

# **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 Brooks, M.D.)

### **Members Present**

1	Robert G. Brooks, M.D	Secretary, Department of Health
2	Ruben J. King-Shaw, Jr.	Secretary, Agency for Health Care Administration
3	Leonard Inge, RPh.	Board of Pharmacy
4	Arthur Palamara, M.D.	Florida Medical Association
5	Mary Ettari	Florida Academy of Physician Assistants
6	Kevin Fogarty, DC	Florida Chiropractic Society
7	Jacqueline Byers, PhD, RN	Florida Nurses Association
8	Alice Lanford	Florida Organization of Nurses Executives
9	Susie White, PhD.	Florida Hospital Association
10	Karen Peterson	Association of Community Hospitals & Health
11		Systems of FL
12	Earnestine "Mikki" Thompson	Florida Society for Respiratory Care
13	Roger Donahue, Ph.D	Licensed Clinical Laboratory Director
14	Bruce Lamb, Esquire	Health Lawyer
15	Jay Cohen, Esquire (Alternate)	Health Lawyer
16	Ray McEachern	Consumer Advocate (Association for Responsible
17		Medicine)
18	Lena Juarez	Consumer Advocate (Appointed by Senate President)
19	Alan Knudsen	Florida Society of Health System Pharmacists
20	Robert Frimmel, DPM	Florida Podiatric Association
21	Violet Nikolici	Consumer Advocate (Appointed by the Governor)
22	Timothy Flynn, M.D.	Florida Medical School Representative
23	Theresa Mortimer Bertram	Florida Association of Homes for the Aging
24	Michael Pinell, M.D., M.H.A.	Florida Statutory Teaching Hospital
25	Cathy Oles, LPN	Board of Nursing
26	Alan Levine	Florida League of Health Care Systems
27	Rhonda Medows, MD	Representative of Health Insurance Industry
28		(Indemnity)

### **Absent:**

29		
30	Michael Jackson, R.Ph	Florida Pharmacy Association
31	May Wong-Chou (Resigned)	Consumer Advocate (Appointed by the Governor)
32	Charles Ross, D.D.S.	Board of Dentistry
33	Dianne Pappachristou, D.O.	Florida Osteopathic Medical Association
34	John Gentile, D.C.	Florida Chiropractic Association
35	Sherrie Manulak	Florida Health Care Risk Mgmt Advisory Council

1	<b>Beth Rominger</b>	<b>Medical Malpractice Profession Liability Insurance</b>
2		<b>Industry</b>
3	<b>Ted Nichols</b>	<b>Health Insurance Industry (Managed Care)</b>
4	<b>David Shapiro, M.D.</b>	<b>Florida Society of Ambulatory Surgical Centers</b>
5	<b>Senator Ronald Silver</b>	<b>Legislator (Appointed by the Senate President)</b>
6	<b>Representative Carole Green</b>	<b>Legislator (Appointed by the House Speaker)</b>
7	<b>Georges El-Bahri, M.D.</b>	<b>Florida Board of Medicine</b>
8	<b>Terry Goodman</b>	<b>Florida Health Care Association</b>
9	<b>Robert Panzer, D.O.</b>	<b>Board of Osteopathic Medicine</b>
10	<b>Lee Cohen, D.D.S.</b>	<b>Florida Dental Association</b>
11	<b>Robert Snyder</b>	<b>Florida Statutory Rural Hospital Council</b>

12           **I.       Welcome**                           **Secretary Brooks**

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

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

21           **II.       Review November 6, 2000 Meeting Minutes**

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

24           **III.       Recommendations From the Regulation Subcommittee**

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

27   ***Motion #1***

- 28 • AHCA shall formalize the “customer relations” function for interaction with complainants.
- 29 • DOH shall identify an internal position to create a customer service liaison to work directly with  
30 consumers and assist them with licensure and/or enforcement issues.
- 31 • Expand the consumer resource capability of AHCA to receive and manage consumer complaints  
32 and inquiries and to provide meaningful status updates regarding the investigation and  
33 prosecution of the complaint to the person who filed the complaint and/or the patient or the  
34 patient’s legal representative.
- 35 • DOH and AHCA shall contract with a private consultant to conduct a comprehensive review of the  
36 health care practitioner disciplinary program. The consultant’s work product will be used to  
37 determine what changes need to be made to enhance the system.

1 **Motion #2**

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

4 **Motion #3 (Opposed – Jay Cohen)**

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

21 **Motion #4**

- 22 • Section 456.078, F.S., Mediation\_\_  
23 • (1) ~~Notwithstanding the provisions of s. 456.073, F.S., the board, or the department when there is~~  
24 ~~no board, shall adopt rules to designate which violations of the applicable professional practice act~~  
25 ~~are appropriate for mediation.~~ The board, or the department when there is no board, may shall  
26 designate as mediation offenses those complaints where harm caused by the licensee is  
27 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.

28 **Motion #5**

- 29 • Section 456.077, F.S., Citation\_\_  
30 • Merge 456.072(b) into section 456.077, F.S., for continuity.  
31 • Change s. 456.072(1) to state that if the subject does not dispute the matter in the citation within  
32 30 days, the citation becomes a final order but not discipline if the violation is the first offense only.

33 **Motion #6**

- 34 • Change subsection (6) to delete “created on or after January 1, 1992.”

- 1 • Repeal s456.073(3), F.S., notices of Non-compliance, if expanded citation and mediation  
2 provisions are adopted.

3 **Motion #7 (Withdrawn)**

4 **Motion #8**

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

7 **Motion #9**

- 8 • Amend s. 395.0197(2), F.S., to correct the citation for risk manager requirements to subsection  
9 397.1074 and not Chapter 626, Part IX.

10 **Motion #10 (Opposed – Ray McEachern)**

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

22 **Motion #11**

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

26 **Motion #12**

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

29 **Motion #13 and Substitute #13 withdrawn.**

30 **III. Recommendations From the Education/Best Practice**  
31 **Subcommittee**

32 **Motion #14 (Opposed Karen Peterson)**

- 33 • Create an Interagency Council on Patient Safety and Excellence. The Council shall consist of  
34 representatives of state agencies responsible for the prevention, regulation and study of health  
35 care, and shall provide ongoing leadership in health care quality improvement in Florida.

- 1 • Focus on quality improvement of patient safety, ensure coordination between agencies and  
2 eliminate duplication of efforts.

3 **Motion #15**

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

10 **IV. Presentation by Mr. Ray McEachern Association for**  
11 **Responsible Medicine & Commission Member**

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

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

- 1 Incidents; The Florida Wrongful Death Law; excerpts from the medical record of a
- 2 DNR patient and information regarding Patient Simulators.
  
- 3 The meeting was adjourned.