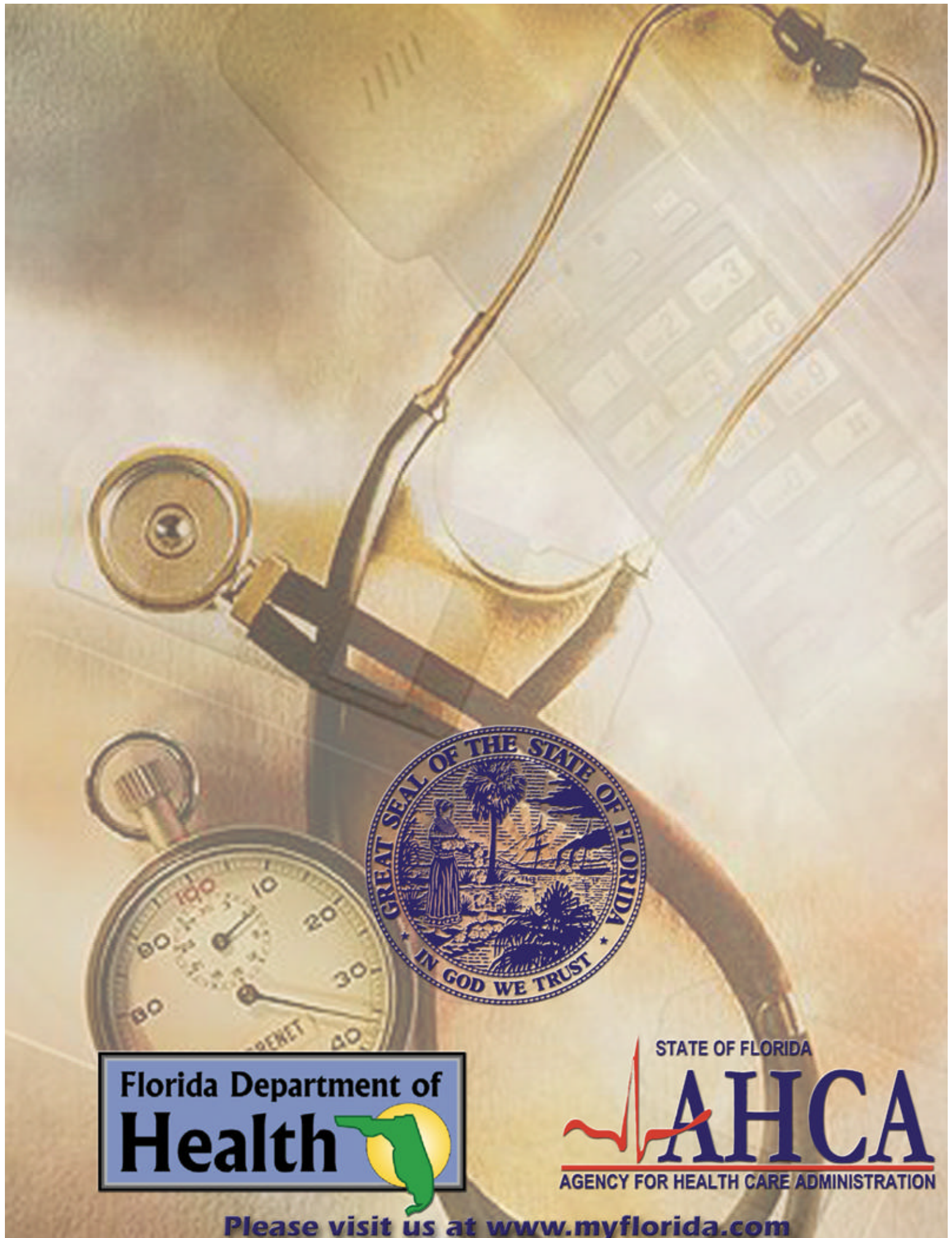
Mandate the Agency for Health Care Administration to implement a continuous quality improvement educational program that consists of training modules for specific topics.

Motion #28 (Memo hand-out from the Cathedral Foundation)

(Passed unanimously)

Require the Agency to create a list-serve that members of quality assurance committees can use to ask and respond to questions about best practices and quality of care issues.

The meeting was adjourned at 5:00 p.m.



Florida Department of
Health 

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 AGENCY FOR HEALTH CARE ADMINISTRATION

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