

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 King-Shaw, Jr.)

1	<u>Members Present</u>	
2	Ruben J. King-Shaw, Jr.	Secretary, Agency for Health Care Administrator
3	Robert G. Brooks, M.D	Secretary, Department of Health
4	Robert Panzer, D.O.	Board of Osteopathic Medicine
5	Leonard Inge, RPh.	Board of Pharmacy
6	Cathy Oles, LPN	Board of Nursing
7	Charles Ross, D.D.S.	Board of Dentistry
8	Lee Cohen, D.D.S.	Florida Dental Association
9	Arthur Palamara, M.D.	Florida Medical Association
10	Dianne Pappachristou, D.O.	Florida Osteopathic Medical Association
11	Mary Ettari	Florida Academy of Physician Assistants
12	Craig Berko, D.C.(Alternate)	Florida Chiropractic Society
13	John Gentile, D.C.	Florida Chiropractic Association
14	Robert Snyder	Florida Statutory Rural Hospital Council
15	Jacqueuline Byers, PhD, RN	Florida Nurses Association
16	Alice Lanford	Florida Organization of Nurses Executives
17	Susie White, PhD.	Florida Hospital Association
18	Karen Peterson	Association of Community Hospitals & Health
19		Systems of FL
20	Sherrie Manulak	Florida Health Care Risk Mgmt Advisory Council
21	Earnestine “ Mikki” Thompson	Florida Society for Respiratory Care
22	Roger Donahue, Ph.D	Licensed Clinical Laboratory Director
23	Bruce Lamb, Esquire	Health Lawyer
24	Jay Cohen, Esquire (Alternate)	Health Lawyer
25	Beth Rominger	Medical Malpractice Profession Liability Insurance
26		Industry
27	Ted Nichols	Health Insurance Industry (Managed Care)
28	Ray McEachern	Consumer Advocate (Association for Responsible
29		Medicine)
30	Lena Juarez	Consumer Advocate (Appointed by Senate President)
31	David Shapiro, M.D.	Florida Society of Ambulatory Surgical Centers
32	Robert Wilson, R.P.h.(Alternate)	Florida Pharmacy Association
33	Alan Knudsen	Florida Society of Health System Pharmacists
34	Bill Bell (Alternate)	Florida League of Health Care Systems
35	Tim Tillo, D.P.M.(Alternate)	Florida Podiatric Association
36	Violet Nikolici	Consumer Advocate (Appointed by the Governor)
37	Timothy Flynn, M.D.	Florida Medical School Representative
38	May Wong-Chou	Consumer Advocate (Appointed by the Governor)

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

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

7 Indicators for staff are timeliness of application processing and quality of customer service.

8 The Department of Health through the Division of Medical Quality Assurance has made
9 customer service a major priority. Board staff continuously looks for ways to speed the
10 process without jeopardizing safety of patients. Additionally, an ombudsman will be hired soon
11 to help applicants seeking licensure as well as our "consumer friendly" web-site.

12 ➤ **The previous Board Chair appointed a Task Force to look at the issue of continued**
13 **competency.**

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

20 ➤ **The assumption of regulatory responsibility for Certified Nursing Assistants.**

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

25 **IV. Public Testimony**

26 **The following individuals gave public testimony:**

- 27 1. Ava Bell
28 2. Stephen Shiffit
29 3. Gary Blankenship

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

32 **V. Discussion of Subcommittee Work Product**

33 **Education/Best Practices Subcommittee:**

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

36 **1. Recommendation:**

37 **Create an Interagency Council on Patient Safety** to provide ongoing state leadership in
38 health care quality improvement in Florida. The council should consist of representatives of
39 state agencies responsible for the provision, regulation and study of health care. The council

1 shall focus on developing policy and proposed legislation on medical errors and patient safety
2 to ensure coordination between agencies and eliminate duplication of efforts.

3 **2. Recommendation:**

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

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

15 The Center shall disseminate the research information on medical errors and patient safety
16 practices to professional societies, hospitals, health plans, ambulatory surgical centers and
17 encourage them to incorporate the patient safety practices in their clinical practice guidelines.
18 Aggregate information on medical errors relating to drugs, medical devices and equipment
19 should be provided to the Food and Drug Administration (FDA) and the FDA shall be
20 encouraged to use the data to develop safety standards that relate to the problems.

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

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

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

31 • **Quality Measurement/Data Collection Subcommittee:**

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

34 **1. Recommendation:**

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

37 **Membership:**

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

4 **Functions:**

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

16 **2. Recommendation:**

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

20 **Components:**

- 21 • Build on existing measures established by other quality initiatives, i.e. morbidity & mortality;
22 infection rates.
- 23 • Guidelines should be established for the creation of new reporting requirements.
- 24 • Eliminate duplication of data reporting.
- 25 • Identify gaps in measurement and make recommendations.
- 26 • Ensure efficient, cost-effective, continuum-based approach.
- 27 • Base measures on a priority matrix for conditions, populations, and settings.
- 28 • Performance measures should reflect “quality of care/performance” measures and
- 29 sentinel/adverse events so multiple aspects of care are reviewed and improved.
- 30 • The data should be collected, analyzed, evaluated and reports disseminated through a
- 31 centralized collection department.
- 32 • Data will be submitted electronically and stored in a secure, limited web-based system.
- 33 • Data integrity checks will be in place, and data will be validated during the survey process, i.e.
- 34 complaint investigations and annual risk management surveys.

35 **3. Recommendation:**

36 Revise the current required adverse event reporting system.

37 **Components:**

- 38 • In addition to mandatory reporting, a voluntary, incentivized, non-punitive system should be
- 39 created to encourage reporting of near misses. Facilities/Providers will be recognized publicly
- 40 as a quality provider. Indicators may include, but are not limited to:
41 a.) Entities/Providers who have implemented a system for 48 hour turnaround time to provide
42 feedback to providers on near-miss and adverse outcome issues.

- 1 b.) Entities/Providers who have implemented a system for 24 hour acknowledgement to
2 patients when a quality of care complaint has been received.
3 c.) Entities/Providers who have participated in an ISMP self-assessment of the facility.
4 • Reporting entities must include a root cause analysis when reporting near misses and adverse
5 outcome events.
6 • Definitions must be developed to ensure consistency in reporting.
7 • Reports submitted in compliance with the adverse events and near miss reporting will be
8 confidential and individuals and entities making the reports will be protected from civil lawsuits
9 and monetary damages.

10 **4. Recommendation:**

11 Develop a mechanism for Quality Measurement Data Analysis and Reporting.

12 **Components:**

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

22 **5. Recommendation:**

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

25 **Function:**

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

30 **Membership:**

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

34 **6. Recommendation:**

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

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

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

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

10 **• Regulation Subcommittee:**

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

13 **The Consumer/complainant Experience:**

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

16 **1. RECOMMENDATION:**

- 17 • The regulatory agency should establish a formalized "customer relations" function for
18 interaction with complainants, that maximizes the complainant's opportunity for information
19 and updates on the status of investigations.
20 • Consider developing a brochure to advise complainants about the investigation process and
21 timeframes.
22 • The role of regulators in consumer education should be strengthened.
23 • The subcommittee has had preliminary discussion about methods of facilitating customer
24 relations, including "ombudsman" models of assistance, and response to complainant
25 dissatisfaction with the complaint investigation process and results. Recommendations have
26 not been fully formulated.

27 **1.1 Specific recommendation:**

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

34 **Quality Improvement and Risk Management Programs**

35 **2. RECOMMENDATION:**

- 36 • The AHCA should determine and implement strategies to provide quick feedback to
37 individual facilities submitting reports of medical errors, as well as statewide feedback to
38 the medical community. Such feedback should include anecdotal summaries and analysis
39 of prevention strategies. This recommendation will impact avoidable errors.

- 1 • A system should be established within the regulatory agency to cross reference various
2 sources of information with incident reports to ensure that facilities are complying with
3 reporting requirements. More reports give a broader base to identify avoidable errors and
4 provide feedback for error reduction.
5 • The AHCA should periodically publish information for the medical community regarding
6 best practices of prevention strategies.
7 • The AHCA should identify strategies to provide educational consultation to facilities
8 regarding mandatory reporting requirements, and to conduct audits of facilities with
9 apparent minimal reporting compliance.
- 10 Meeting adjourned at 5:20 p.m.