STORAGE NAME: h1219.hr.doc
DATE: February 8, 2002

HOUSE OF REPRESENTATIVES
COMMITTEE ON
HEALTH REGULATION
ANALYSIS

BILL #: HB 1219

RELATING TO: Patient Safety Improvement Act

SPONSOR(S): Representative Bowen

TIED BILL(S): None.

ORIGINATING COMMITTEE(S)/COUNCIL(S)/COMMITTEE(S) OF REFERENCE:

(1) HEALTH REGULATION
(2) HEALTH & HUMAN SERVICES APPROPRIATIONS
(3) COUNCIL FOR HEALTHY COMMUNITIES
(4)
(5)

I. SUMMARY:

THIS DOCUMENT IS NOT INTENDED TO BE USED FOR THE PURPOSE OF CONSTRUING STATUTES, OR TO BE CONSTRUED AS AFFECTING, DEFINING, LIMITING, CONTROLLING, SPECIFYING, CLARIFYING, OR MODIFYING ANY LEGISLATION OR STATUTE.

The intent of this bill is to establish a statewide, academically based center that will serve as the designated resource for patient-safety-related research, education, and policy information for the people and institutions of Florida. The bill provides a short title—the "Patient Safety Improvement Act."

The bill creates the Florida Center for Patient Safety to be administratively housed and located at the Health Sciences Center of the University of South Florida in Tampa. It authorizes the center to perform various functions relating to research, data analysis, and information dissemination with regard to patient safety.

The bill maintains the confidentiality of individual patient identifying information as is currently provided under the enumerated provisions of law and provides that patient records shall be used solely for the purpose of research and compilation of information for legislative, regulatory, or other policy purposes as intended by the bill and as authorized under chapter 405, F.S.

The bill provides an effective date of July 1, 2002.

According to the Director of the Suncoast Center for Patient Safety at the Health Sciences Center of the University of South Florida, this bill will require no additional state fiscal resources.

II. SUBSTANTIVE ANALYSIS:

A. DOES THE BILL SUPPORT THE FOLLOWING PRINCIPLES:

1.	Less Government	Yes []	No []	N/A [x]
2.	Lower Taxes	Yes []	No []	N/A [x]
3.	Individual Freedom	Yes []	No []	N/A [x]
4.	Personal Responsibility	Yes []	No []	N/A [x]
5.	Family Empowerment	Yes []	No []	N/A [x]

For any principle that received a "no" above, please explain:

B. PRESENT SITUATION:

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 Commission presented its report to the Governor and Legislature on February 1, 2001. In response, the 2001 Legislature adopted many of the recommendations of the Commission as part of CS/SB 1558 (ch. 2001-277, L.O.F.). The 2001 Legislature, however, did not address the recommendation of the Commission with regard to the formation of a Center for Patient Safety and Excellence in Health Care.

The Commission on Excellence in Health Care recommended that the Legislature should create a Center for Public Safety and Excellence in Health Care, and empower the center 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 a 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 such 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.

C. EFFECT OF PROPOSED CHANGES:

The intent of this bill is to establish a statewide, academically based center that will serve as the designated resource for patient-safety-related research, education, and policy information for the people and institutions of Florida. The bill provides a short title—the “Patient Safety Improvement Act.”

The bill creates the Florida Center for Patient Safety to be administratively housed and located at the Health Sciences Center of the University of South Florida in Tampa. It authorizes the center to perform various functions relating to research, data analysis, and information dissemination with regard to patient safety. Specifically, the bill authorizes the center to:

1. Coordinate public and private resources to conduct and support research in and demonstrations and evaluations of patient safety.

2. Conduct and support research on effective ways to improve and enhance patient safety and participate in the dissemination of the information that is derived from such research to health care providers in training and in practice, health care institutions, patients and their families, and policymakers.

3. Evaluate methods for identifying and promoting patient safety programs.

4. Support dissemination and communication activities to improve and enhance patient safety.

5. Design, conduct, and coordinate studies and surveys to assess aspects of patient safety, including, but not limited to, various clinical, social, and economic outcome or process measures.

6. Develop and test measures and methods for evaluating and enhancing patient safety and promote the use of such measures and methods in practice.

7. Provide technical assistance and gather information on the use of consumer and patient information, and report on patient safety and the resulting effects of intervention policies.

8. Consult with and develop partnerships, as appropriate, with all segments of the health care industry, including health care providers and health care consumers.

9. Establish a State Patient Safety Database to collect, support, and coordinate the analysis of nonidentifying patient safety data submitted voluntarily by health care providers and patient safety organizations.

10. Disseminate information developed through analysis of the State Patient Safety Database concerning the existence and causes of practices that affect patient safety, findings and conclusions regarding patient safety events, outcome measures, and evidence-based recommendations to improve patient safety.

The bill requires the center to establish a voluntary process to enable health care providers or patient safety organizations to report nonidentifying patient safety data. It requires the center to consult with and solicit and consider recommendations from “appropriate” sectors of the health care community, including health care providers, patient safety organizations, and other “relevant” experts.

The following definitions are provided in the bill:

(a) "Center" means the Florida Center for Patient Safety.

(b) "Health care provider" means any physician, nurse, pharmacist, occupational therapist, physical therapist, hospital, or other institution, organization, or person that furnishes health care services and is licensed or otherwise authorized to practice or provide health care services in the state.

(c) "Nonidentifying patient safety data" means patient safety data that are presented in a form and manner that prevents the identification of the health care provider or patient.

(d) "Patient safety data" means:

1. Any data, reports, records, memoranda, analyses, or other quality improvement processes of patient safety events which are:

a. Collected or developed by a health care provider;

b. Reported to a patient safety organization or the State Patient Safety Database;

c. Contained in or collected by a patient safety organization or the State Patient Safety Database;

d. Requested by a patient safety organization for the purposes of monitoring, researching, or improving patient safety; or

e. Reported to a health care provider by a patient safety organization to assist with quality improvement and patient safety effectiveness.

2. Any information related to corrective actions taken in response to patient safety events listed in subparagraph 1.

(e) "Patient safety event" means an event over which a health care provider 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 which could result in patient injury or death or any other adverse incident as defined in s. 395.0197, Florida Statutes.

(f) "Patient safety organization" means a public or private organization that does all of the following:

1. Collects and analyzes data or information about patient safety.

2. Reports nonidentifying patient safety data to the State Patient Safety Database.

3. Provides direct feedback of patient safety data to health care providers.

The bill maintains the confidentiality of individual patient identifying information as is currently provided under the enumerated provisions of law and provides that patient records shall be used solely for the purpose of research and compilation of information for legislative, regulatory, or other policy purposes as intended by the bill and as authorized under chapter 405, F.S.

The bill provides an effective date of July 1, 2002.

D. SECTION-BY-SECTION ANALYSIS:

Please see Effect of Proposed Changes section above.

III. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT:

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

Please see fiscal comments.

2. Expenditures:

Please see fiscal comments.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

None.

2. Expenditures:

None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

To the extent that private entities participate in providing data to the center, there will be an administrative cost for reporting such data.

D. FISCAL COMMENTS:

According to the Director of the Suncoast Center for Patient Safety at the Health Sciences Center of the University of South Florida, this bill will require no additional state fiscal resources.

IV. CONSEQUENCES OF ARTICLE VII, SECTION 18 OF THE FLORIDA CONSTITUTION:

A. APPLICABILITY OF THE MANDATES PROVISION:

This bill does not require counties or municipalities to spend funds or to take action requiring the expenditure of funds.

B. REDUCTION OF REVENUE RAISING AUTHORITY:

This bill does not reduce the authority that counties or municipalities have to raise revenues in the aggregate.

C. REDUCTION OF STATE TAX SHARED WITH COUNTIES AND MUNICIPALITIES:

This bill does not reduce the percentage of state tax shared with counties or municipalities.

V. COMMENTS:

A. CONSTITUTIONAL ISSUES:

None.

B. RULE-MAKING AUTHORITY:

None.

C. OTHER COMMENTS:

According to the proponents of this bill, there are at least two centers for patient safety currently established in Florida at the University of South Florida and the Florida State University. However, they believe that a coordinated statewide center would enable them to apply for more federal grants and be more effective in providing leadership to health care providers in the area of patient safety.

VI. AMENDMENTS OR COMMITTEE SUBSTITUTE CHANGES:

None.

VII. SIGNATURES:

COMMITTEE ON HEALTH REGULATION:

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