SENATE STAFF ANALYSIS AND ECONOMIC IMPACT STATEMENT

(This document is based on the provisions contained in the legislation as of the latest date listed below.)

BILL: SB 1912

SPONSOR: Senator Peaden

SUBJECT: Health Care

DATE: April 3, 2003 REVISED: _____ _____ _____ _____

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Harkey	Wilson	HC	Fav/10 amendments
2.	Deffenbaugh	Deffenbaugh	BI	Favorable
3.			JU	
4.			AHS	
5.			AP	
6.				

I. Summary:

This bill revises laws relating to risk management programs in hospitals, ambulatory surgical centers, and mobile surgical facilities.

The bill permits a licensed hospital, ambulatory surgical center, or mobile surgical facility to apply to the Agency for Health Care Administration (AHCA) for certification of a quality improvement program that results in the reduction of adverse incidents at that facility. AHCA must consult with the Department of Financial Services (DFS) in developing criteria for the certification, and insurers must file with DFS a discount rate or rates applicable for medical liability insurance coverage to reflect the implementation of a certified quality improvement program.

The bill requires a licensed hospital, ambulatory surgical center, or mobile surgical facility to notify AHCA of all medical malpractice lawsuits filed against it or a member of its staff when the underlying cause of action pertaining to the staff member involved the licensed facility. The report must be submitted to AHCA within 15 days after the facility receives notice or becomes aware that an action has been initiated against the facility or its current or former staff. The plaintiff is also required to provide a copy of the claim to AHCA, and AHCA must determine whether the facility filed adverse incident reports as required in s. 395.0197, F.S. AHCA must publish information about litigation filed against licensed facilities annually.

Each licensed hospital, ambulatory surgical center, or mobile surgical facility must establish a specified nurse-to-patient ratio, and each licensed facility must work with AHCA to determine the circumstances and methods for varying an established ratio.

The bill adds mental or physical abuse of a nurse or other staff member as grounds for discipline of a staff member or physician who delivers health care services at a hospital, ambulatory surgical center, or mobile surgical facility. Documents and communications pertaining to the professional conduct of a physician or hospital staff that are not generated during the course of deliberation, investigation, or analysis of a peer review panel or similar body are not privileged. In response to a request for discovery, a claim of privilege must be accompanied by a list of the documents or communications for which privilege is asserted with patient-identifying information redacted from the list. The bill specifies information that must be included in the list. A defendant's monetary liability under this section must not exceed $250,000.

The bill revises the requirements for the internal risk management program that every hospital, ambulatory surgical center, or mobile surgical facility must implement. A facility's risk manager must give written notice to a patient, patient's family member, or patient's designated representative that the patient was the subject of an adverse incident. A person who had the duty to file an incident report and failed to do so, is subject to disciplinary action by the facility and the appropriate regulatory board and subject to a fine of up to $1,000 per day for each day the report was not timely submitted. The 24-hour notification and the 15-day report must be filed for all adverse incidents, and the adverse incident notification and reports must be discoverable in disciplinary proceedings. The bill requires AHCA to publish an annual report card for each hospital, ambulatory surgical center, and mobile surgical facility providing descriptive information about the facility and its services; adverse incidents; procedures performed; disciplinary actions taken against professionals; infants abducted or discharged to the wrong family; and closed claims. The bill requires a risk manager to report every allegation of sexual misconduct to AHCA and requires a facility at which an incident of sexual abuse occurs to offer the victim of the abuse testing for sexually transmissible diseases at no cost to the victim.

The bill: deletes a 10 percent "ceiling" on fee increases that is imposed on DOH and regulatory boards; requires DOH to publish its annual report regarding health care practitioners to the website and the report must also include statistics and relevant information regarding the number of health care practitioners licensed by the department to provide services in Florida and professional liability claims reported by insurers for medical physicians, dentists, and health maintenance organizations.

The bill revises requirements for the information reported to DOH for compilation into practitioner profiles, to include all final disciplinary actions, sanctions, claims and actions involving professional negligence, and provides penalties for failure to timely submit such information as specified in the bill. DOH's duties and responsibilities for the practitioner profiles is revised: to require compilation within 15 business days of receipt of submitted information, to include descriptions of disciplinary administrative complaints and hyperlinks to final orders listed in a web site of recent disciplinary actions; to provide comparison reports of professional liability claims; to include dates of hospital or ambulatory surgical center disciplinary action; to provide easy-to-read explanations of disciplinary action; and to provide a link in each practitioner's profile to the practitioner's professional website.

Practitioners are required to review and verify the information submitted to DOH within 30 days and to update any required information in the profile within 15 days after final activity that renders such information a fact. Practitioners must report all claims involving professional

negligence to DOH or be subject to administrative fines for not timely reporting the information as specified in the bill. The requirements for providing notice to patients of not carrying medical malpractice insurance is revised for medical physicians. Medical and osteopathic physicians are subject to suspension for the failure to pay damages for medical malpractice claims up to the amounts required by the financial responsibility within 30 days after a judgment or order, until DOH receives proof of payment. The financial thresholds for reporting and investigating professional negligence claims is revised for medical and osteopathic physicians. Medical physicians are subject to discipline for refusing to provide health care based on a patient's participation in pending or past litigation or disciplinary actions unless the discipline or litigation directly involved the physician.

The bill extends immunity from civil liability for health care committees, groups, commissions or entities when involved in activities for quality improvement review, evaluation, and planning in a state-licensed facility. The bill establishes requirements for protecting privileged communications of medical staff committees, utilization review committees, or other committees, boards, groups, commissions or other entities when engaged in deliberating, investigating, or analyzing quality improvement. Procedures are specified for discovery requests and the redaction of patient information when appropriate. Patient safety organizations must submit statistical reports to DOH, AHCA, and the Department of Financial Services.

The Department of Financial Services and DOH must jointly publish a list of all health care professionals authorized to practice in Florida who do not carry medical malpractice insurance. The bill requires statements to be included in final settlement statements relating to medical malpractice and prohibits confidential legal settlement pertaining to medical malpractice actions.

The Department of Financial Services is required to revise its closed claim form for readability at the 9th grade level and to reflect self-reporting from medical and osteopathic physicians of all professional claims or actions for damages. The department must compile annual statistical reports, and develop annualized historical statistical summaries of the closed claim data as specified in the bill.

This bill amends ss. 395.004, 395.0193, 395.0197, 456.025, 456.026, 456.041, 456.042, 456.049, 456.051, 458.320, 458.331, 459.0085, and 459.015, F.S. The bill creates ss. 395.0056, and 395.0187, F.S., and seven unnumbered sections of law.

II. Present Situation:

Licensure Fees for Hospitals, Ambulatory Surgical Centers, and Mobile Surgical Facilities

Section 395.004, F.S., requires that a license to operate a hospital, ambulatory surgical center or mobile surgical facility be made under oath to AHCA on forms provided by AHCA. This section requires that the fee schedule for the biennial license, the provisional license, and the license renewal fee of a hospital, ambulatory surgical center or mobile surgical facility be calculated to cover the cost of regulation and be established in rule. The rate may not be less than $9.50 per hospital bed and not more than $30 per hospital bed. The minimum fee must be $1,500, and the total collected from all licensed facilities may not be more than is necessary to carry out the requirements of part I of ch. 395, F.S.

Hospital Nursing Staffing Requirements

Part I of ch. 395, F.S., provides for the regulation of hospitals, ambulatory surgical centers, and mobile surgical facilities. The Florida Statutes and the Florida Administrative Code are general in their definition of staffing levels in these health care facilities. Section 395.1055(1)(a), F.S., states that "Sufficient numbers and qualified types of personnel and occupational disciplines are on duty and available at all times to provide necessary and adequate patient care and safety."

Florida Administrative Code, 59A-3.2085(5), Nursing Service, states that "Each hospital shall be organized and staffed to provide quality-nursing care to each patient. Where a hospital's organizational structure does not have a nursing department or service, it shall document the organizational steps it has taken to assure that oversight of the quality of nursing care provided to each patient is accomplished."

Rule 59A-3.2085(5)(f), F.A.C., further states that "A sufficient number of qualified registered nurses shall be on duty at all times to give patients the nursing care that requires the judgment and specialized skills of a registered nurse, and shall be sufficient to ensure immediate availability of a registered nurse for bedside care of any patient when needed, to assure prompt recognition of an untoward change in a patient's condition, and to facilitate appropriate intervention by nursing, medical or other hospital staff members."

Rule 59A-3.2085(5)(g), F.A.C., states that "Each Class I and Class II hospital shall have at least one licensed registered nurse on duty at all times on each floor or similarly titled part of the hospital for rendering patient care services."

Rule 59A-3.2085(5)(h), F.A.C., states that "Each hospital shall maintain a list of licensed personnel, including private duty and per diem nurses, with each individual's current license number, and documentation of the nurses' hours of employment, and unit of employment within the hospital."

The Code of Federal Regulations, section 482.23(b), Standard: Staffing and Delivery of Care, states that: "The nursing service must have adequate numbers of licensed registered nurses, licensed practical (vocational) nurses, and other personnel to provide nursing care to all patients as needed. There must be supervisory and staff personnel for each department or nursing unit to ensure, when needed, the immediate availability of a registered nurse for bedside care of any patient."

Researchers at the University of Pennsylvania School of Nursing's Center for Health Outcomes and Policy Research published results of a study titled, "Hospital Nurse Staffing and Patient Mortality, Nurse Burnout, and Job Dissatisfaction" in the *Journal of the American Medical Association* (Vol. 288, No. 16, October 23/30, 2002). The researchers performed cross-sectional analyses of linked data from 10,184 staff nurses surveyed, 232,342 general, orthopedic, and vascular surgery patients discharged from the hospital in 1998-99, and administrative data from 168 nonfederal adult general hospitals in Pennsylvania. The researchers concluded that, "In hospitals with high patient-to-nurse ratios, surgical patients experience higher risk-adjusted 30-day mortality and failure-to-rescue rates, and nurses are more likely to experience burnout and job dissatisfaction."

Peer Review and Disciplining of Professional Health Care Providers

Under s. 395.0193, F.S., each licensed hospital, ambulatory surgical center, and mobile surgical facility must provide written, binding procedures for peer review of licensed physicians who practice at the facility. If it is reasonably believed that the actions of a physician or staff member may constitute grounds for discipline, a peer review panel must investigate and determine whether grounds for discipline exist. The governing board of a licensed facility, after considering the recommendations of its peer review panel must suspend, deny, revoke, or curtail the privileges of, or reprimand, counsel or require education, of a staff member or physician after a final determination has been made that one or more of the following grounds exist:

- Incompetence;
- Being found to be a habitual user of intoxicants or drugs to the extent that he or she is deemed dangerous to himself, herself, or others;
- Mental or physical impairment which may adversely affect patient care;
- Being found liable by a court of competent jurisdiction for medical negligence or malpractice involving negligent conduct;
- One or more settlements exceeding $10,000 for medical negligence or malpractice involving negligent conduct by the staff member;
- Medical negligence other than as specified in paragraph (d) or paragraph (e); or
- Failure to comply with the policies, procedures, or directives of the risk management program or any quality assurance committees of any licensed facility.

In accordance with ss. 458.337 and 459.016, F.S., any disciplinary actions taken must be reported in writing to the Division of Health Quality Assurance of the agency within 30 working days after its initial occurrence, regardless of the pendency of appeals to the governing board of the hospital. The notification must identify the disciplined practitioner, the action taken, and the reason for such action. All final disciplinary actions taken under subsection (3), if different from those which were reported to the agency within 30 days after the initial occurrence, must be reported within 10 working days to the Division of Health Quality Assurance of the agency in writing and must specify the disciplinary action taken and the specific grounds therefore. The division must review each report and determine whether it potentially involved conduct by the licensee that is subject to disciplinary action, in which case s. 456.073, F.S., will apply. The reports are not subject to inspection under s. 119.07(1), F.S., even if the division's investigation results in a finding of probable cause.

The statute prohibits monetary liability on the part of, and cause of action for damages against, any licensed facility, its governing board or governing board members, peer review panel, medical staff, or disciplinary body, or its agents, investigators, witnesses, or employees; a committee of a hospital; or any other person, for any action taken without intentional fraud in carrying out the provisions of the section.

For a single incident or series of isolated incidents that are nonwillful violations of the reporting requirements of this section, the agency must first seek to obtain corrective action by the facility. If correction is not demonstrated within the timeframe established by the agency or if there is a pattern of nonwillful violations, the agency may impose an administrative fine, not to exceed $5,000 for any violation of the reporting requirements. The administrative fine for repeated nonwillful violations must not exceed $10,000 for any violation. The administrative fine for each

intentional and willful violation may not exceed $25,000 per violation, per day. The fine for an intentional and willful violation of the section may not exceed $250,000.

The proceedings and records of peer review panels, committees, and governing boards are not subject to inspection under s. 119.07(1), F.S.; and meetings held pursuant to achieving the objectives of such panels, committees, and governing boards are not open to the public under the provisions of chapter 286, F.S.

The investigations, proceedings, and records of the peer review panel, a committee of a hospital, a disciplinary board, or a governing board, or agent thereof with whom there is a specific written contract for that purpose are not subject to discovery or introduction into evidence in any civil or administrative action against a provider of professional health services arising out of the matters that are the subject of evaluation and review by such group. A person who was in attendance at a meeting of such group or its agent may not be permitted or required to testify in any such civil or administrative action as to any evidence or other matters produced or presented during the proceedings of such group or its agent or as to any findings, recommendations, evaluations, opinions, or other actions. However, the statute specifies that information, documents, or records otherwise available from original sources are not to be construed as immune from discovery or use in any such civil or administrative action merely because they were presented during proceedings of such group, and any person who testifies before such group or who is a member of such group may not be prevented from testifying as to matters within his or her knowledge, but such witness may not be asked about his or her testimony before such a group or opinions formed by him or her as a result of such group hearings.

The law provides for the awarding of costs and attorney's fees to a defendant who prevails in an action brought by a staff member or physician who delivers health care services at the licensed facility against any person or entity that initiated, participated in, was a witness in, or conducted any review as authorized by the section. As a condition of any staff member or physician bringing any action against any person or entity that initiated, participated in, was a witness in, or conducted any review as authorized by this section and before any responsive pleading is due, the staff member or physician must post a bond or other security, as set by the court having jurisdiction of the action, in an amount sufficient to pay the costs and attorney's fees.

Internal Risk Management Program for Hospitals, Ambulatory Surgical Centers, and Mobile Surgical Facilities

As a licensure requirement, each hospital, ambulatory surgical center, and mobile surgical facility is required, at a minimum, under s. 395.0197, F.S., to establish an internal risk management program. Such a program is considered to be part of what is known as the quality assurance process that hospitals, ambulatory surgical centers, and mobile surgical facilities use in their day-to-day operations to ensure that "adverse incidents," are conscientiously examined on a continuous basis. The statute defines adverse incident to be an event over which health care personnel could exercise control, which is associated with the medical intervention rather than the condition for which the intervention was performed, and which resulted in one of the following:

- Death;
- Brain or spinal damage;

- Permanent disfigurement;
- Fracture or dislocation of bones or joints;
- Limitation of neurological, physical, or sensory functioning;
- Any condition that required specialized medical attention or surgical intervention;
- Any condition that required transfer of the patient to another facility or a unit providing a more acute level of care;
- Performance of a surgical procedure on the wrong patient, a wrong surgical procedure, or a surgical procedure otherwise unrelated to the patient's diagnosis or medical condition;
- Required surgical repair of damage resulting to a patient from a planned surgical procedure, where the damage was not a recognized specific risk; or
- A procedure to remove unplanned foreign objects remaining from a surgical procedure.

At a minimum, an internal risk management program must provide for: 1) the investigation and analysis of the frequency and causes of general categories and specific types of adverse incidents causing injury to patients; 2) the development of appropriate measures to minimize the risk of injuries and adverse incidents to patients, including specifying the circumstances under which staff may have access to patients in a recovery room subject to alternative surveillance measures; 3) the analysis of patient grievances that relate to patient care and the quality of medical services; and 4) the development and implementation of an incident reporting system based upon the affirmative duty of all health care providers and all agents and employees of the licensed facility to report adverse incidents.

The facility's governing board is responsible for the internal risk management program. The board is required to engage a risk manager to implement and oversee the program. Risk managers are exempted from liability and legal action for activities they undertake in implementing an internal risk management program that is in conformity with law as long as they are not intentionally fraudulent in their conduct. The qualifications of a risk manager, procedures for licensure, and fees are established in s. 395.10974, F.S.

Reports of Adverse Incidents

The statute requires facilities licensed under ch. 395, F.S., to provide the Agency for Health Care Administration with the following reports concerning adverse incidents:

A *notification of certain adverse incidents* to be issued within one business day after the risk manager receives an adverse incident report and determines that any of the following occurred:

- The death of a patient;
- Brain or spinal damage to a patient;
- The performance of a surgical procedure on the wrong patient;
- The performance of a wrong-site surgical procedure; or
- The performance of a wrong surgical procedure.

The written notification must be delivered by facsimile or by overnight mail and must include the identity of the affected patient; the type of adverse incident; the initiation of an investigation

by the facility; and whether the events causing the adverse incident pose a potential risk to other patients.

An *adverse incident report* must be issued within 15 calendar days after the occurrence of any of the following adverse incidents:

- The death of a patient;
- Brain or spinal damage to a patient;
- The performance of a surgical procedure on the wrong patient;
- The performance of a wrong-site surgical procedure;
- The performance of a wrong surgical procedure;
- The performance of a surgical procedure that is medically unnecessary or otherwise unrelated to the patient's diagnosis or condition;
- The surgical repair of damage resulting to a patient from a planned surgical procedure, where the damage is not a recognized specific risk; or,
- The performance of procedures to remove unplanned foreign objects remaining from a surgical procedure.

An *annual report* summarizing the incident reports that have been filed in the facility for the year. The annual report must include:

- The total number of adverse incidents;
- A listing of the types of operations or diagnostic or treatment procedures that resulted in injury and the number of incidents;
- A listing of the types of injuries caused and the number of incidents;
- A code number using the health care professional's license number and a separate code number identifying all other individuals directly involved in the adverse incident; and,
- A description of all malpractice claims against the facility.

Health Care Practitioner Licensure Fees, Receipts and Dispositions

Section 456.025(1), F.S., requires the Department of Health (DOH) or each board to set, by rule, licensure renewal fees which are based on specified criteria, including requirements that such fees may not be more than 10 percent greater than the fee imposed for the previous biennium and may not be more than 10 percent greater than the actual cost to regulate that profession for the previous biennium. s. 456.025(3), F.S., requires each board or DOH if there is no board, to determine by rule, the amount of license fees for the profession it regulates, based upon long-range estimates of revenue from DOH. Each board is responsible for ensuring that the licensure fees set out are adequate to cover all anticipated costs in order to maintain a reasonable cash balance. If a board does not take sufficient action within one year after notification from DOH that license fees are projected to be inadequate, the department must set licensure fees within the caps on behalf of the board in order to cover anticipated costs and to maintain required cash balances. The department must include recommended fee cap increases in its annual report to the Legislature. DOH must prepare an annual report with statistics and relevant information, profession by profession, pursuant to s. 456.026, F.S.

Practitioner Profiles

Section 456.039, F.S., requires each licensed physician, osteopathic physician, chiropractic physician, and podiatric physician to submit specified information which, beginning July 1, 1999, has been compiled into practitioner profiles to be made available to the public. The information must include: graduate medical education; hospitals at which the physician has privileges; the address at which the physician will primarily conduct his or her practice; specialty certification; year the physician began practice; faculty appointments; a description of any criminal offense committed; a description of any final disciplinary action taken within the most recent 10 years; and professional liability closed claims reported to the Department of Insurance within the most recent 10 years exceeding $5,000. In addition the physician may submit: professional awards and publications; languages, other than English, used by the physician to communicate with patients; and an indication of whether the physician participates in the Medicaid program. Each person who applies for initial licensure as a medical physician, osteopathic physician, chiropractic physician, or podiatric physician must, at the time of application, and each medical physician, osteopathic physician, chiropractic physician, or podiatric physician must, in conjunction with the renewal of the license, submit the information required for practitioner profiles.

Section 456.039, F.S., requires medical physicians, osteopathic physicians, chiropractic physicians, and podiatric physicians to submit fingerprints for a national criminal history check as part of initial licensure. The section also requires already licensed medical physicians, osteopathic physicians, chiropractic physicians, and podiatric physicians to submit, on a one-time-basis, a set of fingerprints for the initial renewal of their licenses after January 1, 2000, to DOH. DOH must submit the fingerprints of licensure renewal applicants to the Florida Department of Law Enforcement (FDLE) and FDLE then must forward the fingerprints to the Federal Bureau of Investigation for a national criminal history check for the initial renewal of the applicant's license after January 1, 2000. For any subsequent renewal of the applicant's license, DOH must submit the required information for a statewide criminal history check of the applicant.

Section 456.0391, F.S., requires advanced registered nurse practitioners to comply with the practitioner profiling requirements and submit fingerprints and specified information for compilation into a practitioner profile. DOH began compiling profiles for advanced registered nurse practitioners on July 1, 2001.

Section 456.041, F.S., requires DOH to indicate if the criminal history information reported by a medical physician, osteopathic physician, chiropractic physician, or podiatric physician or advanced registered nurse practitioner is not corroborated by a criminal history check. DOH or the board having regulatory authority over the practitioner must investigate any information it receives when it has reasonable grounds to believe that the practitioner has violated any law that relates to the practitioner's practice. Each practitioner's profile must include the following statement: "The criminal history information, if any exists, may be incomplete; federal criminal history information is not available to the public." The subject of each profile is given 30 days to make corrections of any factual inaccuracies in the profile before it is published or given to the public. DOH may not include disciplinary action taken by a licensed hospital or ambulatory surgical center in the practitioner profile.

Medical physicians, osteopathic physicians, chiropractic physicians, and podiatric physicians applying for licensure renewal must submit the information required for the practitioner profiles, however, an applicant who has submitted fingerprints to DOH for a national criminal history check upon initial licensure and is renewing his or her license for the first time, only needs to submit the information and fee required for a statewide criminal history check.

Section 456.043, F.S., requires DOH to develop or contract for a computer system to accommodate the new data collection and storage requirements for practitioner profiles. The department is authorized to contract with and negotiate any interagency agreement necessary to develop and implement the practitioner profiles. DOH shall have access to any information or record maintained by the Agency for Health Care Administration, including any information or record that is otherwise confidential and exempt from ch. 119, F.S., and s. 24(a), Art. I of the State Constitution, so that the department may corroborate any information that practitioners are required to report under s. 456.039 or s. 456.0391, F.S.

Section 456.042, F.S., requires DOH to update each practitioner's profile periodically and an updated practitioner's profile is subject to the same requirement as an original profile with respect to the period within which the practitioner may review the profile for the purpose of correcting factual inaccuracies.

Financial Responsibility and Closed Claims

Sections 458.320 and 459.0085, F.S., require Florida-licensed allopathic and osteopathic physicians to maintain professional liability insurance or other specified financial responsibility to cover potential claims for medical malpractice as a condition of licensure, with specified exemptions. Physicians who have hospital privileges must maintain professional liability insurance or other financial responsibility to cover an amount not less than $250,000 per claim. Physicians without hospital privileges must carry sufficient insurance or other financial responsibility in coverage amounts of not less than $100,000 per claim. Physicians who do not carry professional liability insurance must provide notice to their patients. A physician is said to be "going bare" when that physician has elected not to carry professional liability insurance. Physicians who go bare must either provide notice by posting a sign which is prominently displayed in the reception area and clearly noticeable by all parties or provide a written statement to each patient. Such sign or statement must state:

> "Under Florida law, physicians are generally required to carry medical malpractice insurance or otherwise demonstrate financial responsibility to cover potential claims for medical malpractice. YOUR DOCTOR HAS DECIDED NOT TO CARRY MEDICAL MALPRACTICE INSURANCE. This is permitted under Florida law subject to certain conditions. Florida imposes penalties against noninsured physicians who fail to satisfy adverse judgments arising from claims of medical malpractice. This notice is provided pursuant to Florida law."

With specified exceptions, the Department of Health must suspend on an emergency basis, any licensed allopathic or osteopathic physician who fails to satisfy a medical malpractice claim against him or her within specified time frames.

Section 627.912, F.S., requires insurers to report "closed claims" that involve any action for damage for personal injuries in the performance of professional services by a Florida-licensed medical physician, osteopathic physician, podiatric physician, dentist, hospital, crisis stabilization unit, health maintenance organization, ambulatory surgical center, or attorney to the Department of Insurance. DOH must review each closed claim involving a Florida-licensed medical physician, osteopathic physician, podiatric physician, or dentist and determine whether any of the incidents that resulted in the claim involved conduct by the licensed health care practitioner that is subject to disciplinary action.

Section 456.049, F.S., requires medical physicians, osteopathic physicians, physician assistants, podiatric physicians, and dentists to report "closed claims" for damages for personal injury that are alleged to have been caused by the negligence of the practitioner that are not covered by an insurer and reported as a closed claim under s. 627.912, F.S., to DOH. Section 456.051, F.S., specifies that "closed claims" reported under s. 456.049 and s. 627.912, to DOH are public information except for the name of the claimant or injured person. Any information that DOH possesses that relates to a bankruptcy proceeding by a medical physician, osteopathic physician, physician assistant, podiatric physician, or dentist is public information.

Sections 458.331 and 459.015, F.S., provide grounds for which an allopathic or osteopathic physician may be subject to discipline by his or her board. Allopathic and osteopathic physicians may be subject to discipline for gross or repeated malpractice or the failure to practice medicine with that level of care, skill, and treatment recognized by a reasonably prudent similar physician as being acceptable under similar conditions and circumstances. "Repeated malpractice" includes, but is not limited to, three or more claims for medical malpractice within the previous 5-year period resulting in indemnities being paid in excess of $25,000. If it is reported that a physician has had three or more claims with indemnities exceeding $25,000 each within the previous 5-year period, DOH must investigate the occurrences upon which the claims were based and determine if action by the department against the physician is warranted.

III. Effect of Proposed Changes:

Section 1. Adds a new subsection (3) to s. 395.004, F.S., to permit a licensed hospital, ambulatory surgical center, or mobile surgical facility to apply to AHCA for certification of a quality improvement program that results in the reduction of adverse incidents at that facility. AHCA must consult with the Department of Financial Services in developing criteria for the certification. Insurers must file with the Department of Financial Services a discount in the rate or rates applicable for medical liability insurance coverage to reflect the implementation of a certified quality improvement program. The Department of Financial Services, as it reviews rate discounts, must consider whether a certified quality improvement program is covered under a risk management program offered by an insurer.

Section 2. Creates s. 395.0056, F.S., to require a licensed hospital, ambulatory surgical center, or mobile surgical facility to notify AHCA of all medical malpractice lawsuits filed against it or a member of its staff when the underlying cause of action pertaining to the staff member involved the licensed facility. The facility must notify AHCA within 15 days after it receives notice or becomes aware that an action has been initiated against the facility or its current or former staff. The plaintiff is also required to provide a copy of the claim to AHCA, and AHCA must

determine whether the facility filed adverse incident reports as required in s. 395.0197, F.S. AHCA must publish information about litigation filed against licensed facilities annually.

Section 3. Creates s. 395.0187, F.S., to require each licensed hospital, ambulatory surgical center, or mobile surgical facility to establish a nurse-to-patient ratio consistent with the findings of the "Pennsylvania Study" that was supported by the National Institute of Nursing Research. Each licensed facility must work with AHCA to determine the circumstances and methods for varying an established ratio.

Section 4. Amends s. 395.0193, F.S., relating to peer review, to add mental or physical abuse of a nurse or other staff member as grounds for discipline of a staff member or physician who delivers health care services at a hospital, ambulatory surgical center, or mobile surgical facility. The bill specifies that documents and communications pertaining to the professional conduct of a physician or hospital staff that are not generated during the course of deliberation, investigation, or analysis of a peer review panel, a committee of a hospital, a disciplinary board, or a governing board with whom there is a specific written contract for that purpose, are not privileged. In response to a request for discovery, a claim of privilege must be accompanied by a list of the documents or communications for which privilege is asserted with patient-identifying information redacted from the list. The bill specifies information that must be included in the list: the date of the document or communication; the name and address of the document's author or the communication's originator, unless that person is a patient; the name and address of the party who received the document or communication; the date the document or communication was received; the name and address of the document's custodian or the originator of the communication; and the statutory or case law on which the privilege is asserted. A defendant's monetary liability under this section must not exceed $250,000.

Section 5. Amends s. 395.0197, F.S., to revise the requirements for the internal risk management program that every hospital, ambulatory surgical center, or mobile surgical facility must implement. This section:

- Removes the exemption from risk management training that licensed health care practitioners currently are afforded if they are required to complete continuing education coursework under ch. 456, F.S., or their respective practice act.
- Requires a facility to have a system by which the risk manager must give written notice to a patient, patient's family member, or patient's designated representative that the patient was the subject of an adverse incident.
- Requires each licensed hospital, ambulatory surgical center, or mobile surgical facility to report to AHCA and the Department of Health (DOH), annually, the name, license number, period of coverage, notices of intent to sue received, and judgments entered against each health care practitioner for which it assumes liability. In their annual reports, AHCA and DOH must include statistics that report the number of licensed facilities that assume liability and the number of health care professionals, by profession, for whom they assume liability.
- Makes a person who had the duty to file an incident report and who failed to do so subject to disciplinary action by the facility and the appropriate regulatory board and subject to a fine of up to $1,000 per day for each day the report was not timely submitted.

- Requires the 24-hour notification and the 15-day report to be filed for all adverse incidents, as defined in s. 395.0197(5), F.S., that have occurred or when there is a reasonable possibility that it has occurred.
- Permits the adverse incident notification and reports to be discoverable in disciplinary proceedings.
- Requires AHCA to annually publish on its website a trend analysis of adverse incidents, including an analysis of errors, omissions, negligence, and closed claims reported under ss. 627.912 and 627.9122, F.S.
- Requires AHCA to publish an annual report card for each hospital, ambulatory surgical center, and mobile surgical facility providing descriptive information about the facility and its services; adverse incidents; procedures performed; disciplinary actions taken against professionals; infants abducted or discharged to the wrong family; and closed claims.
- Requires a risk manager to report every allegation of sexual misconduct to AHCA.
- Requires a facility at which an incident of sexual abuse occurs to offer the victim of the abuse testing for sexually transmissible diseases, if appropriate, and provide all such testing at no cost to the victim.
- Requires AHCA to make available to the public information about any willful or nonwillful adverse incident that was not timely reported and the sanctions authorized.

Section 6. Amends s. 456.025, F.S., relating to the Department of Health's or board's authority to set license renewal fees for health care practitioners within the department's Division of Medical Quality Assurance, to delete provisions that limit the department's or board's authority to set license renewal fees which are no more than 10 percent greater than the fee imposed during the previous 2-year licensure period and that are no more than 10 percent greater than the actual cost to regulate a profession.

Section 7. Amends s. 456.026, F.S., relating to the annual report of the Department of Health's Division of Medical Quality Assurance, to require the department to publish the report to its website simultaneous with delivery of the report to the presiding officers of the Legislature. The report must be directly accessible on the department's Internet homepage highlighted by easily identifiable links. The report must also include additional statistics and relevant information detailing: the number of health care practitioners licensed by the department or otherwise authorized to provide services in Florida, if known to the department; information on the professional liability claims and actions reported by insurers as closed claims for medical physicians, osteopathic physicians, podiatric physicians or dentists; and closed claims for health maintenance organizations licensed under pt. I, ch. 641, F.S

Section 8. Amends s. 456.041, F.S., relating to practitioner profiles, to require the Department of Health to develop a format to compile uniformly any information submitted by certain health care practitioners. Medical physicians and osteopathic physicians are required to report to the department and their board, all final disciplinary actions, sanctions by governmental agencies or facilities licensed by state law, and claims or actions for personal injury reported under s. 456.051, F.S., no later than 15 calendar days after such action or sanction is imposed. Failure to submit the information within the 15 calendar days subjects the physician to discipline by their

board and a fine of $100 per day that the information is not submitted following the expiration of the 15-day reporting period.

The Department of Health must update the practitioner profile with disciplinary actions, sanctions and claims for personal injury within 15 business days. Criminal history information must indicate on each profile whether the criminal history information included in the practitioner profile is, or is not, corroborated by a criminal history check. The department or the board having regulatory authority over the practitioner must investigate any information received and limitations under current law which narrow such investigations to "reasonable grounds to believe that the practitioner has violated any law that relates to the practitioner's practice."

The department must provide in each practitioner profile, a narrative description of every final disciplinary action taken against the practitioner that explains the administrative complaint and the final discipline imposed on the practitioner. The department must include a hyperlink to each final order listed in its website report of dispositions of recent disciplinary actions taken against practitioners. The department must include a hyperlink to comparison reports of closed claims filed against a practitioner in the practitioner's profile. The department must include in the practitioner profiles the date of any disciplinary action taken by a licensed hospital or ambulatory surgical center against a practitioner. Any practitioner who is disciplined for failing to report disciplinary actions, sanctions or claims of personal injury as required by the bill must report the date the disciplinary action was imposed. The department must state whether the action related to professional competence and whether it related to the delivery of services to a patient.

The Department of Health would no longer have to consult with board having jurisdiction over a practitioner to include information in his or her profile that is a public record and relates to the practitioner's ability to competently practice his or her profession. The department must make a practitioner's profile available at the end of a 30-day period under which the practitioner may review and verify the factual accuracy of the contents of the profile. The practitioner is required to review and verify the accuracy of his or her profile and is made subject to a fine of up to $100 per day for a failure to verify the profile contents and to correct any factual errors in his or her profile within the 30-day period.

The department must include a statement in each profile that has not been reviewed by the practitioner, the fact that the practitioner has not verified the information contained in the profile. Each profile must contain an easy-to-read explanation of any disciplinary action taken and the reason that sanctions were imposed. The department may provide one link in each profile to a practitioner's professional website if the practitioner requests that such a link be included in his or her profile.

Section 9. Amends s. 456.042, F.S., to revise requirements for a practitioner to update information in the profile from periodically to quarterly. A practitioner must submit updates of required information within 15 days after the final activity that renders such information a fact. An updated profile is subject to the same requirements as an original profile.

Section 10. Amends s. 456.049, F.S., to require medical physicians, osteopathic physicians, podiatric physicians, or dentists to report all claims or actions for damages for personal injury alleged to have been caused by the licensee rather than just those claim that are not reported by

insurers as "closed claims" under s. 627.912, F.S. The practitioner's board, or department when there is no board, must fine the practitioner up to $500 for the failure to comply with reporting requirements within 60 days after the payment of a claim or disposition of action for damages has been determined. The failure of the claimant to comply within 90 days subjects the practitioner to a fine of up to an additional $1,000. Any practitioner who has not reported the claims or actions as required by this section, and who is the subject of a subsequent action for damages at which time it is determined that he or she paid or had paid on his or her behalf a claim for damages, shall be subject to discovery of all such unreported information during the subsequent action.

Section 11. Amends s. 456.051, F.S., to require the Department of Health, within 15 calendar days of its receipt, to make available as part of a practitioner's profile, any report of a claim for damages filed with the department by a practitioner or his or her insurer as a closed claim or any bankruptcy proceeding involving the practitioner that the department has obtained.

Section 12. Amends s. 458.320, F.S., relating to financial responsibility requirements for medical physicians, to revise the disclosure requirements for any licensed physician who practices without malpractice insurance ("goes bare"), to require a sign with specified dimensions and in boldface type as specified by the Department of Health to be displayed in at least two distinct spaces in the reception area and each space or room used for examination or treatment of patients. Such notice must be clearly visible to all patients and others who accompany a patient on an office visit. As an alternative the physician who goes "bare" may provide a written statement, printed in bold-face type with a minimum font size of 12 which must state: "YOUR DOCTOR HAS DECIDED NOT TO CARRY MEDICAL MALPRACTICE INSURANCE. This notice is provided pursuant to Florida law.

Notwithstanding any other provision of this section, the Department of Health must suspend the license of any physician against whom has been entered a final judgment, arbitration award, or other order or who has entered into a settlement agreement to pay damages arising out of a claim for medical malpractice, if all appellate remedies have been exhausted and payment up to amounts required by this section has not been made within 30 days after the entering of such judgment, award, or order or agreement, until proof of payment is received by the department. This requirement does not apply to a physician who has met the financial responsibility requirements by obtaining medical malpractice insurance.

Section 13. Amends s. 458.331, F.S., relating to grounds for which a medical physician may be subject to discipline, to increase the threshold amount from $25,000 to $50,000 of indemnities paid within a 5-year period for purposes of the violation of gross or repeated malpractice. To conform, the threshold amount for physician closed claims reported and investigated by the Department of Health is increased from $25,000 to $50,000. The ground relating to gross or repeated malpractice or the failure to practice medicine with that level of care, skill, and treatment which is recognized by a reasonably prudent similar physician as being acceptable under similar conditions and circumstances for a which a physician may be disciplined, is revised to require the recommended order by an administrative law judge or a final order of the Board of Medicine finding a violation under this ground to specify whether the licensee was found to have committed "gross malpractice," "repeated malpractice," or "failure to practice medicine with that level of care, skill, and treatment which is recognized as being acceptable

under similar conditions and circumstances," or any combination thereof. Any publication of the Board of Medicine must also specify under which ground or combination thereof the physician was subject to discipline.

Additional grounds for which a physician may be subject to discipline by the Board of Medicine include refusing to provide health care based on a patient's participation in pending or past litigation or participation in any disciplinary action, unless such litigation or disciplinary action directly involves the physician who is requested to provide services.

Section 14. Amends s. 459.0085, F.S., relating to the financial responsibility requirements for osteopathic physicians, to provide, notwithstanding any other provision of this section, that the Department of Health must suspend the license of any osteopathic physician against whom has been entered a final judgment, arbitration award, or other order or who has entered into a settlement agreement to pay damages arising out of a claim for medical malpractice, if all appellate remedies have been exhausted and payment up to amounts required by this section has not been made within 30 days after the entering of such judgment, award, or order or agreement, until proof of payment is received by the department. This requirement does not apply to a physician who has met the financial responsibility requirements by obtaining medical malpractice insurance.

Section 15. Amends s. 459.015, F.S., relating to grounds for which a osteopathic physician may be subject to discipline, to increase the threshold amount from $25,000 to $50,000 of indemnities paid within a 5-year period for purposes of the violation of gross or repeated malpractice. To conform, the threshold amount for physician closed claims reported and investigated by the Department of Health is increased from $25,000 to $50,000.

Section 16. Creates an undesignated section of law, to make each member of, or health care professional consultant to, any committee, board, group, commission, or other entity immune from civil liability for any act, decision, omission, or utterance done or made in the performance of his or her duties while serving as a member or consultant to such committee, board, group, commission, or other entity established and operated for purposes of quality improvement review, evaluation, and planning in a state licensed health care facility. The act, decision, omission, or utterance may not be made or done in bad faith or with malicious intent. Such entities must function primarily to review, evaluate, or make recommendations relating to:

- The duration of patient stays in health care facilities;
- The professional services furnished with respect to the medical, dental, psychological, podiatric, chiropractic, or optometric necessity for such services;
- The purpose of promoting efficient use of available health care facilities and services;
- The adequacy or quality of professional services;
- The competency and qualifications for professional staff privileges;
- The reasonableness or appropriateness of charges made by or on behalf of health care facilities; and
- Patient safety.

The committee, board, group, commission, or other entity must be established in accordance with requirements of the Joint Commission on Accreditation of Healthcare Organizations,

established and duly constituted by one or more public or licensed private hospitals or behavioral health agencies, or established by a governmental agency.

Section 17. Creates an undesignated section, to establish a privilege from disclosure or discovery for all communications, both oral and written, of any medical staff committee, utilization review committee, or other committee, board, group, commission, or other entity, as specified in ch. 395, F.S., relating to hospitals or ch. 641, F.S., relating to health maintenance organizations, which originate in the course of such committees' deliberation, investigation, or analysis. Such communications are privileged and may not be disclosed or obtained by legal discovery proceedings unless a circuit court, after a hearing and for good cause, orders the disclosure of such proceedings, minutes, records, reports, or communications. For purposes of this section, accreditation and peer review records are considered privileged communications.

Definitions for the terms "patient safety data" and "patient safety organization" are provided.

Any documents and communications pertaining to the professional conduct of a physician or staff member of the facility or pertaining to service delivered by a physician or staff member of the facility which are not generated during the course of deliberation, investigation, and analysis of a patient safety organization are not considered privileged. In response to a request for discovery, a claim of privilege by a patient safety organization must be accompanied by a list identifying all documents or communications for which the privilege is asserted. The list and a document or communication, must be reviewed in camera by a court for a determination of whether the document or communication is privileged. Patient identifying information shall be redacted or otherwise excluded from the list, unless a court of competent jurisdiction orders disclosure of such information.

A list of documents or communications for which privilege is asserted must include: the date of creation of the document or communication; the name and address of the document's author or communication's originator, unless a patient; name and address of the party from whom the document was received; the date the document or communication was received; the name and address of the original document's custodian or communication's originator; and the statutory or case law on which the privilege is asserted.

The section does not provide any additional privilege to a hospital, physician, or behavioral health provider with respect to any medical record kept for any patient in the ordinary course of business of operating a hospital, licensed physician's office, or behavioral health provider or to any facts or information in such records. The section does not preclude or affect discovery of or production of evidence relating to hospitalization or treatment of any patient in the ordinary course of hospitalization or treatment.

A patient safety organization must promptly remove all patient-identifying information after receipt of a complete patient safety data report unless such organization is otherwise permitted by state or federal law to maintain such information. The exchange of patient safety data among health care providers or patient safety organizations which does not identify any patient shall not constitute a waiver of any privilege established under this section. Reports of patient safety data to patient safety organizations does not abrogate obligations to make reports to the Department of Health, the Agency for Health Care Administration, or other state or federal law regulatory

agencies. Employers are prohibited from taking retaliatory actions against an employee who in good faith makes a report of patient safety data to a patient safety organization. Each patient safety organization convened under this section must quarterly submit statistical reports of its findings to the Department of Health, the Agency for Health Care Administration, and the Department of Financial Services. Each department must use such statistics for comparison to information the department generates from its regulatory operations and to improve its regulation of health care providers.

Section 18. Creates an undesignated section of law to require the Department of Health and the Department of Financial Services to jointly publish a list, updated semiannually, of all health care professionals authorized to practice in this state, licensed under the medical practice act or the osteopathic practice act, and who do not carry medical malpractice insurance. This list must indicate the last date such health care professional was covered by professional liability insurance and any explanation of insurance status deemed appropriate.

Section 19. Creates an undesignated section of law to require each final settlement relating to medical malpractice to include the following statement: "The decision to settle a case may reflect the economic practicalities pertaining to the cost of litigation and is not, alone, an admission that the insured failed to meet the required standard of care applicable to the patient's treatment. The decision to settle a case may be made by the insurance company without consulting its client for input."

Section 20. Creates an undesignated section of law to provide that notwithstanding any other provision of law to the contrary, confidential legal settlements pertaining to medical malpractice are prohibited. A legal settlement shall be public information.

Section 21. Creates an undesignated section of law, to require the Department of Financial Services to revise its closed claim form for readability at the 9th grade level. The department must compile annual statistical reports that provide data summaries of all closed claims, including the number of closed claim files pertaining to the referent health care professional or health care entity, the nature of the errant conduct, the size of payments, and the frequency and size of noneconomic damage awards. The department must develop annualized historical statistical summaries beginning with the 1976 state fiscal year and publish these reports on its website no later than the 2005 state fiscal year. The form must meet the following minimum requirements:

- Medical physicians, osteopathic physicians, and physician assistants must report to the Department of Financial Services and the Department of Health any claim or action for damages for personal injury alleged to have been caused by error, omission, or negligence in the performance of such licensee's professional services or based on a claimed performance of professional services without consent if the claim was not covered by an insurer required to report under s. 627.912, F.S., is not a claim for medical malpractice, subject to s. 766.106, F.S., and resulted in: a final judgment, settlement, or final disposition not resulting in payment. Reports must be filed with the Department of Financial Services no later than 60 days following the occurrence of any final judgment, settlement, or disposition.

Health professional reports must include information specified in the bill and any other information that the Department of Financial Services requires to analyze and evaluate the nature, causes, location, cost, and damages involved in professional liability cases.

Section 22. Creates an undesignated section of law to provide a severability clause which states that if any provision of this act or its application to any person or circumstance is held invalid, the invalidity does not affect other provisions or applications of the act which can be given effect without the invalid provision or application, and to this end the provisions of this act are severable.

Section 23. Provides an effective date upon becoming a law.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

The provisions of this bill have no impact on municipalities and the counties under the requirements of Article VII, Section 18 of the Florida Constitution.

B. Public Records/Open Meetings Issues:

The provisions of this bill have no impact on public records or open meetings issues under the requirements of Art. I, s. 24(a) and (b) of the Florida Constitution.

C. Trust Funds Restrictions:

The provisions of this bill have no impact on the trust fund restrictions under the requirements of Article III, Subsection 19(f) of the Florida Constitution.

V. Economic Impact and Fiscal Note:

A. Tax/Fee Issues:

The bill eliminates caps on the amount by which health care practitioner licensure fees are permitted to increase from one biennium to the next.

B. Private Sector Impact:

Physicians will incur costs to timely comply with the additional reporting requirements under sections 7 and 8 of the bill. Medical physicians will incur costs to provide notice of going “bare” (without medical malpractice insurance) and to show proof of payment for medical malpractice liabilities incurred by the physician within the requirements of the bill.

Parties to settlements involving medical malpractice may incur costs related to additional liabilities that would be otherwise confidential under current law.

Licensed hospitals, ambulatory surgical centers, and mobile surgical facilities will incur the cost of recruiting and hiring nurses to meet new staffing ratios, working with AHCA to determine acceptable variation from the ratios, revising the facility's risk management program and procedures for adverse incident reports.

C. Government Sector Impact:

Section 1. AHCA would incur costs for implementing a quality improvement certification program for hospitals, ambulatory surgical centers, and mobile surgical facilities (which would then be eligible for a medical malpractice rate reduction). AHCA estimates that this would require 1 additional FTE (Government Operations Consultant III), responsible for working with the Department of Financial Services to develop certification criteria, promulgating rules, reviewing information submitted by providers, and coordinating communication.

Sections 2-5 ACHA would incur costs for determining whether facilities filed adverse incident reports, working with each licensed facility to determine acceptable variations from nurse staffing ratios, revising the format for adverse incident reports, and publishing an annual report card for each facility. AHCA has estimated that this will require 4 additional FTE's (a Registered Nurse Consultant, two Health Services and Facilities Consultants, and an Administrate Secretary)

The estimated fiscal impact on AHCA from Sections 1-5 (5 additional FTEs) is as follows:

Fiscal Impact on Agency for Health Care Administration

	Amount Year 1 FY 2003-04	Amount Year 2 FY 2004-05
1. Non-Recurring Impact:		
Expenditures:		
4 FTE Professional staff	$ 14,500	$ -0-
1 FTE Support staff	$ 3,042	$ -0-
Total Non-Recurring Expense	$ 17,562	$ -0-
2. Recurring Impact:		
Expenditures:		
4 FTE Professional staff	$ 250,227	$ 250,227
1 FTE Support staff	$ 34,353	$ 34,353
Total Recurring Expense	$ 284,580	$ 284,580
Total Expenses:	$ 302,122	$ 302,122

The Department of Health will incur costs to publish the Medical Quality Assurance Division's annual report for health care practitioners to its website and include additional statistics and information specified in sections 7 and 8 of the bill, including the required

timely updates of such information; to develop a format to uniformly compile any information submitted by certain health care practitioners; to complete narrative descriptions of disciplinary actions and provide hyperlinks to websites; to update the information in the practitioner profiles within 15 days; to impose additional disciplinary fines and actions on physicians for failure to timely report specified information under section 10 of the bill.

Note: Amendment #2 by Health, Aging, and Long-Term Care **deletes sections 2-5** of the bill and inserts three new sections. As amended, the only new responsibility on AHCA would be to study the types of information the public would find relevant in the selection of a hospital and report its findings to the Legislature by January 15, 2004.

The Department of Health and the Department of Financial Services will incur costs to jointly publish a list of all health care practitioners who are authorized to practice in Florida and who do not carry medical malpractice insurance.

The Department of Financial Services will incur costs to implement its responsibilities for revising the handling of closed claims data and the reporting of such information under section 21 of the bill.

VI. Technical Deficiencies:

On page 30, line 17, the reference to "department" should be changed to "Division of Medical Quality Assurance."

On page 63, line 4, after "analysis of" should add "patient safety data by."

On page 63, line 23, before "Patient" should add "Unless otherwise provided by law."

On page 65, line 6, "law" should be deleted.

VII. Related Issues:

On page 31, lines 7-12, the Department of Health does not have regulatory jurisdiction over entities licensed under pt. I, ch. 641, F.S.

Section 12 of the bill revises the manner in which a medical physician who does not carry medical malpractice insurance must disclose this fact to his or her patients but does not impose the same disclosure requirements on an osteopathic physician who does not carry medical malpractice insurance.

In sections 1 and 21 of the bill, references to "Department of Financial Services" should be changed to "Office of Insurance Regulation."

VIII. Amendments:

1 by Health, Aging, and Long-Term Care:
A technical correction, changes Department of Financial Services to Office of Insurance Regulation. (WITH TITLE AMENDMENT)

2 by Health, Aging, and Long-Term Care:
Deletes sections 2-5 of the bill, relating to litigation notice requirements, nurse/patient staffing ratios, peer review procedures, and internal risk management programs, and inserts three new sections that require:

- Each licensed hospital, ambulatory surgical center, and mobile surgical facility to adopt a patient safety plan and appoint a patient safety officer and a patient safety committee.
- Each facility to inform each patient, or an individual who serves as proxy for a developmentally disabled or incapacitated person who has not executed an advance directive, about unintended outcomes of care that result in serious harm to the patient.
- AHCA to study the types of information the public would find relevant in the selection of a hospital and report its findings to the Legislature by January 15, 2004. (WITH TITLE AMENDMENT)

3 by Health, Aging, and Long-Term Care:
A technical correction, changes department to Division of Medical Quality Assurance.

4 by Health, Aging, and Long-Term Care:
Deletes the requirement that DOH include in its annual report concerning finances, administrative complaints, disciplinary actions, and recommendations, information about claims or actions for damages caused by the errors, omissions, or negligence of officers or directors of HMOs licensed under part I of ch. 641, F.S.

5 by Health, Aging, and Long-Term Care:
Adds requirements for osteopathic physicians to provide public notice, if they do not carry medical malpractice insurance, in a specified format. (WITH TITLE AMENDMENT)

6 by Health, Aging, and Long-Term Care:
Replaces section 17 of the bill, relating to patient safety data, to provide new definitions of patient safety data and patient safety organization and to specify that patient safety data are not subject to discovery or introduction into evidence in a civil or administrative action. (WITH TITLE AMENDMENT)

7 by Health, Aging, and Long-Term Care:
A clarifying amendment, inserts “patient safety data by”

8 by Health, Aging, and Long-Term Care:
A clarifying amendment, inserts “unless otherwise provided by law”

9 by Health, Aging, and Long-Term Care:
A technical amendment, deletes the word law.

10 by Health, Aging, and Long-Term Care:
A technical amendment, changes department to office.