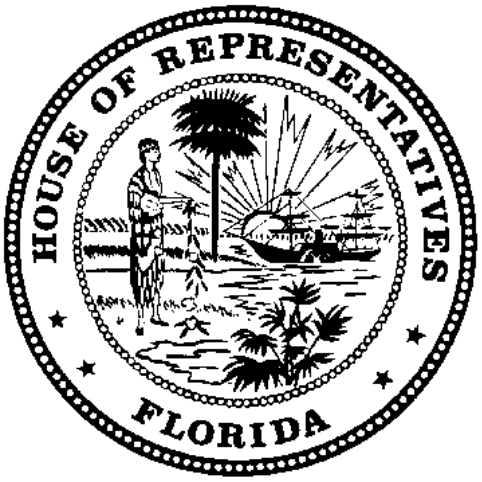


Committee on Health Quality

Tuesday, February 5, 2008
9:00 AM – 10:45 AM
306 HOB

COMMITTEE MEETING PACKET

Marco Rubio
Speaker

Gayle Harrell
Chair

House of Representatives

Committee on Health Quality

AGENDA

February 5, 2008
9:00 AM – 10:45 AM
(306 HOB)

I. Opening Remarks

II. Consideration of HB 285 by Kiar -- Clinical Nurse Specialists

III. Workshop relating to revisions of the hospital Code 15 reporting system

IV. Presentation by the Department of Health regarding the status of the Comprehensive Statewide Tobacco Education and Use Prevention Program

V. Presentation by the Department of Health regarding the status of the Physician Workforce Assessment and Development Program

VI. Closing Remarks & Adjournment

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 285 Clinical Nurse Specialists

SPONSOR(S): Kiar

TIED BILLS: **IDEN./SIM. BILLS:** SB 736

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR
1) Committee on Health Quality		Owen	Lowell
2) Healthcare Council			
3)			
4)			
5)			

SUMMARY ANALYSIS

House Bill 285 authorizes the Florida Board of Nursing to grant a waiver of the specialty area certification requirement for an applicant for certification as a clinical nurse specialist, if the applicant is academically prepared as a clinical nurse specialist in a specialty area where no certification exam is available.

The bill may implicate Article II, s.3 of the Florida Constitution as an unlawful delegation of legislative authority (See Constitutional Issues).

The bill appears to have no significant fiscal impact on state or local governments (See Fiscal Analysis).

The bill takes effect July 1, 2008.

I. SUBSTANTIVE ANALYSIS

A. HOUSE PRINCIPLES ANALYSIS:

This bill does not appear to implicate any of the House Principles.

B. EFFECT OF PROPOSED CHANGES:

Present Situation

Part I of Chapter 464, F.S., governs the licensure and regulation of nurses in Florida. Nurses are licensed by the Department of Health (department) and are regulated by the Board of Nursing (board). Licensure requirements to practice professional nursing include completion of education requirements, demonstration of passage of a department-approved examination, a clean criminal background screening, and payment of applicable fees.[1] Renewal is biennial and contingent upon completion of certain continuing medical education requirements.

Section 464.0115, F.S., recognizes a clinical nurse specialist (CNS) as a person who has met the following criteria:

- Licensed to practice professional nursing;
- Completion of a master's degree in a clinical nursing specialty; and
- Certification in a specialty area from a nationally recognized certifying body as determined by the Board of Nursing.

A CNS is trained to be an expert clinician in a specialized area of nursing practice, such as a particular disease state or population. As an article authored by the National Association of Clinical Nurse Specialists (national association) in the journal *Clinical Nurse Specialist* notes, "the essence of the CNS practice expertise is embedded in a specialty."[2] The national association notes that there are approximately 54,000 CNSs in the United States, of which approximately 25% are certified or recognized by a state board.[3] The national association comments that one factor in the low number of CNSs may be that "valid and reliable certification examinations are not available."[4] Florida began certification of CNSs on July 1, 2007.[5] According to the board, there are no certified clinical nurse specialists as of January 2008.

The board has recognized four national certifying bodies: the American Nurses Credentialing Center, the American Association of Critical-Care Nurses, the Oncology Nursing Certification Corporation, and the National Board for Certification of Hospice and Palliative Care Nurses. In addition, the board has recognized the following CNS specialties:

- Advanced Diabetes Management
- Adult Health
- Child/Adolescent Psychiatric and Mental Health
- Psychiatric and Mental Health

[1] Section 464.009, F.S., provides an alternative to licensure by examination for nurses through licensure by endorsement.
[2] *Regulatory Credentialing of Clinical Nurse Specialists*, 17 Clinical Nurse Specialist 163 (2003).
[3] *Id.*
[4] *Id.*
[5] *See* CS/CS/SB 248; Chapter 2007-167, L.O.F.

- Gerontological
- Pediatric
- Public/Community Health
- Advanced Oncology CNS
- Certified Critical-Care CNS
- Hospice and Palliative Care CNS

However, this list is only a subset of the specialty training available in programs that prepare CNSs; as noted above, certification exams are not available for all CNS specialties. As an example, there is no certification exam for a CNS trained in emergency medicine.

Effect of Proposed Changes

The bill authorizes an applicant for certification as a CNS to petition the board for a waiver from the certification exam requirement found in s. 464.0115(1), F.S., if the applicant is licensed to practice nursing and has completed a master's degree in a clinical nursing specialty, but cannot complete a certification exam because no certification exam is available in his or her respective specialty.

The bill requires the petitioner to:

- Be academically prepared as a CNS in a specific specialty area;
- Hold a master's degree in nursing that includes clinical experience in the specialty area; and
- Complete 1,000 hours of supervised clinical experience in the specialty area, including a minimum of 500 hours of supervised post-graduate clinical practice.

The bill authorizes the board to grant a nonrenewable certificate that is valid for up to 12 months while the petitioner completes his or her supervised post-graduate clinical practice.

The bill authorizes the board to renew the waiver every two years, if the CNS continues to be ineligible for certification due to the unavailability of a certification course in the CNS' specialty area.

C. SECTION DIRECTORY:

Section 1: Revises requirements for certification as a clinical nurse specialist.

Section 2: Provides an effective date.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   None.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

None.

2. Expenditures:

None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

None.

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

Not applicable because the bill does not appear to require counties or cities to spend funds or take action requiring the expenditure of funds; reduce the authority that cities or counties have to raise revenues in the aggregate; or reduce the percentage of a state tax shared with cities or counties.

2. Other:

This bill may implicate Article II, s.3[6] of the Florida Constitution as an unlawful delegation of legislative authority. This section of the Florida Constitution "prohibits the delegation of legislative powers absent ascertainable minimal standards and guidelines."[7] Two exceptions to this non-delegation doctrine are generally recognized where "it is impracticable to lay down a definite comprehensive rule . . . (1) when the subject of the statute relates to licensing and the determination of the fitness of the applicant to be licensed, and (2) when the statute regulates businesses operated as a privilege rather than as a right which are potentially dangerous to the public."[8] Here, the bill gives the board broad discretion to waive the statutory certification requirement if the CNS is

[6] "The powers of the state government shall be divided into legislative, executive and judicial branches. No person belonging to one branch shall exercise any powers appertaining to either of the other branches unless expressly provided herein."

[7] *Department of Business Regulation, Div. of Alcoholic Beverages and Tobacco v. Jones*, 474 So.2d 359, 361 (Fla. Dist. Ct. App. 1985).

[8] *Id.* at 362 (citing *Florida Waterworks Association v. Florida Public Service Commission,* 473 So.2d 237, 245 (Fla. Dist. Ct. App. 1985)).

"academically prepared" in a specialty area where no certification exam exists. However, the authority granted to the board does not appear to turn on the issue of "personal fitness" but rather academic preparation.

B. RULE-MAKING AUTHORITY:

No additional rulemaking authority is required as a result of this bill.

C. DRAFTING ISSUES OR OTHER COMMENTS:

The Department of Health recommends extending the effective date of the bill to October 1, 2008 in order to provide additional time to implement the waiver process.

D. STATEMENT OF THE SPONSOR

No statement submitted.

IV. AMENDMENTS/COUNCIL SUBSTITUTE CHANGES

HOUSE AMENDMENT FOR COUNCIL/COMMITTEE PURPOSES

Amendment No. 1 (for drafter's use only)

Bill No. **0285**

COUNCIL/COMMITTEE ACTION

ADOPTED	__ (Y/N)
ADOPTED AS AMENDED	__ (Y/N)
ADOPTED W/O OBJECTION	__ (Y/N)
FAILED TO ADOPT	__ (Y/N)
WITHDRAWN	__ (Y/N)
OTHER	_____

Council/Committee hearing bill: Committee on Health Quality

Representative Kiar offered the following:

Amendment

Remove everything after the enacting clause and insert:

Section 1. Subsection (1) of section 464.0115, Florida Statutes, is amended to read:

464.0115 Certification of clinical nurse specialists.--

(1) Any nurse seeking certification as a clinical nurse specialist must apply to the department and submit proof that he or she holds a current license to practice professional nursing, a master's degree in a clinical nursing specialty, and either: ~~current certification in a specialty area as a clinical nurse specialist from a nationally recognized certifying body as determined by the board.~~

(a) Current certification in a specialty area as a clinical nurse specialist from a nationally recognized certifying body as determined by the board; or

(b) Proof that the clinical nurse specialist is academically prepared as a clinical nurse specialist in a specialty area for which there is no certification within the clinical nurse specialist role and specialty and 1,000 hours of

clinical experience in the clinical specialty for which the individual was academically prepared with a minimum of 500 hours of clinical practice after graduation. The applicant clinical nurse specialist must submit an affidavit to the Board of Nursing affirming the required hours of clinical experience. Falsification of such affidavit shall constitute grounds for discipline in accordance with s. 464.018(1)(f).

Section 2. This act shall take effect October 1, 2008.

A bill to be entitled

An act relating to clinical nurse specialists; amending s. 464.0115, F.S.; revising requirements for certification as a clinical nurse specialist; providing an effective date.

Be It Enacted by the Legislature of the State of Florida:

Section 1. Subsections (2) and (3) of section 464.0115, Florida Statutes, are renumbered as subsections (3) and (4), respectively, and a new subsection (2) is added to that section to read:

464.0115 Certification of clinical nurse specialists.--

(1) Any nurse seeking certification as a clinical nurse specialist must apply to the department and submit proof that he or she holds a current license to practice professional nursing, a master's degree in a clinical nursing specialty, and current certification in a specialty area as a clinical nurse specialist from a nationally recognized certifying body as determined by the board.

(2) A clinical nurse specialist may petition the board for a waiver from the certification requirements of subsection (1) if the clinical nurse specialist is academically prepared as a clinical nurse specialist in a specialty area for which no certification examination exists within the clinical nurse specialist role. The board may determine that a clinical nurse specialist must obtain certification in an available specialty area in lieu of the specific specialty or subspecialty for which no certification examination exists. The petitioner must be

academically prepared as a clinical nurse specialist in a specific specialty area of clinical nurse specialist practice, have a master's degree in nursing that includes clinical experience in that specialty area, and have 1,000 hours of supervised clinical experience in that specialty area, including a minimum of 500 hours of supervised clinical practice after graduation. The board may grant a nonrenewable certificate for no longer than 12 months for the supervised postgraduate clinical experience. The board may renew a waiver granted under this subsection for 2-year periods provided the clinical nurse specialist continues to be ineligible for certification as a clinical nurse specialist by an organization acceptable to the board.

Section 2. This act shall take effect July 1, 2008.

CODE 15 REPORTING SYS

A bill to be entitled

An act relating to quality assurance and incident reporting; amending s. 395.0197, F.S., changing the incident reporting requirements; amending s.408.05 F.S., creating a new subsection 408.05 (6), F.S., relating to reportable incident collection and reporting; amending s. 641.55, F.S., changing the incident reporting requirements; providing an effective date.

Be It Enacted by the Legislature of the State of Florida:

Section 1. Section 395.0197, Florida Statutes, is amended to read:

395.0197 Internal risk management program.—

(1) Every licensed facility shall, as a part of its administrative functions, establish an internal risk management program that includes all of the following components:

(a) The investigation and analysis of the frequency and causes of general categories and specific types of reportable ~~adverse~~ incidents, as defined in this section or by federal law, to patients.

(b) The development of appropriate measures to minimize the risk of reportable ~~adverse~~ incidents to patients, including, but not limited to:

1. Risk management and risk prevention education and training of all nonphysician personnel as follows:

a. Such education and training of all nonphysician personnel as part of their initial orientation; and

b. At least 1 hour of such education and training annually for all personnel of the licensed facility working in clinical areas and providing patient care, except those persons licensed as health care practitioners who are required to complete continuing education coursework pursuant to chapter 456 or the respective practice act.

2. A prohibition, except when emergency circumstances require otherwise, against a staff member of the licensed facility attending a patient in the recovery room, unless the staff member is authorized to attend the patient in the recovery room and is in the company of at least one other person. However, a licensed facility is exempt from the two-person requirement if it has:

a. Live visual observation;

b. Electronic observation; or

c. Any other reasonable measure taken to ensure patient protection and privacy.

3. A prohibition against an unlicensed person from assisting or participating in any surgical procedure unless the facility has authorized the person to do so following a competency assessment, and such assistance or participation is done under the direct and immediate supervision of a licensed physician and is not otherwise an activity that may only be performed by a licensed health care practitioner.

4. Development, implementation, and ongoing evaluation of procedures, protocols, and systems to accurately identify patients, planned procedures, and the correct site of the planned procedure so as to minimize the performance of a surgical procedure on the wrong patient, a wrong surgical procedure, a

wrong-site surgical procedure, or a surgical procedure otherwise unrelated to the patient's diagnosis or medical condition.

(c) The analysis of patient grievances that relate to patient care and the quality of medical services.

(d) A system for informing a patient or an individual identified pursuant to s. 765.401(1) that the patient was the subject of ~~an~~ reportable ~~adverse~~ incident as defined in subsection (5). Such notice shall be given by an appropriately trained person designated by the licensed facility as soon as practicable to allow the patient an opportunity to minimize damage or injury. Documentation of the notification should be placed in the patient's medical record.

(e) 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 health care facility to report on reportable ~~adverse~~ incidents to the risk manager, or to his or her designee, within 3 business days after their occurrence.

(2) The internal risk management program is the responsibility of the governing board of the health care facility. Each licensed facility shall hire a risk manager, licensed under s. 395.10974, who is responsible for implementation and oversight of such facility's internal risk management program as required by this section. A risk manager must not be made responsible for more than four internal risk management programs in separate licensed facilities, unless the facilities are under one corporate ownership or the risk management programs are in rural hospitals.

~~(3) In addition to the programs mandated by this section, other innovative approaches intended to reduce the frequency and severity of medical malpractice and patient injury claims shall be encouraged and their implementation and operation facilitated. Such additional approaches may include extending internal risk management programs to health care providers' offices and the assuming of provider liability by a licensed health care facility for acts or omissions occurring within the licensed facility. Each licensed facility shall annually report to the agency and the Department of Health the name and judgments entered against each health care practitioner for which it assumes liability. The agency and Department of Health, in their respective annual reports, shall include statistics that report the number of licensed facilities that assume such liability and the number of health care practitioners, by profession, for whom they assume liability.~~

(4) The agency shall adopt rules to implement the provisions of this section. ~~governing the establishment of internal risk management programs to meet the needs of individual licensed facilities~~. Each internal risk management program shall include the use of incident reports to be filed with an individual of responsibility who is competent in risk management techniques in the employ of each licensed facility, such as an insurance coordinator, or who is retained by the licensed facility as a consultant. The individual responsible for the risk management program shall have free access to all medical records of the licensed facility. The incident reports are part of the workpapers of the attorney defending the licensed facility in litigation relating to the licensed facility and are subject to

discovery, but are not admissible as evidence in court. A person filing an incident report is not subject to civil suit by virtue of such incident report. As a part of each internal risk management program, the incident reports shall be used to develop categories of incidents which identify problem areas. Once identified, procedures shall be adjusted to correct the problem areas.

(5) For purposes of reporting to the agency and Department of Health, pursuant to this section, the term "reportable incident" means an event which is associated in whole or in part with medical intervention, or lack thereof, rather than the condition for which such intervention occurred, specifically:

(a) Surgical Events:

1. Surgery performed on the wrong body part, defined as any surgery performed on a body part that is not consistent with the documented informed consent for that patient. Excludes emergency situations that occur in the course of surgery and/or whose exigency precludes obtaining informed consent.

2. Surgery performed on the wrong patient, defined as any surgery on a patient that is not consistent with the documented informed consent for that patient.

3. Wrong surgical procedure performed on a patient, defined as any procedure performed on a patient that is not consistent with the documented informed consent for that patient. Excludes emergency situations that occur in the course of surgery and/or whose exigency precludes obtaining informed consent.

4. Retention of a foreign object in a patient after surgery or other procedure. Excludes objects intentionally implanted as

part of a planned intervention and objects present prior to surgery that were retained.

5. Intraoperative or immediately post-operative death in an American Society of Anesthesiologist Class I patient, defined as a normal, healthy patient, including but not limited to, a patient who has no organic, physiological, biochemical, or psychiatric disturbance. The pathologic processes for which the operation is to be performed are localized and do not entail a systemic disturbance. Includes all American Society of Anesthesiologists Class I patient deaths in situations where anesthesia was administered; the planned surgical procedure may or may not have been carried out.

(b) Product or Device Events:

1. Patient death or serious disability associated with the use of contaminated drugs, devices, or biologics provided by the health care facility. Includes, but is not limited to, generally detectable contaminants in drugs, devices, or biologics regardless of the sources of contamination and/or product.

2. Patient death or serious disability associated with the use or function of a device in patient care in which the device was used for functions other than as intended and in a manner not consistent with reasonable standards of medical practice. Includes, but is not limited to, catheters, drains, and other specialized tubes, infusion pumps, and ventilators.

3. Patient death or serious disability associated with intravascular air embolism that occurs while being cared for in a health care facility. Excludes deaths associated with neurosurgical procedures known to be a high risk of intravascular air embolism.

(c) Patient Protection Events:

1. Infant discharged to the wrong person.

2. Patient death or serious disability associated with patient elopement for more than four hours. Excludes events involving competent adults.

3. Patient suicide, or attempted suicide at a health care facility resulting in serious disability.

(d) Care Management Events

1. Patient death or serious disability associated with a medication error, including but not limited to, errors involving the wrong drug, wrong dose, wrong patient, wrong time, wrong rate, wrong preparation or wrong route of administration. Excludes reasonable differences in clinical judgment on drug selection and dose.

2. Patient death or serious disability associated with a hemolytic reaction due to the administration of ABO-incompatible blood or blood products.

3. Maternal death or serious disability directly or indirectly associated with labor or delivery in a low-risk pregnancy while being cared for in the hospital. Includes known events that occur within forty-two (42) days post-delivery. Excludes deaths from pulmonary or amniotic fluid embolism, acute fatty liver of pregnancy or cardiomyopathy.

4. Death or serious disability (kernicturus) associated with failure to identify and treat hyperbilirubinemia in neonates.

5. Stage 2, 3, or 4 pressure ulcers acquired after admission to the hospital. Excludes progression from Stage 1 to Stage 2 if Stage 1 was recognized upon admission and excludes

progression from Stage 2 to Stage 3 if Stage 2 was recognized upon admission.

6. Patient death or serious disability due to spinal manipulation therapy performed in the hospital.

(e) Environmental Events

1. Patient death or serious disability associated with an electric shock while being cared for in the hospital. Excludes events involving planned treatment, such as electrical countershock.

2. Any incident in which a line designated for oxygen or other gas to be delivered to a patient contains the wrong gas or is contaminated.

3. Patient death or serious disability associated with a burn incurred from any source while being cared for in the hospital.

4. Patient death or serious disability associated with a fall while being cared for in the hospital.

5. Patient death that occurs while a patient is in seclusion or restraint, patient death and occurs within 24 hours after the patient has been removed from seclusion or restraint, and each patient death known to the facility that occurs within one week after seclusion of restraint use where it is reasonable to assume that it contributed directly or indirectly to a patient's death.

(6) For the purposes of this section Serious Disability means:

(a) A physical and mental impairment that substantially limits one or more major life activities of an individual;

(b) A loss of bodily function if the impairment or loss lasts more than seven days or is still present at the time of discharge from a hospital or ambulatory surgery center; or

(c) The loss of a body part.

(7) Reportable incidents, whether occurring in the licensed facility or arising from health care prior to admission in the licensed facility, shall be reported electronically through an online portal by the facility to the agency and Department of Health within 15 calendar days after its occurrence. The reportable incidents will be available immediately to the Department of Health for review through the electronic submission portal. The facilities Chief Executive Officer (CEO) shall certify quarterly, through the electronic submission portal, that all reportable incidents the previous quarter have been reported, and that their reportable incidents submissions are accurate.

The agency may grant extensions to this reporting requirement for more than 15 days upon justification submitted in writing by the facility administrator to the agency. These reports are exempt from disclosure under chapter, 119, Florida Statute or any other law providing access to public records, nor be discoverable or admissible in any civil or administrative action, except in disciplinary proceedings by the Department of Health or the appropriate regulatory authority, nor shall they be available to the public as part of the record of investigation for and prosecution in disciplinary proceedings made available to the public by the agency or Department of Health or the appropriate regulatory board. However, the Department of Health or the appropriate regulatory board shall make available, upon written request by a health care professional against whom

probable cause has been found, any such records which form the basis of the determination of probable cause. The agency or Department of Health may investigate any such incident and prescribe measures that must or may be taken in response to the incident. The Department of Health shall review each incident and determine whether it potentially involved conduct by the health care professional regulated by the Department of Health and is subject to disciplinary action, in which case the provisions of s. 456.073 shall apply.

(8) Within 60 days of the occurrence of a reportable incident, the Agency shall require the facility to submit a written plan of correction, root cause analysis form, and patient safety lessons learned from the facility.

(9) The agency shall do the following:

(a) Publish on the agency's website, no less than quarterly, a summary and trend analysis of reportable incidents received pursuant to this section, which shall not include information that would identify the patient, the reporting facility, or the health care practitioners involved.

(b) Publish on the agency's website an annual report that shall describe the reported incidents submitted summarized in aggregate form, highlight patient safety lessons learned, common root cause analysis findings, and notable corrective action plans.

~~(5) For purposes of reporting to the agency pursuant to this section, the term "adverse incident" means an event over which health care personnel could exercise control and which is associated in whole or in part with medical intervention, rather~~

~~than the condition for which such intervention occurred, and which:~~

~~(a) Results in one of the following injuries:~~

~~1. Death;~~

~~2. Brain or spinal damage;~~

~~3. Permanent disfigurement;~~

~~4. Fracture or dislocation of bones or joints;~~

~~5. A resulting limitation of neurological, physical, or sensory function which continues after discharge from the facility;~~

~~6. Any condition that required specialized medical attention or surgical intervention resulting from nonemergency medical intervention, other than an emergency medical condition, to which the patient has not given his or her informed consent; or~~

~~7. Any condition that required the transfer of the patient, within or outside the facility, to a unit providing a more acute level of care due to the adverse incident, rather than the patient's condition prior to the adverse incident;~~

~~(b) Was the performance of a surgical procedure on the wrong patient, a wrong surgical procedure, a wrong site surgical procedure, or a surgical procedure otherwise unrelated to the~~

~~patient's diagnosis or medical condition;~~

~~(c) Required the surgical repair of damage resulting to a patient from a planned surgical procedure, where the damage was not a recognized specific risk, as disclosed to the patient and documented through the informed consent process; or~~

~~(d) Was a procedure to remove unplanned foreign objects remaining from a surgical procedure.~~

~~(6)(a) Each licensed facility subject to this section shall submit an annual report to the agency summarizing the incident reports that have been filed in the facility for that year. The report shall include:~~

~~1. The total number of adverse incidents.~~

~~2. A listing, by category, of the types of operations, diagnostic or treatment procedures, or other actions causing the injuries, and the number of incidents occurring within each category.~~

~~3. A listing, by category, of the types of injuries caused and the number of incidents occurring within each category.~~

~~4. A code number using the health care professional's licensure number and a separate code number identifying all other individuals directly involved in adverse incidents to patients, the relationship of the individual to the licensed facility, and~~

~~the number of incidents in which each individual has been directly involved. Each licensed facility shall maintain names of the health care professionals and individuals identified by code numbers for purposes of this section.~~

~~5. A description of all malpractice claims filed against the licensed facility, including the total number of pending and closed claims and the nature of the incident which led to, the persons involved in, and the status and disposition of each claim. Each report shall update status and disposition for all prior reports.~~

~~(b) The information reported to the agency pursuant to paragraph (a) which relates to persons licensed under chapter 458, chapter 459, chapter 461, or chapter 466 shall be reviewed by the agency. The agency shall determine whether any of the incidents potentially involved conduct by a health care professional who is subject to disciplinary action, in which case the provisions of s. 456.073 shall apply.~~

~~(c) The report submitted to the agency shall also contain the name and license number of the risk manager of the licensed facility, a copy of its policy and procedures which govern the measures taken by the facility and its risk manager to reduce the risk of injuries and adverse incidents, and the results of such~~

~~measures. The annual report is confidential and is not available to the public pursuant to s. 119.07(1) or any other law providing access to public records. The annual report is not discoverable or admissible in any civil or administrative action, except in disciplinary proceedings by the agency or the appropriate regulatory board. The annual report is not available to the public as part of the record of investigation for and prosecution in disciplinary proceedings made available to the public by the agency or the appropriate regulatory board. However, the agency or the appropriate regulatory board shall make available, upon written request by a health care professional against whom probable cause has been found, any such records which form the basis of the determination of probable cause.~~

~~(7) Any of the following adverse incidents, whether occurring in the licensed facility or arising from health care prior to admission in the licensed facility, shall be reported by the facility to the agency within 15 calendar days after its occurrence:~~

~~(a) The death of a patient;~~

~~(b) Brain or spinal damage to a patient;~~

~~(c) The performance of a surgical procedure on the wrong patient;~~

~~(d) The performance of a wrong site surgical procedure;~~

~~(e) The performance of a wrong surgical procedure;~~

~~(f) The performance of a surgical procedure that is medically unnecessary or otherwise unrelated to the patient's diagnosis or medical condition;~~

~~(g) The surgical repair of damage resulting to a patient from a planned surgical procedure, where the damage is not a recognized specific risk, as disclosed to the patient and documented through the informed consent process; or~~

~~(h) The performance of procedures to remove unplanned foreign objects remaining from a surgical procedure.~~

~~The agency may grant extensions to this reporting requirement for more than 15 days upon justification submitted in writing by the facility administrator to the agency. The agency may require an additional, final report. These reports shall not be available to the public pursuant to s. 119.07(1) or any other law providing access to public records, nor be discoverable or admissible in any civil or administrative action, except in disciplinary proceedings by the agency or the appropriate regulatory board, nor shall they be available to the public as part of the record of investigation for and prosecution in disciplinary proceedings~~

~~made available to the public by the agency or the appropriate regulatory board. However, the agency or the appropriate regulatory board shall make available, upon written request by a health care professional against whom probable cause has been found, any such records which form the basis of the determination of probable cause. The agency may investigate, as it deems appropriate, any such incident and prescribe measures that must or may be taken in response to the incident. The agency shall review each incident and determine whether it potentially involved conduct by the health care professional who is subject to disciplinary action, in which case the provisions of s. 456.073 shall apply.~~

~~(8) The agency shall publish on the agency's website, no less than quarterly, a summary and trend analysis of adverse incident reports received pursuant to this section, which shall not include information that would identify the patient, the reporting facility, or the health care practitioners involved. The agency shall publish on the agency's website an annual summary and trend analysis of all adverse incident reports and malpractice claims information provided by facilities in their annual reports, which shall not include information that would identify the patient, the reporting facility, or the~~

~~practitioners involved. The purpose of the publication of the summary and trend analysis is to promote the rapid dissemination of information relating to adverse incidents and malpractice claims to assist in avoidance of similar incidents and reduce morbidity and mortality.~~

(10) ~~(9)~~ The internal risk manager of each licensed facility shall:

(a) Investigate every allegation of sexual misconduct which is made against a member of the facility's personnel who has direct patient contact, when the allegation is that the sexual misconduct occurred at the facility or on the grounds of the facility.

(b) Report every allegation of sexual misconduct to the administrator of the licensed facility.

(c) Notify the family or guardian of the victim, if a minor, that an allegation of sexual misconduct has been made and that an investigation is being conducted.

(d) Report to the Department of Health every allegation of sexual misconduct, as defined in chapter 456 and the respective practice act, by a licensed health care practitioner that involves a patient.

(11) ~~(10)~~ Any witness who witnessed or who possesses actual

knowledge of the act that is the basis of an allegation of sexual abuse shall:

(a) Notify the local police; and

(b) Notify the hospital risk manager and the administrator.

For purposes of this subsection, "sexual abuse" means acts of a sexual nature committed for the sexual gratification of anyone upon, or in the presence of, a vulnerable adult, without the vulnerable adult's informed consent, or a minor. "Sexual abuse" includes, but is not limited to, the acts defined in s. 794.011(1)(h), fondling, exposure of a vulnerable adult's or minor's sexual organs, or the use of the vulnerable adult or minor to solicit for or engage in prostitution or sexual performance. "Sexual abuse" does not include any act intended for a valid medical purpose or any act which may reasonably be construed to be a normal caregiving action.

(12) ~~(11)~~ A person who, with malice or with intent to discredit or harm a licensed facility or any person, makes a false allegation of sexual misconduct against a member of a licensed facility's personnel is guilty of a misdemeanor of the second degree, punishable as provided in s. 775.082 or s. 775.083.

~~(12) In addition to any penalty imposed pursuant to this~~

~~section, the agency shall require a written plan of correction,~~ ~~root cause analysis, and patient safety lessons learned from the facility within 45 days of the reportable incident. For a single incident or series of isolated incidents that are nonwillful violations of the reporting requirements of this section, the agency shall first seek to obtain corrective action by the facility. If the correction is not demonstrated within the timeframe established by the agency or if there is a pattern of nonwillful violations of this section, the agency may impose an administrative fine, not to exceed $5,000 for any violation of the reporting requirements of this section. The administrative fine for repeated nonwillful violations shall 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 this section may not exceed $250,000. In determining the amount of fine to be levied, the agency shall be guided by s. 395.1065(2)(b).~~

(13) The agency shall have access to all licensed facility records necessary to carry out the provisions of this section. The records obtained by the agency under subsection (6), or subsection (7), ~~or subsection (9)~~ are exempt from disclosure

under chapter, 119, Florida Statute ~~not available to the public under s. 119.07(1)~~, nor shall they be discoverable or admissible in any civil or administrative action, except in disciplinary proceedings by the agency or the appropriate regulatory board, nor shall records obtained pursuant to s. 456.071 be available to the public as part of the record of investigation for and prosecution in disciplinary proceedings made available to the public by the agency or the appropriate regulatory board. However, the agency or the appropriate regulatory board shall make available, upon written request by a health care professional against whom probable cause has been found, any such records which form the basis of the determination of probable cause, except that, with respect to medical review committee records, s. 766.101 controls.

(14) The meetings of the committees and governing board of a licensed facility held solely for the purpose of achieving the objectives of risk management as provided by this section shall not be open to the public under the provisions of chapter 286. The records of such meetings are confidential and exempt from s. 119.07(1), except as provided in subsection (13).

(15) The agency may ~~shall~~ review, as part of its licensure inspection process, the internal risk management program at each

licensed facility regulated by this section to determine whether the program meets standards established in statutes and rules, whether the program is being conducted in a manner designed to reduce reportable ~~adverse~~ incidents, and whether the program is appropriately reporting incidents under this section.

(16) There shall be no monetary liability on the part of, and no cause of action for damages shall arise against, any risk manager, licensed under s. 395.10974, for the implementation and oversight of the internal risk management program in a facility licensed under this chapter or chapter 390 as required by this section, for any act or proceeding undertaken or performed within the scope of the functions of such internal risk management program if the risk manager acts without intentional fraud.

(17) A privilege against civil liability is hereby granted to any licensed risk manager or licensed facility with regard to information furnished pursuant to this chapter, unless the licensed risk manager or facility acted in bad faith or with malice in providing such information.

(18) The Department of Health shall have access to all identifying information submitted on the reportable incident. The agency and Department of Health shall have access to all facility records relevant to the reportable incident.

~~(18) If the agency, through its receipt of any reports required under this section or through any investigation, has a reasonable belief that conduct by a staff member or employee of a licensed facility is grounds for disciplinary action by the appropriate regulatory board, the agency shall report this fact to such regulatory board.~~

(19) It shall be unlawful for any person to coerce, intimidate, or preclude a risk manager from lawfully executing his or her reporting obligations pursuant to this chapter. Such unlawful action shall be subject to civil monetary penalties not to exceed $10,000 per violation.

(20) For a single incident or series of isolated incidents that are nonwillful violations of the reporting requirements of this section, the agency shall first seek to obtain corrective action by the facility. If the correction is not demonstrated within the timeframe established by the agency or if there is a pattern of nonwillful violations of this section, the agency may impose an administrative fine, not to exceed $5,000 for any violation of the reporting requirements of this section. The administrative fine for repeated nonwillful violations shall 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 this section may not exceed $250,000. In determining the amount of fine to be levied, the agency shall be guided by s. 395.1065(2)(b).

Section 2. Section 408.05 (2) Florida Center for Health Information and Policy Analysis, is amended to read:--

(1) ESTABLISHMENT.--The agency shall establish a Florida Center for Health Information and Policy Analysis. The center shall establish a comprehensive health information system to provide for the collection, compilation, coordination, analysis, indexing, dissemination, and utilization of both purposefully collected and extant health-related data and statistics. The center shall be staffed with public health experts, biostatisticians, information system analysts, health policy experts, patient safety experts, economists, and other staff necessary to carry out its functions.

(2) HEALTH-RELATED DATA.--The comprehensive health information system operated by the Florida Center for Health Information and Policy Analysis shall identify the best available data sources and coordinate the compilation of extant health-related data and statistics and purposefully collect data on:

(a) The extent and nature of illness and disability of the

state population, including life expectancy, the incidence of various acute and chronic illnesses, and infant and maternal morbidity and mortality.

(b) The impact of illness and disability of the state population on the state economy and on other aspects of the well-being of the people in this state.

(c) Environmental, social, and other health hazards.

(d) Health knowledge and practices of the people in this state and determinants of health and nutritional practices and status.

(e) Health resources, including physicians, dentists, nurses, and other health professionals, by specialty and type of practice and acute, long-term care and other institutional care facility supplies and specific services provided by hospitals, nursing homes, home health agencies, and other health care facilities.

(f) Utilization of health care by type of provider.

(g) Health care costs and financing, including trends in health care prices and costs, the sources of payment for health care services, and federal, state, and local expenditures for health care.

(h) Family formation, growth, and dissolution.

(i) The extent of public and private health insurance coverage in this state.

(j) The quality of care provided by various health care providers.

(k) Patient safety in health facilities.

Section 3. Section 408.05(6) is created to read, The Florida Center shall have responsibility for collecting and analyzing reportable incidents submitted by health facility risk managers under section 395.0197, Florida Statutes. The Florida Center may do a quality assurance review of reportable incidents. Incidents may be reviewed for accuracy, completeness, and compliance. The Florida Center is also responsible for the agency reportable incident reporting requirements, pursuant to section, 395.0197, Florida Statutes.

Section 4. Section 641.55, Florida Statutes, is amended to read:

641.55 Internal risk management program.--

(1) Every organization certified under this part shall, as a part of its administrative functions, establish an internal risk management program which shall include the following components:

(a) The investigation and analysis of the frequency and

causes of general categories and specific types of reportable ~~adverse~~ incidents causing injury to patients;

(b) The development of appropriate measures to minimize the risk of injuries and reportable ~~adverse~~ incidents to patients, including risk management and risk prevention education and training of all nonphysician personnel as follows:

1. Such education and training of all nonphysician personnel as part of their initial orientation; and

2. At least 1 hour of such education and training annually for all nonphysician personnel of the organization who work in clinical areas and provide patient care;

(c) The analysis of patient grievances which relate to patient care and the quality of medical services; and

(d) The development and implementation of an incident reporting system based upon the affirmative duty of all providers and all agents and employees of the organization to report injuries and reportable ~~adverse~~ incidents to the risk manager.

(2) The risk management program shall be the responsibility of the governing authority or board of the organization. Every organization which has an annual premium volume of $10 million or more and which directly provides health care in a building owned or leased by the organization shall hire a risk manager,

certified under ss. 395.10971-395.10975, who shall be responsible for implementation of the organization's risk management program required by this section. A part-time risk manager shall not be responsible for risk management programs in more than four organizations or facilities. Every organization which does not directly provide health care in a building owned or leased by the organization and every organization with an annual premium volume of less than $10 million shall designate an officer or employee of the organization to serve as the risk manager.

(3) In addition to the programs mandated by this section, other innovative approaches intended to reduce the frequency and severity of medical malpractice and patient injury claims shall be encouraged and their implementation and operation facilitated. Additional approaches may include extending risk management programs to provider offices or facilities.

(4) The Agency for Health Care Administration shall adopt rules necessary to carry out the provisions of this section, including rules governing the establishment of required internal risk management programs to meet the needs of individual organizations and each specific organization type governed by this part. The office shall assist the agency in preparing these rules. Each internal risk management program shall include the

use of incident reports to be filed with the risk manager. The risk manager shall have free access to all organization or provider medical records. The incident reports shall be considered to be a part of the workpapers of the attorney defending the organization in litigation relating thereto and shall be subject to discovery, but not be admissible as evidence in court, nor shall any person filing an incident report be subject to civil suit by virtue of the incident report and the matters it contains. As a part of each internal risk management program, the incident reports shall be utilized to develop categories of incidents which identify problem areas. Once identified, procedures must be adjusted to correct these problem areas.

~~(5)(a) Each organization subject to this section must submit an annual report to the agency summarizing the incident reports that were filed in the organization during the preceding calendar year pertaining to services rendered on the premises of the organization. The report must be on a form prescribed by rule of the agency and must include, with respect to medical services rendered on the premises of the organization:~~

~~1. The total number of adverse incidents causing injury to patients.~~

~~2. A listing, by category, of the types of operations, diagnostic or treatment procedures, or other actions causing the injuries and the number of incidents occurring within each category.~~

~~3. A listing, by category, of the types of injuries caused and the number of incidents occurring within each category.~~

~~4. The name of each provider or a code number using each health care professional's license number and a separate code number identifying all other individuals directly involved in adverse incidents causing injury to a patient, the relationship of the individual or provider to the organization, and the number of incidents with the organization in which each individual or provider has been directly involved. Each organization must maintain names of the health care professionals and individuals identified by code numbers for purposes of this section.~~

~~5. A description of all medical malpractice claims filed against the organization or its providers, including the total number of pending and closed claims and the nature of the incident that led to, the persons involved in, and the status and disposition of each claim. Each report must update status and disposition for all prior reports.~~

~~6. A report of all disciplinary actions taken against any~~

~~provider or any medical staff member of the organization, including the nature and cause of the action.~~

~~(b) The information reported to the agency under paragraph (a) which relates to providers licensed under chapter 458, chapter 459, chapter 461, or chapter 466 must also be reported to the agency quarterly. The agency shall review the information and determine whether any of the incidents potentially involved conduct by a licensee that is subject to disciplinary action, in which case s. 456.073 applies.~~

~~(c) Except as otherwise provided in this subsection, any identifying information contained in the annual report and the quarterly reports under paragraphs (a) and (b) is confidential and exempt from s. 119.07(1). This information must not be available to the public as part of the record of investigation for and prosecution in disciplinary proceedings made available to the public by the agency or the appropriate regulatory board. However, the agency shall make available, upon written request by a practitioner against whom probable cause has been found, any such information contained in the records that form the basis of the determination of probable cause under s. 456.073.~~

~~(d) The annual report shall also contain the name of the risk manager of the organization, a copy of its policy and~~

~~procedures governing the measures taken by the organization and its risk manager to reduce the risk of injuries and adverse or untoward incidents, and the result of these measures.~~

(5) ~~(6)~~ If a reportable ~~n adverse or untoward~~ incident, whether occurring in the facilities of the organization or arising from health care prior to enrollment by the organization or admission to the facilities of the organization or in a facility of one of its providers, results in a reportable incident as defined by section 395.0197

~~(a) The death of a patient;~~

~~(b) Severe brain or spinal damage to a patient;~~

~~(c) A surgical procedure being performed on the wrong patient; or~~

~~(d) A surgical procedure unrelated to the patient's diagnosis or medical needs being performed on any patient,~~

the organization must report this incident to the agency within 15 ~~3 working~~ days after its occurrence. ~~A more detailed follow up report must be submitted to the agency within 10 days after the first report.~~ The agency may require ~~an~~ additional information.~~,~~ ~~final report~~. Reports under this subsection will be available to the Department of Health immediately through electronic means.

~~must be sent immediately by the agency to the appropriate regulatory board whenever they contain references to a provider licensed under chapter 458, chapter 459, chapter 461, or chapter 466.~~ These reports are confidential and are exempt from s. 119.07(1). This information is not available to the public as part of the record of investigation for and prosecution in disciplinary proceedings made available to the public by the Department of Health, agency or the appropriate regulatory board. However, the Department of Health ~~agency~~ shall make available, upon written request by a practitioner against whom probable cause has been found, any such information contained in the records that form the basis of the determination of probable cause under s. 456.073. The agency or Department of Health may investigate, as it deems appropriate, any such incident and prescribe measures that must or may be taken by the organization in response to the incident. The Department of Health ~~agency~~ shall review each incident and determine whether it potentially involved conduct by the licensee which is subject to disciplinary action, in which case s. 456.073 applies.

(7) In addition to any penalty imposed under s. 641.52, the agency may impose an administrative fine, not to exceed $5,000, for any violation of the reporting requirements of subsection (5)

~~or subsection (6)~~.

(8) The agency, Department of Health and, upon subpoena issued under s. 456.071, the appropriate regulatory board must be given access to all organization records necessary to carry out the provisions of this section. Any identifying information contained in the records obtained under this section is confidential and exempt from s. 119.07(1). The identifying information contained in records obtained under s. 456.071 is exempt from s. 119.07(1) to the extent that it is part of the record of investigation for and prosecution in disciplinary proceedings made available to the public by the Department of Health ~~agency~~ or the appropriate regulatory board. However, the Department of Health ~~agency~~ must make available, upon written request by a practitioner against whom probable cause has been found, any such information contained in the records that form the basis of the determination of probable cause under s. 456.073, except that, with respect to medical review committee records, s. 766.101 controls.

(9) The agency shall review, no less frequently than annually, the risk management program of each organization regulated by this section to determine whether the program meets standards established in statutes and rules, whether the program

is being conducted in a manner designed to reduce reportable ~~adverse~~ incidents, and whether the program is appropriately reporting incidents under subsections (5) ~~and (6)~~.

(10) There shall be no monetary liability on the part of, and no cause of action for damages shall arise against, any risk manager certified under part IX of chapter 626 for the implementation and oversight of the risk management program in an organization authorized under this chapter for any act or proceeding undertaken or performed within the scope of the function of such risk management program if the risk manager acts without intentional fraud.

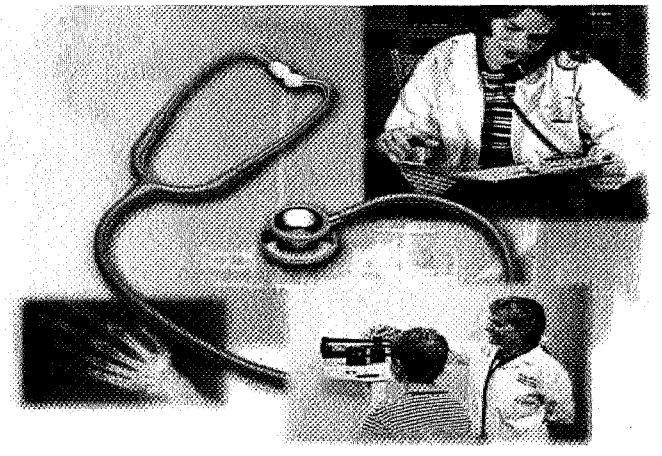
(11) If the agency, ~~through its receipt of the annual reports prescribed in subsection (5) or~~ through any investigation, has a reasonable belief that conduct by a provider, staff member, or employee of an organization may constitute grounds for disciplinary action by the appropriate regulatory board, the agency shall report this fact to the regulatory board.

~~(12) The agency shall send information bulletins to all organizations as necessary to disseminate trends and preventive data derived from its actions under this section or under s. 395.0197.~~

The gross data compiled under this section or s. 395.0197 shall be furnished by the agency upon request to organizations to be utilized for risk management purposes. The agency shall adopt rules necessary to carry out the provisions of this section.

Section 5. This act shall take effect October 1, 2008.

Assessment of Progress Made By the Florida Patient Safety Corporation Toward Achieving Select Statutory Requirements



Studies Performed by the Florida Academic Patient Safety Centers

- Nova Southeastern University College of Osteopathic Medicine
- The Florida State University College of Medicine
- The University of Florida College of Medicine, Gainesville/Jacksonville
- The University of South Florida Colleges of Public Health and Medicine

Prepared For: The Florida Patient Safety Corporation
June 2006

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CHAPTER 1

Assessment of the 'Code 15' Adverse Event Reporting System

Assessment of the 'Code 15' Adverse Event Reporting System

June 2006

Executive Summary

Since 1975, versions of Florida Law (currently, F.S. 395.0197(7)) *have required that health care institutions timely report to the state the occurrence of certain adverse medical events. The reports must be submitted within 15 days of their occurrence, and must include the identities of the reporting institution and any involved healthcare providers, and information about the location and outcome of the incident, the condition(s) or procedure(s) or equipment involved, an analysis of the likely cause of the incident and the corrective measures undertaken. The 15-day reporting period has served as the basis for moniker of "Code 15 Reports".*

The Florida Academic Patient Safety Network has prepared this assessment of the Code 15 reports and the data base that represents its operation. We provide an analysis of the content and utility of the reporting system and offer recommendations for its improvement.

The principle findings are:

1. Under reporting of adverse medical events under the Code 15 system appears to be pervasive. Two independent studies estimate that the Code 15 system under reports by roughly one order of magnitude. The origin of this underreporting has its origin in multiple factors:
    a. The reporting of adverse events is perceived by health care personnel as a trigger for punishment, rather than for education and improvement;

b. The requirement of identifying practitioners ostensibly involved in adverse events is perceived as inherently punitive;

c. Licensed Healthcare Risk Managers (LHRM) within health care institutions report that they are often pressured by administrators to find ways not to report.

d. Furthermore, LHRMs (who are licensed by the State of Florida) report that they are not well supported or strategically placed in healthcare organizations to properly address manage and oversee Code 15 guidelines.

e. Reporting of Code 15 events by individual institutions is not complemented by any feedback from the state that could serve as a basis for general risk reduction or patient safety improvement nor is there any guidance or assistance to educate the risk managers about dealing with future events.

f. Most LRHMs have never seen and/or have no idea if the Agency for Health Care Administration (AHCA) has done any analysis of the information provided them. The few LHRMs who state they are aware of the "data analysis" state that what is produced is not useful and is neither geographically or facility focused. The rationale for geographic specific analysis being that in any geographic area, there may be morbidities and mortalities that suggest specific interventions to specific issues, that may not be productive in other areas. The rationale for facility specific feedback of event analysis, would be to facilitate identification of issues unique to that facility. The AHCA analysis and examples of applications can be found) on the AHCA website (http://www.fdhc.state.fl.us/MCHQ/Health_Facility_Regulation/Risk/statistics.shtml) titled as "Risk Management Statistical Reports – Index by Calendar Year).

g. There is much ambiguity between the Florida Statute 395.0197 and the Florida Administrative Code (FAC) 59A 10.002(4) and the various interpretations of surveyors and risk managers, that the end product is difficult to analyze with any legitimacy.

h. The education, training, skills, and experience of the AHCA surveyors are highly variable. Some of the surveyors are not licensed health care providers and most have never been licensed as risk managers in the state of Florida. This creates difficulties for LHRMs in working productively with the surveyors, as a team, and/or in collaboration when needed to create interventions and audits that ensure improvement in quality of patient care.

i. LHRMs in the process of doing their job are expected to be familiar with an in ordinate number of Florida Statutes. (Appendix 1 displays select statutes for which LHRM's responsibilities apply) This is in part due to the fact in smaller facilities there aren't any healthcare attorneys "in house. Consider the following examples of problems a LHRM might be asked to resolve in any one day:

   i. how to facilitate transfer of a patient that another facility refuses to take when their facility is unable to provide services;

   ii. whether or not an "informed consent" is in fact valid or not;

   iii. who can and cannot give/obtain consent to a particular procedure;

   iv. assisting a practitioner in providing disclosure to an adverse event that has occurred;

   v. investigating allegations of sexual misconduct;

vi. helping staff determine how to manage families who insist on having copies of their medical records in the middle of a hospitalization

vii. how to deal with medical staff who refuse to give their home phone numbers when they are on call and who do not answer their pagers or cell phones

viii. how to deal with practitioners who are not available over the holiday or weekends and have not left some other practitioner on call to cover their patients;

ix. how to deal with a situation when a practitioner appears to have written orders to discharge a patient that has been "Baker Acted" when the patient has not yet been seen or evaluated by a physiatrist or any other mental health counselor.

j. LHRMs are assigned many duties that cross over into the risk management arena and are thus presumed to be within the scope of their job descriptions on a facility-by-facility basis. Unfortunately, there are never enough full time equivalents (FTEs) allowed for the carry out the assigned tasks. Consider that the average risk manager, in addition to their statutory duties under Florida Statute 395.0197 is expected to participate, more often than not in all or many of the following:

(1). quality assurance;

(2). Joint Commission on Accreditation of Healthcare Organization (JCAHO) surveys;

(3). function as committee members, if not committee leaders on Sentinel Event Teams and either assist or prepare of root cause analysis forms per JCAHO mandate;

(4). function in some capacity during peer review activities;

(5). assist with or be responsible for production requests associated with both Notice of Intents to Initiate Medical Malpractice Suits and status Medical Malpractice suits;

(6). participate in interviews of potential witnesses;

(7). attend hearings, motions, and sometimes depositions;

(8). coordinate Patient Safety Teams/ Committees and/or activities

(9). negotiate potential claims/ grievances;

k. There is no evidence that the State effectively sanctions health care institutions that may not be reporting.

2. *Analysis.* Donald Berwick of the Institute of Healthcare Improvement has criticized patient safety activities in the U.S. as being obsessed with reporting, at the expense of analysis [1]. Our findings with respect to the Florida system support this criticism. Our analyses of adverse events that are captured in the Code 15 system indicate that these data are largely superficial, based on "person" models of adverse events [2,3] in which the "remedial" efforts stop when an 'error' is discovered, rather than using the 'error' as the starting point for investigation and improvement [4-8]. The quality of the data collected and maintained by AHCA within the Code 15 system are so poor that AHCA has not been able to engage in any meaningful analysis and/or reporting. We conclude

that the State of Florida has never dedicated sufficient resources for any meaningful analysis of adverse medical event data, and the State has essentially ignored the invalidity of the existing system and data for decades.

a. The short 15-day time frame required from event to report discourages detailed analysis of errors and contributes to superficial reports and simplistic analyses.

b. Risk managers charged with reporting have little dedicated time or resources to use in investigation and analysis.

~~c.~~ Risk managers charged with investigation and reporting of events, are not placed in the administrative hierarchy such that they are enabled to execute authoritatively interventions and/or policy changes that need to be made. This is particularly true when it comes to medical staff.

d. Indexing and categorization of errors that does occur is not ~~very~~ useful since it is based in the language of the domain, not the language of human performance. The coding schemes used (such as the ICD-9) are often ambiguous, difficult to apply, and not helpful for improvement. One LHRM will take the same clinical scenario, or "adverse event" as another LHRM, and assign different ICD-9 codes to the mandated data fields for reporting.

e. The Code 15 reporting system is premised on an "accounting model" which emphasizes case definitions, categorization, summarization and trending. This "counting" model has not proven useful in safety activities in other hazardous domains, where it has been dropped in favor of a more qualitative model emphasizing the context of the incident and the narratives surrounding it [1].

f. Resources within health care institutions and within the AHCA to support the investigative and analytic functionality of an adverse medical event reporting system are insufficient.

3. *Corrective actions. There is little substantive evidence within the Code 15 report documents that health care institutions respond to adverse events with effective* corrective actions steps.

   a. The 15-day deadline encourages interventions that are rapidly implemented, such as remedial education or discipline. These interventions give the appearance of action but are weak modalities for improvement.

   b. Risk managers in healthcare organizations are generally not in positions of power and have little ability to affect change. This limits the horizons of what it is possible for them to do in response to adverse events.

Recommendations.

This analysis of the Code 15 reports and reporting system yields recommendations that are consistent with those proffered in the 2004 reports to the State. There are three categories of recommendation: Reporting should **be "safe" for all affected parties**; analyses of events should be informed and **independent**; and the reporting process should be **effective and useful**. .

1. *Make reporting safe.* The two major impediments to reporting are fear of punishment, and the sense that reporting is ineffective [9,10]. The success of adverse event reporting in Florida will be dependent on making reporting safe for the reporters.

a. The reporting system should be separated from the regulatory system to reduce the perception that reporting adverse events is linked to punitive actions. Removing the reporting linkage to the issuance of regulations or of sanctions will reduce the perception among health care personnel that reporting risks punishment. The Florida Patient Safety Corporation might be a natural host for an improved reporting system, particularly if it could be constituted as a Patient Safety Organization under Federal law (the Patient Safety and Quality Improvement Act of 2005). This would complement the FPSC's current demonstration project for reporting "near miss" cases.

b. Develop ironclad confidentiality protections for reporting bodies against legal discovery by attorneys, journalists and individuals involved in adverse events. This underscores the importance of maintaining a separate, de-identified reporting system and the regulatory/legal processes associated with malpractice litigation and/or professional regulation.

c. Eliminate the requirement to report individual identifiers (*e.g.*, license or Social Security numbers) for those involved in adverse incidents.

2. *Make analysis informed and independent.* The current system shows little evidence of being informed by the advances in the safety sciences from the past 25 years. In addition, the investigations suffer from conflicts of interest.

a. Establish the independence of the reporting system from the larger regulatory system, as noted above. The body responsible for the system should be an advocate for safety *and only for safety*.

b. Develop expertise in accident investigation and analysis that can be brought to bear in important cases.

c. Abandon the person model of accident causation. Reports identifying "human error", "mental lapses" *etc* as causes of adverse events are indications of inadequate investigations and a system driven by punitive, rather than corrective vision, or of a system that does not allot sufficient resources in man hours to the task of "risk management".

d. Abandon the accounting perspective for the design and operation of the reporting system. Instead of aiming at acquiring a large number of relatively superficial reports, the goal should be changed to acquiring a smaller number of truly insightful reports that can educate and improve the system of care statewide. The objective should shift from breadth to depth.

e. Develop a pilot project for accident investigation similar to that of the National Transportation Safety Board. At least one such project (MedCAS, *Medical Case Analysis System*) has been started in critical care medicine, so it might be feasible to partner with this project.

f. Either extend the time frame for reporting, or break it into 2 phases. For example, notification of a potential incident might still be required in 15 days, with a definitive report to follow at some other interval (say, 90 days).

g. Change the responsibility for the development of reports from the hospital risk manager to the organization's safety officer. This change would emphasize that the purpose of the reporting system is for learning, not for accountability.

h. Fund and support the analytic function of the reporting system adequately at the institutional and at the state level.

i. Consider using the same model that JCAHO does when it comes to the analysis and plan portion of dealing with reportable events and near misses. Prepare a root cause analysis, submit these to the state. These could be used to produce a useful tool such as a "Code Alert" for specific recurring events. The state could require that the root causes and/or contributing factors be incorporated into the facility policies and procedures.

3. *Make reporting useful.* This will help overcome the second obstacle to reporting [9,10] related to the fact that there is currently no feedback from the system.

   a. The entity charged with operating the reporting system should provide incidence, prevalence and trend reports to the community of healthcare organizations and practitioners in the state, at regular intervals. These reports should serve as sentinel indicators of threats, hazards, and other risks to patient safety identified and include suggestions for better identifying and managing factors associated with those risks.

   b. Similarly, the entity charged with operating the reporting system should report to healthcare organizations on the development of understandings about risks and hazards associated specifically with their report.

In conclusion, major changes are required for the Code 15 system to achieve its potential to systematically learn about and improve patient safety in Florida. . The best approach is to integrate the intended (but unfulfilled) purpose of the Code 15 reporting process into a statewide,

de-identified, anonymous electronic reporting system that builds into and beyond the pilot project currently being developed by the Florida Patient Safety Corporation. The present system discourages complete, accurate and useful reporting, and does little if anything, to improve patient safety or quality of care in the State, but in not achieving most of its intended purposes, it requires the expenditure of substantial state funds that could be more effectively and efficiently spent on a viable reporting system.

Final Report

An Assessment of Florida's Code 15 Reporting System And Recommendations for Improvement

Introduction

This report is one of several deliverables commissioned by the Florida Patient Safety Corporation in fiscal year 2005 – 2006, and coordinated through the University of South Florida for performance by the Florida Academic Patient Safety Centers. The Corporation requested an assessment of Florida's 'Code 15' adverse event reporting system that would include: analysis and evaluation of patient safety data, quality and Agency for Healthcare Research and Quality (AHRQ) patient safety indicators, and data associated with medical malpractice closed claims, and adverse incidents reported to the Agency for Health Care Administration (AHCA) and the Department of Health.

This report is organized in 6 parts. The first section reviews the current functioning of the system, from the point of view of both the risk managers (who prepare the reports) and of AHCA who receives them. The second section provides an epidemiological overview of the data contained in the system, and relates these to the AHRQ Patient Safety Indicators. The third section reports on special pediatric considerations, and the fourth concerns the content of a sample of reports. The last two sections analyze the findings and provide recommendations for improvement.

The Process of Code 15 Reporting

Lucian Leape, a widely known and early champion of patient safety, maintains that even in setting of mandatory reporting "... in the end, all reporting is voluntary" [11,12]. It is therefore important to examine any reporting system from the perspective of the reporters, to elucidate their understanding of the process and their experiences with it. The following section is compiled from a series of unstructured interviews with risk managers across the state of Florida.

State of Florida statute 395.0197(7) requires the mandatory reporting of adverse events that occur in a Florida hospital or ambulatory surgical center to AHCA (see Appendix 2). These reports are called "Code 15s", referring to the 15-day window after the occurrence of an adverse event in which the report must be filed. Adverse event reports have been collected confidentially by the state since 1975, and in the current formalized method since 1985. Reports can be made electronically, by mail and/or fax. The primary source for these reports (as interpreted from Statute 395.0197) is the risk management programs of the hospitals and ambulatory care centers, who are required to maintain these programs for certification by the state of Florida and the Joint Commission for Accreditation of Healthcare Organizations (JCAHO).

An adverse event within a Florida hospital or ambulatory care center is initially reported to the risk manager(s) of the facility in which it occurred. The risk managers (alone or in conjunction with other hospital stakeholders) are expected to perform an initial investigation to determine whether this event meets the definition of an adverse event as specified within Florida statute 395.0197(5) (See Appendix). If the incident meets this definition and results in one of 7

potential outcomes or injuries designated by the statute, then the facility must report the incident to ACHA within 15 days as a 'Code 15'. (Appendix 3 is the Code 15 form)

Florida law requires that health care institutions hire state licensed health care risk managers. Risk managers from throughout the state of Florida, stated they do not have formal training in submitting these reports to AHCA and that there was a high degree of variability across institutions as to how to proceed once a possible Code 15 case occurs in their institution. For example, some organizations perform formal root cause analyses prior to reporting and include their findings along with their corrective action plan while others submit a more rudimentary description of the incident and a superficial assessment of causality. Those interviewed for this process felt that the degree of variability was a significantly a consequence of the short time frame for submitting a report (15 days) and highly variable individual organization support and resources to perform an adequate analysis prior to reporting.

Reporters described significant stress coping with a "morass of ambiguity" when attempting to determine whether or not an event meets the statutory requirement for reporting. The statutory description of the mandatory reporting requirements contains many qualifiers and ambiguities, and so may be variably interpreted by many hospital and ambulatory surgical staff. For example, the statute describes a reportable event as harm caused "under the control" of a clinician. It is easy to understand how many clinicians fail to report because they do not believe that the situation leading to the adverse event was "under their control." The usefulness of such a report in education and improvement is not embedded in the statutory language. There is no culture of safety encouraged by the reporting requirements. Other interviewees described confusion due to

conflicts between the risk management statute, the Florida Administrative Code. (FAC 59A-10.002(4), and the actual ICD-9 Codes that are included on the formal Code 15 form.

Example: A vaginal delivery was complicated by a ruptured uterus and required surgical repair of the uterus. The LHRM did not consider this event to meet the criteria for reporting as vaginal delivery is not a "surgical event". The only one of the seven reportable criteria that this event could possibly have met would be defined by Florida Statute 395.0197 (7)(g) as: " The surgical repair of damage resulting to a patient from a planned surgical procedure , where the damage is not a recognized specific risk, as disclosed to the patient through the documented informed consent process Note that this is an actual situation in which a surveyor mandated the LHRM report the incident when the LHRM did not believe this event to be reportable. There are multiple ambiguous issues to deal with in determining whether this is to be reported or not. Consider the following:

1) Definition of Surgery- the average healthcare professional would call surgery "an event that occurs in the operating room".
2) Neither the risk management statute nor the FAC define what surgery is, however the Code 15 reporting form states that the only ICD-9 codes to be used in describing the event that resulted in the adverse outcome must be in the range of 01-99.9. Do you go by what is found in these codes, the statute or the FAC?
3) The statute states the pre-requisites to an event becoming reportable are "an event **over which healthcare personnel could exercise control** AND **which is associated in whole or in part with medical**

intervention, rather than the condition for which such intervention occurred, and which results in one of the following injuries..." (FS 395.0197(5).

4) However, under FAC 59A-10.002(4), the following is found,

a. "Adverse or untoward incident" for purposes of reporting to the department means an event over which healthcare could exercise control and:

b. is associated in whole or in part with medical intervention as described in subsection (17) below rather than the condition for which such intervention occurred, and

c. is not consistent with or expected to be a consequence of such medical intervention (Note by authors: This statement is not consistent with the risk management statute i.e.; or

d. occurs as a result of medical intervention to which the patient has not given his informed consent or;

e. occurs as the result of any other action or **lack thereof** *(Note by authors: This statement **infers** that incidents involving omissions in care as well as interventions should be included which is not consistent with the statute)*

In the example above, what if the practitioner had failed to identify signs and symptoms that the fetus was too large for vaginal delivery? Would this then be a reportable event?

There appears to be significant organizational pressure within health care organizations to limit reporting in order to reduce "being on the AHCA radar" and not visible for possible legal discovery and liability exposure purposes should the reports become public. There is also a natural, reasonable reluctance among some organizations to expose, and thereby place at risk high profile practitioners (*e.g.*, high rank in organization, high revenue generating practice) to scrutiny from AHCA and potentially the licensure boards if AHCA decides to forward the reported incident. Some LHRMs are not as familiar as others as to the conditions under which AHCA would more likely than not forward a report to a practitioner's licensing board. It should be noted that, even if the confidentiality rules governing Code 15 reports preclude such a referral, the perception that it might be possible still affects the decision to report. This is particularly true for two reasons, the new "three strikes law" (Florida Statute 456.50 "Repeated Medical Malpractice") and the fact that the letter sent to the practitioners under review identifies the LHRM by name as the "complainant" in the case. This does not facilitate the best of relations between risk managers and medical staff or other licensed employees who can be disciplined by a regulatory board in follow-up to a Code 15 report.

Risk managers interviewed felt that the overall 'quality' of reports is extremely variable and often "white washed" by the reporting organization to limit scrutiny. The majority of the reports are submitted with an action plan. The risk managers interviewed agreed that such actions plans are generally not very useful. Even when there is sufficient time for a thorough investigation, the reports are generally written in such a way as to provide the minimum information to satisfy AHCA. The aim is to avoid providing so much information as to produce punitive action or bring scrutiny to the institutions unless the issue is without question one that can only be

corrected by involvement by AHCA. In these instances, LHRMs are generally incredibly clear and to the point. This often results in reported action plans that are sparse in content and not easily audited for effectiveness in the post intervention stage.

When asked to describe the events following the report of an incident, interviewees listed four potential outcomes. Once received, the report and action plan are reviewed an AHCA staff member who may:

1. Accept the report and sign off on the facility's response to the event.
2. Accept the report and response but request follow-up information to be forwarded by the facility.
3. Not accept the action plan and request more details about the investigation and revisions to the action plan until they are acceptable to AHCA
4. Send AHCA risk managers or field agents to investigate the incident on site and perform medical record reviews for additional cases. The field agents are often not risk managers and may not have clinical experience. No interviewee had worked with a field agent who was currently in practice.

How the Code 15 System Works from AHCA's View

When a report is received by AHCA, a staff member enters the information into a central database. After the report is entered electronically, an AHCA nurse / risk manager reviews the report and if needed, contacts the hospital to gather additional information. This process is often iterative; numerous "back and forth" exchanges take place prior to the final acceptable corrective action plan.

If after engaging the reporting facility AHCA is not satisfied with the corrective action plan or if the incident is particularly problematic, AHCA may initiate an onsite survey, in which an AHCA field staffer conducts a site visit. Interviewees provide no data regarding the frequency with which a field agent was sent to perform a specific investigation. Larger, busier facilities noted that frequently there are AHCA representatives on site. If, at the site visit, AHCA is not satisfied with the reporting facility's corrective action plan, a fine in the amount of $5,000 may be levied. Additionally, in extreme cases when the facility is uncooperative, AHCA can pursue federal action in the form of a Medicare sanction.

Although AHCA has the authority to do so, it rarely cites facilities with a failure to report a Code 15 event. If a facility deliberately fails to report, there is no mechanism that would alert AHCA. In rare cases, AHCA may discover a case when the media brings attention to it. AHCA typically files approximately 15 "failure to report" citations per year. First offenders are usually required to provide a plan of corrective action, similar to what is required in the actual report. Repetitive failures to report can be fined up to $5,000.

Upon resolution of a Code 15 report, a hard copy of the final report is filed in storage and the electronic version is saved in a computer database. Until recent upgrades to this computer system and software, queries of the data required cumbersome manual searches through paper documents. When queried about what they thought the final outcome of their reports were once the action plans were accepted by ACHA, the interviewees were uncertain.

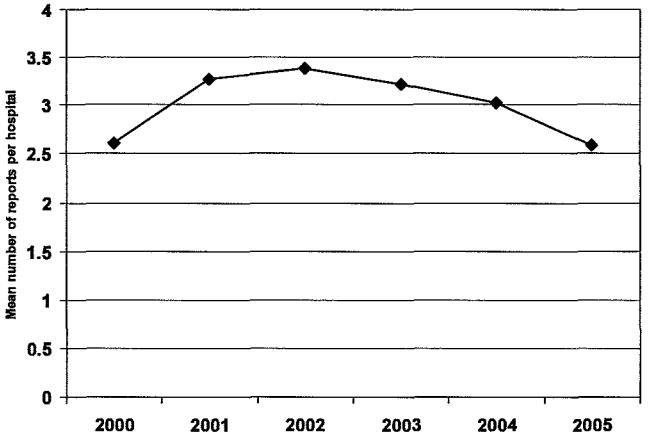
Epidemiological Analysis

Frequency of Reports. During the 6-year period from 2000 to 2005, a total of 5,149 Code 15 reports were filed with AHCA by hospitals. Considerable variability was observed with respect to the frequency of reports from each facility. For example, in 2005, the average Florida hospital reported 2.6 (SD = 5.7) adverse incidents and this ranged from 0 to 81 across hospitals in the state. The frequency of a given hospital's reports, for a given year, was significantly correlated with the frequency of that hospital's reports in any other given year (see Table 1). That is, the number of reports a hospital had in 2005 was positively correlated with the number of reports for that hospital in 2004, 2003, 2002, 2001, and 2000. However, the strength of association weakened over time. As a result, the average number of reports per hospital has been slightly declining over the past 5 years (see Figure 1).

Table-1: Bivariate correlations representing frequency of reports by year

	Year 2000	Year 2001	Year 2002	Year 2003	Year 2004	Year 2005
Year 2000	1.000					
Year 2001	.673**	1.000				
Year 2002	.607**	.705**	1.000			
Year 2003	.479**	.606**	.720**	1.000		
Year 2004	.341**	.428**	.562**	.654**	1.000	
Year 2005	.260**	.370**	.392**	.453**	.374**	1.000

Figure 1 Annual Trend in Average Number of Reports Per Hospital Florida, 2000- 2005



Factors Associated with Hospital Reporting.

When considering the total number of Code 15 reports submitted over the 2000- 2005 time period, numerous factors appeared to relate to the frequency of reports. For example, hospitals accredited by JCAHO (n=175) had a greater average number of reports over the six year period when compared to non-JCAHO accredited facilities (n=35) (25.6 *vs.* 6.0; p<.001). Moreover, teaching hospitals (n=9) had almost three times more reports that the average non-teaching hospital (n=201) (67.00 vs. 20.4; p=.021). While no differences existed between investor owned and not-for-profit hospitals, the average daily occupancy rate (average daily census divided by number of beds) was weakly correlated with the number of code 15 reports submitted to AHCA between 2000 and 2005 (r=.137; p=.046). We also examined the ratio of total admission to full time equivalent nurses at a given facility and did not find any significant correlation with report frequency.

To determine the independent effect of each of these variables on the frequency of reports, an ordinary least square regression model was specified (see Table 2). Results suggest that after controlling for all other factors in the model, tax status, JCAHO accreditation, teaching status, and bed size were all significantly related to the number of reports, while system affiliation and occupancy rate were not.

Table-2: Factors influencing the cumulative frequency of code-15 reports among Florida hospitals (2000-2005)

Dependent variable: cumulative frequency of reports (2000-2005)	**Standardized Coefficient**	**t**	**P-value**
Variable included in the model			
Hospital is member of a system	-.081	-1.015	.31
Not-for-profit tax status	.164	1.962	.05
Not accredited by JCAHO	-.200	-2.501	.01
Not a member of the council of teaching hospitals	-.165	-2.077	.04
Bed size	.492	5.426	<.001
Percent daily occupancy	.051	.622	.54
Overall model	Adjusted R^2=.368	F=11.766	<.001

Using the AHRQ PSIs to examine the validity of Code 15s. To test the reliability and validity of Code-15 reports, the AHRQ Patient Safety Indicators (PSIs) were applied to select Florida hospital discharge data. Florida's hospital discharge database is generally recognized as one of the most accurate and useful sources of utilization and financial data among state hospital reporting systems in the U.S. The AHRQ PSIs were developed to make use of readily available hospital inpatient administrative data, such as those produced by Florida, and are part of the Healthcare Cost and Utilization Project (HCUP). The PSIs are intended to help health leaders identify potential adverse events occurring during hospitalization. The PSI measures, which have been previously validated, reflect quality of care inside hospitals, but focus on surgical complications and other iatrogenic events. To compare the AHRQ measures to Code-15 data,

we selected two specific PSIs because they were most likely to overlap with a Code-15 reportable event. The two PSIs selected include *foreign body left during procedure* (PSI #5), and *Postoperative hip fracture* (PSI#8).

PSI #5: Foreign Body Left during Procedure defined as *discharges with foreign body accidentally left in during procedure per 1,000 discharges* is calculated in the following manner.

Numerator: Discharges with ICD-9-CM codes for foreign body left in during procedure in any secondary diagnosis field. Including the following ICD-9-CM codes:

9984 FOREIGN BODY ACCIDENTALLY LEFT DURING A PROCEDURE
9987 ACUTE REACTIONS TO FOREIGN SUBSTANCE ACCIDENTALLY LEFT DURING A PROCEDURE
Foreign body left in during:
E8710 SURGICAL OPERATION
E8711 INFUSION OR TRANSFUSION
E8712 KIDNEY DIALYSIS OR OTHER PERFUSION
E8713 INJECTION OR VACCINATION
E8714 ENDOSCOPIC EXAMINATION
E8715 ASPIRATION OF FLUID OR TISSUE, PUNCTURE, AND CATHETERIZATION
E8716 HEART CATHETERIZATION
E8717 REMOVAL OF CATHETER OR PACKING
E8718 OTHER SPECIFIED PROCEDURES
E8719 UNSPECIFIED PROCEDURE

Denominator: All surgical discharges defined by specific DRGs and an ICD-9-CM code for an operating room procedure. Excluded are patients with ICD-9-CM diagnosis codes for anesthesia complications in the principal diagnosis field, patients with codes for poisoning due to anesthetics (E8551, 9681-4, 9687) and any diagnosis code for active drug dependence, active non-dependent abuse of drugs, or self-inflicted injury.

PSI #8: Postoperative hip fracture, defined as *cases of in-hospital hip fracture per 1,000 surgical discharges with an operating room procedure,* is calculated in the following manner.

Numerator: Discharges with ICD-9-CM code for hip fracture in any secondary diagnosis field.

Denominator: All surgical discharges defined by specific DRGs and an ICD-9-CM code for an operating room procedure. Excluded are patients with ICD-9-CM code for hip fracture in the principal diagnosis field, cases where the only operating room procedure is hip fracture repair, or where a procedure for hip fracture repair occurs before the first operating room procedure. Also excluded are all patients with diseases and disorders of the musculoskeletal system and connective tissue (MDC 8); patients with principal diagnosis codes for seizure, syncope, stroke, coma, cardiac arrest, anoxic brain injury, poisoning, delirium or other psychoses, or trauma; any diagnosis of metastatic cancer, lymphoid malignancy, bone malignancy or self-inflicted injury; obstetrical patients in MDC 14; or patients 17 years of age or younger.

A single year period during 2000-2005 was randomly selected as the case-study time period. The PSIs for that year were calculated using AHRQ software and the Florida hospital discharge database (obtained from AHCA). We identified the top 5 hospitals with respect to the frequency for *foreign body left during procedure* (PSI #5) and separately for *postoperative hip fracture* (PSI #8). Next, we identified all Code-15 reports submitted by each of the top identified facilities. The corresponding Code-15 reports were examined and classified as either pertaining to PSI #5 or PSI #8, or not. Next, we tabulated the total number of PSI #5 and PSI #8 events for the year among all Florida hospitals. In addition, we estimated the total number of Code-15

reports, for all hospitals, that were for either foreign body left during procedure or postoperative hip fractures.

Overall, the findings consistently suggest that the Code-15 reports under represent the number of adverse events occurring in hospitals as identified by PSI #5 and PSI #8. Available Code-15s typically represented approximately 11.5 to 17.6% of events, as measured by the PSIs examined. Table-3 and Table-4 display the results from PSI #5 and PSI #8 and the corresponding code-15 reports representing the respective events.

A total of 26 occurrence of PSI #5 were identified in the top 5 Florida hospitals for this PSI. It is important to note that none of the top 5 hospitals by frequency were in the top 5 hospitals by rate for PSI #5. Regardless, the 26 occurrences were represented by only 3 (12% of 26) Code-15 reports for a similar event. Likewise, the total number of PSI #5 occurrences for all Florida hospitals, for the same given year, was 85. However, only 15 (18%) Code-15 reports were filed for a foreign body left during procedure that occurred at the reporting hospital.

A total of 16 occurrences of PSI #8 were identified in the top 5 Florida hospitals for this event. It is important to note that none of the top 5 hospitals by frequency were in the top 5 hospitals by rate for PSI #8. Overall, the 16 occurrences were represented by only 2 (12%) Code-15 reports for a similar event. The total number of PSI #8 occurrence for all Florida hospitals, for the same given year, was 107. However, due to limitations in the data, it was not possible to identify all code-15 reports relating to postoperative hip fractures.

The manifest observation is that the objective, discharge diagnosis basis for establishing a possible window into adverse events varies substantially from the more subjective Code 15 reports of ostensibly similar classes of events.

Table 3: The occurrence of foreign body left during procedure among the top most frequent hospitals for this event, for a given year in Florida.

	Number of Foreign Body Left during Procedure (PSI #5)	Number of Code 15 reports for Foreign body left during procedure
Hospital A	7	2
Hospital B	6	0
Hospital C	5	0
Hospital D	4	0
Hospital E	4	1
Total	**26**	**3**
Total number (all hospitals) of Code 15s reports for a foreign body left during procedure: **15**		
Total number of foreign body left during procedure per PSI #5: **85**		
Note: none of the hospitals in this table had the highest rate of foreign body left during procedure.		

Table 4: The occurrence of postoperative hip fractures among the top most frequent hospitals for this event, for a given year in Florida.

	Number of postoperative hip fractures (PSI #8)	Number of Code 15 reports for postoperative hip fractures
Hospital A	4	2
Hospital B	3	0
Hospital C	3	0
Hospital D	3	0
Hospital E	3	0
Total	**16**	**2**
Total number (all hospitals) of Code 15s reports for a foreign body left during procedure: **N/A**		
Total number of foreign body left during procedure per PSI #8: **107**		
Note: none of the hospitals in this table had the highest rate of postoperative hip fractures.		

Pediatric Considerations

Reporting requirements for pediatric cases do not differ from adult adverse events. However, children present unique challenges when studying quality and safety (see Table 5), which often leads to their exclusion from other patient safety studies[c]. Indeed, the landmark IOM report on patient safety noted above contained fewer than a half dozen citations that were specific to children. What we do know about the quality and safety of care, including hospital care, for children is concerning.[d,e]

Table 5: Why Children are Different from Adults

1. **The unique characteristics of childhood** are captured by the concept of the four D's (differences):
   a. Development—Children develop at a rapid rate and their health depends in large measure on the success of their cognitive, emotional, and physical growth and development. In the hospital setting, this raises specific issues related to appropriate communication, physiologic changes and medical management.
   b. Dependency – Children depend on parents and other adults for financing, accessing, receiving, and evaluating the quality of health care (some exceptions for adolescents and emancipated minors). In the hospital setting, this translates into unique communication issues which are a frequent root cause of medical error.
   c. Differential epidemiology—children experience a unique pattern of health, illness, and disability which drives the diagnoses for which they are hospitalized. Children with complex, chronic illnesses experience frequent hospitalizations putting them at higher risk of medical error.
   d. Demographic patterns—the high rate of children living in poverty, and the disproportionate numbers of children who are racial and ethnic minorities also raises issues for pediatric patient safety including the greater prevalence of limited English proficiency which has been associated with increased medical error occurrences.

[c] Forrest C, Simpson L, Clancy C. (1997) Child health services research: challenges and opportunities. *Journal of the American Medical Association*, 277(22):1787-1793
[d] Leatherman, S & McCarthy, D. (2004) Quality of Healthcare For Children and Adolescents: A Chartbook. *Commonwealth Fund*, New York, NY
[e] Perrin, J.M., Bloom, S.R., (2004) Promoting safety and adolescent health care: conference overview. Ambulatory Pediatrics, Vol.4 (1):43-46.

Recently, five review articles based on a conference in 2003 brought together what we know about pediatric patient safety across sectors (including ambulatory, emergency department and inpatient settings) and articulated a comprehensive research agenda for the future.[f g h i] The first study to comprehensively assess pediatric patient safety using the same patient safety indicators described earlier (PSIs) concluded that the AHRQ PSIs identified frequent patient safety problems in children with substantial impact. Rates of PSI events varied from 1 to 703 per 100,000 discharges (death in low mortality DRG and failure to rescue, respectively). Rates were even more common among children under 30 days old and under 1 year old. PSI events had significant impact on child outcomes and costs: mortality odds increased from 1.3 to 76.6 depending on the event, and length of stay increases as high as an additional 24 days were found. Of note is the fact that Medicaid insurance was significantly associated with many of the PSIs.[j] In addition, because of how pediatric hospitalizations differ from those for adults, it is important to assess the scope and nature of event reporting for children. Almost every child in American stays overnight in a hospital: that is where they are born. Low birth weight and otherwise sick newborns may have excessively long hospital stays during which they are exposed to significant error prone processes.[k] Indeed, Kaushal et al documented that when errors do occur their impact

[f] Miller, M.R., Pronovost, P.J., Burstin, H.R. (2004) Pediatric patient safety in the ambulatory setting. *Ambulatory Pediatrics, Vol.4(1)*:47-54

[g] Chamberlain, J.M., Slonim, A., Joseph, J.G., (2004) Reducing errors and promoting safety in pediatric emergency care. *Ambulatory Pediatrics, Vol.4(1)*:55-63

[h] Johnson, K.B., & Davidson C.L (2004). Information technology: its importance to child safety. *Ambulatory Pediatrics, Vol.4(1)*:64:72.

[i] Kaushal, R., Jaggi, T., Walsh, K., Fortescue, E.B., Bates, D.W. (2004) Pediatric medication errors: what do we know? What gaps remain? *Ambulatory Pediatrics, Vol.4(1)*:73-81.

[j] Zhan, C. & Miller, M.R., (2003) Excess length of stay, charges, and mortality attributable to medical injuries during hospitalization. *JAMA. 290(14)*:1868-74.

[k] Horbar, J.D., Plsek, P.E., Leahy, K, Schriefer, J., (2003) Evidence-based quality improvement in neonatal and perinatal Medicine: the NIC/Q 2000 Experience. *Pediatrics Supplement, Vol. 111 (4)*:e395-e547

may be greater due to the different physiologic capability of the child, particular infants, to buffer the insult.[l] At the other end of the pediatric age spectrum, Woods et al recently described the patient safety profile for adolescents and found the incidence of adverse events in adolescents in the Colorado and Utah Medical Practice Study to be significantly higher than all other age groups of children. The incidence of preventable adverse events in adolescents was also significantly higher than that of children 1-12 years old, but not significantly different than infants.[m] Interestingly, the authors found that adolescent-specific factors contributed to 54.8% of the described patient safety problems. Since the publication of the study by Miller et al, substantial additional work has been conducted to further refine the PSIs and make them more appropriate to the epidemiology of children and children's hospital care. Recent analyses in Florida using these indicators to assess pediatric hospital safety reveal that for just three types of patient safety events (decubitus ulcer, selected infections due to medical care and lacerations), the event rate was 2.07 per 1,000 discharges, or a total of nearly 400 events each year.

In the face of these national patterns of adverse events in children and adolescents, it is clear that while few children over the age of a week have an inpatient hospital stay today (2.6% in 1999 nationally and 175,541 discharges in Florida in 2003), many more children, particularly poor and chronically ill children, use other hospital services, including the emergency department and

[l] Kaushal, R., Bates, D.W., Landrigan, C., et al. (2001) Medication errors and adverse drug events in pediatric inpatients. *JAMA Vol. 285*:2114-2120.

[m] Wood DM, Holl JL, Klein JD, Thomas EJ. Patient safety problems in adolescent medical care. *J Adolesc Health, 2006.* Vol.38(1):5-12.

outpatient clinics. [n] Indeed, children insured by public insurance are more likely to be hospitalized in any given year and made up 51% of all hospitalizations for children 0-17 years in Florida in 2003. In addition, there were over 210,000 children born in Florida in 2003, of which 6.3% were low birthweight, putting them at higher risk of many adverse outcomes, including medical error. Finally, while most children are hospitalized in community hospitals, 32.8% are hospitalized in specialized children's hospitals and these are often the sickest and most vulnerable children (HCUPNet, 2006).

Because of these numerous differences between adult and pediatric services themselves as well as specific issues with pediatric patient safety, one cannot assume that a safe hospital for adults will by extension also be safe for children or that improvements in the safety of an institution will naturally translate into similar levels of benefit for pediatric patients. Understanding the nature of events reported to the Code 15 system has the potential to shed some light on those children and/or clinical scenarios that are highest risk to infants and children, particularly poor and chronically ill children.

Frequency of Code 15 Reports

Patient Characteristics: There were 335 reports in children 0-18 years from hospitals and ambulatory surgery centers during the six year period (2000-2005) which is the focus of this analysis (Table 6). Overall, the majority of reports (45.7%) were among children 0-1 year (Table 7). The second highest proportion of reports was among adolescents 15-18 years (27.5%). The

[n] Simpson L, Zodet MW, Chevarley FM, Owens P, Dougherty D, McCormick M. (2004) Health care for children and youth in the United States: 2002 report on trends in access, utilization, quality, and expenditures. *Ambulatory Pediatrics.* 2004; 4:131-153.

proportion in each age group remained relatively constant over the six year period, with one exception in 2005, when the largest proportion was noted among 1-4 year olds. It is not clear from these data if the change in the distribution of reports in 2005 represents a single year difference or the beginning of a trend. Overall, 53.7% of all reports were among males, a proportion that varied little over the six year period (from 48.1% to 59.7%).

Table 6: The occurrence of reports for children 0-18 years, Florida, 2000-2005.

Type of Report	2000		2001		2002		2003		2004		2005		Total	
Ambulatory Surgery	3	5.6%	3	5.3%	1	1.6%	2	3.6%	1	2.2%	6	9.8%	16	4.8%
Hospital	51	94.4%	54	94.7%	61	98.4%	54	96.4%	44	97.8%	55	90.2%	319	95.2%
Total	54	100.0%	57	100.0%	62	100.0%	56	100.0%	45	100.0%	61	100.0%	335	100.0%

Table 7: The occurrence of reports for children 0-18 years, by age group, Florida, 2000-2005.

	2000		2001		2002		2003		2004		2005		Total	
Age														
	n	%	n	%	n	%	n	%	n	%	n	%	n	%
0 - < 1 year	31	57.4%	25	43.9%	31	50.0%	33	58.9%	18	40.0%	15	24.6%	153	45.7%
1-4 years	4	7.4%	8	14.0%	5	8.1%	2	3.6%	5	11.1%	17	27.9%	41	12.2%
5-9 years	3	5.6%	0	0.0%	4	6.5%	1	1.8%	4	8.9%	8	13.1%	20	6.0%
10-14 years	5	9.3%	4	7.0%	4	6.5%	7	12.5%	4	8.9%	5	8.2%	29	8.7%
15-18 years	11	20.4%	20	35.1%	18	29.0%	13	23.2%	14	31.1%	16	26.2%	92	27.5%
Total	54	100.0%	57	100.0%	62	100.0%	56	100.0%	45	100.0%	61	100.0%	335	100.0%

Table 8: The occurrence of reports for children 0-18 years, by gender, Florida, 2000-2005.

	2000		2001		2002		2003		2004		2005		Total	
Gender														
	n	%	n	%	n	%	n	%	n	%	n	%	n	%
Female	28	51.9%	24	42.1%	25	40.3%	26	46.4%	22	48.9%	30	49.2%	155	46.3%
Male	26	48.1%	33	57.9%	37	59.7%	30	53.6%	23	51.1%	31	50.8%	180	53.7%
Total	54	100.0%	57	100.0%	62	100.0%	56	100.0%	45	100.0%	61	100.0%	335	100.0%

For the 332 reports for which an admitting diagnosis was available, there were over 242 admitting diagnoses, with the most common (63 or 19%) being related to a perinatal condition in the mom or baby.

Types of Reports: The vast majority of reports were in hospitals (>90% in each year) (Table 6). The death of the child was the most common type of reportable event (33.4%), making up one third of all reports over the six year period (Table 9). The next most frequent types of report were for surgical repair (16.4%) and unrelated procedures (13.1%). The least frequent type of report was for wrong patient procedure (2.4%). However, not surprisingly given the epidemiology of children's hospitalizations, the types of reports did vary by age group (Table 10). Death was the most frequent type of report for children 0-4 years and children 10-14 years, but not for children 5-9 years or adolescents 15-18 years. Surgical repair was the most frequent report for those age groups. Brain damage, a known perinatal adverse event, accounted for 21.6% of reports for children 0-1 year. The type of report by gender varied somewhat depending on the type of event (Table 11). For example, wrong patient procedures were only in boys (8 out of 8) and wrong site procedures were largely among boys (8 out of 9 reports) while unrelated procedure reports were more often in girls (21 out of 31 reports). When examining patient zip code, nearly half of these were missing or N/A (46.4%).

Table 9: The occurrence of reports for children 0-18 years, by type of report, Florida, 2000-2005.

	2000		2001		2002		2003		2004		2005		Total	
	n	%	n	%	n	%	n	%	n	%	n	%	n	%
Death	16	29.6%	25	43.9%	18	29.0%	13	23.2%	15	33.3%	25	41.0%	112	33.4%
Fetal Death		0.0%		0.0%	5	8.1%	7	12.5%		0.0%	3	4.9%	15	4.5%
Brain Damage	7	13.0%	4	7.0%	11	17.7%	15	26.8%	6	13.3%	3	4.9%	46	13.7%
Spinal Damage	3	5.6%	4	7.0%		0.0%		0.0%	2	4.4%	1	1.6%	10	3.0%
Wrong site procedure	1	1.9%	2	3.5%	1	1.6%	2	3.6%	2	4.4%	1	1.6%	9	2.7%
Wrong patient procedure	2	3.7%	2	3.5%	1	1.6%	3	5.4%		0.0%		0.0%	8	2.4%
Wrong surgical procedure	2	3.7%		0.0%		0.0%	2	3.6%	2	4.4%	5	8.2%	11	3.3%
Unrelated procedure	3	5.6%	4	7.0%	3	4.8%	4	7.1%	9	20.0%	8	13.1%	31	9.3%
Remove foreign object	6	11.1%	6	10.5%	7	11.3%		0.0%	4	8.9%	5	8.2%	28	8.4%
Surgical Repair	8	14.8%	7	12.3%	11	17.7%	10	17.9%	5	11.1%	10	16.4%	51	15.2%
Other	6	11.1%	3	5.3%	5	8.1%		0.0%		0.0%		0.0%	14	4.2%
Total	54	100.0%	57	100.0%	62	100.0%	56	100.0%	45	100.0%	61	100.0%	335	100.0%

Table 10: The occurrence of reports for children 0-18 years, by type of report and age group, Florida, 2000-2005.

	0 - 1 year		1-4 years		5-9 years		10-14 years		15-18 years		Total	
	n	%	n	%	n	%	n	%	n	%	n	%
Death	56	36.6%	20	50.0%	5	25.0%	9	31.0%	22	23.9%	112	33.4%
Fetal Death	12	7.8%	0	0.0%	0	0.0%	0	0.0%	3	3.3%	15	4.5%
Brain Damage	33	21.6%	4	10.0%	0	0.0%	3	10.3%	6	6.5%	46	13.7%
Spinal Damage	4	2.6%	1	2.5%	0	0.0%	1	3.4%	4	4.3%	10	3.0%
Wrong site procedure	1	0.7%	1	2.5%	3	15.0%	1	3.4%	3	3.3%	9	2.7%
Wrong patient procedure	7	4.6%	0	0.0%	0	0.0%	1	3.4%	0	0.0%	8	2.4%
Wrong surgical procedure	4	2.6%	1	2.5%	2	10.0%	0	0.0%	4	4.3%	11	3.3%
Unrelated procedure	15	9.8%	6	15.0%	0	0.0%	6	20.7%	4	4.3%	31	9.3%
Remove foreign object	5	3.3%	1	2.5%	4	20.0%	5	17.2%	13	14.1%	28	8.4%
Surgical Repair	11	7.2%	4	10.0%	6	30.0%	3	10.3%	27	29.3%	51	15.2%
Other	5	3.3%	3	7.5%	0	0.0%	0	0.0%	6	6.5%	14	4.2%
Total	153	100.0%	41	100.0%	20	100.0%	29	100.0%	92	100.0%	335	100.0%

Table 11: The occurrence of reports for children 0-18 years, by type of report and gender, Florida, 2000-2005.

	Female		Male		Total	
	n	%	n	%	n	%
Death	49	43.8%	63	56.3%	112	33.4%
Fetal Death	9	60.0%	6	40.0%	15	4.5%
Brain Damage	16	34.8%	30	65.2%	46	13.7%
Spinal Damage	5	50.0%	5	50.0%	10	3.0%
Wrong site procedure	1	11.1%	8	88.9%	9	2.7%
Wrong patient procedure	0	0.0%	8	100.0%	8	2.4%
Wrong surgical procedure	5	45.5%	6	54.5%	11	3.3%
Unrelated procedure	21	67.7%	10	32.3%	31	9.3%
Remove foreign object	13	46.4%	15	53.6%	28	8.4%
Surgical Repair	31	60.8%	20	39.2%	51	15.2%
Other	5	35.7%	9	64.3%	14	4.2%
Total	155	46.3%	180	53.7%	335	100.0%

Table 12: The occurrence of reports for children 0-18 years, by whether or not the Medical Examiner was notified by year, Florida, 2000-2005.

Medical Examiner Notified	2000		2001		2002		2003		2004		2005		Total	
Med. Ex. Notified	n	%	n	%	n	%	n	%	n	%	n	%	n	%
N	47	87.0%	45	78.9%	47	75.8%	47	83.9%	35	77.8%	45	73.8%	266	79.4%
Y	7	13.0%	12	21.1%	15	24.2%	9	16.1%	10	22.2%	16	26.2%	69	20.6%
Grand Total	54	100.0%	57	100.0%	62	100.0%	56	100.0%	45	100.0%	61	100.0%	335	100.0%

Hospital Characteristics

The frequency of reporting among hospitals in the dataset is shown in Table 13. Overall, 125 hospitals reported at least one Code 15 event in children between 2000 and 2005. The amount of variability in the frequency of reports from each facility was less than in adults. The number of reports in any given year for a given hospital ranged from 0 to 11. Of these, 75% reported only one event over the entire period examined and 23% reported two to five reports. Only two hospitals reported more than 20 events from 2000-2005. Not surprisingly given the nature of the

requirements of the Code 15 system, the single largest proportion of reports occurred in operating rooms (24%) and labor & delivery related locations (21%) (Table 14).

Table 13: The number of hospitals filing reports, by number of reports, by year, Florida, 2000-2005.

Number of Hospitals with:	2000		2001		2002		2003		2004		2005		Total	
	n	%	n	%	n	%	n	%	n	%	n	%	n	%
1 report	31	76.0%	28	80.0%	34	77.0%	23	66.0%	24	83.0%	30	71.0%	70	75.0%
2-5 reports	10	24.0%	6	17.0%	10	23.0%	11	31.0%	4	14.0%	12	29.0%	41	23.0%
6-10 reports	0	0.0%	0	0.0%	0	0.0%	1	3.0%	0	0.0%	0	0.0%	11	0.4%
11-15 reports	0	0.0%	1	3.0%	0	0.0%	0	0.0%	1	3.0%	0	0.0%	1	1.0%
16-20 reports	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%
More than 20 reports	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	2	0.0%
Total	41	100.0%	35	100.0%	44	100.0%	35	100.0%	29	100.0%	42	100.0%	125	100.0%

Table 14: The location of occurrence for reports, Florida, 2000-2005.

Location	n	%
Operating Room	82	24%
Labor & Delivery	69	21%
Patient Room	44	13%
Other	41	12%
Emergency Room	30	9%
Intensive Care Unit (including NICU/PICU)	21	6%
Other	49	15%
Total	335	100%

To examine the nature of events reports by those hospitals reporting the greatest number of events, we examined the top eight hospitals (Table 15). Two of these hospitals reported over 20 events each, and of these 43% (21/49) were the death of a child (see Table 16). Brain damage and unrelated procedures were the second and third most frequent type of events reported among these top reporting hospitals (15 and 13 reports respectively). For the two hospitals with the greatest number of reports, the majority of reports (63%) was in children less than a year old (31/49) and were related to perinatal events. Interestingly, 16% were in adolescents 15 – 18 years (8/49) cared for at these hospitals.

Table 15: Hospitals with the greatest number of reports by year, Florida, 2000-2005.

	2000	2001	2002	2003	2004	2005	Total
	n	n	n	n	n	n	n
Hospital A	1	11	3	4	3	3	25
Hospital B	1	0	5	6	11	1	24
Hospital C	1	0	1	2	2	5	11
Hospital D	0	1	4	2	1	2	10
Hospital E	1	0	3	3	1	1	9
Hospital F	1	5	1	0	1	1	9
Hospital G	3	0	1	1	1	2	8
Hospital H	1	3	1	2	1	0	8

Table 16: Hospitals with the greatest number of reports by type of report, Florida, 2000-2005.

	Hospital A	Hospital B	Hospital C	Hospital D	Hospital E	Hospital F	Hospital G	Total
	n	N	n	n	n	n	n	n
Death	15	6	5	2	5	2	3	38
Fetal Death	0	1	0	1	0	0	0	2
Brain Damage	5	6	1	2	0	0	1	15
Spinal Damage	0	1	0	0	0	0	0	1
Wrong site procedure	0	0	1	0	0	1	1	3
Wrong patient procedure	1	0	0	0	0	0	0	1
Wrong surgical procedure	0	1	0	0	0	0	0	1
Unrelated procedure	1	6	1	3	0	1	1	13
Remove foreign object	1	1	3	0	1	2	3	11
Surgical Repair	2	2	0	2	2	3	0	11
Other	0	0	0	0	1	0	0	1
Total	25	24	11	10	9	9	11	97

Content Analysis

The dataset that was provided for this study only contained the first 250 characters in each of the following areas of the report: circumstances, analysis, and corrective actions taken. A modified content analysis approach was used to review the narratives related to the "analysis" field to identify the most frequent themes (Table 17). Exemplar quotes of the content of this field are

provided in Table 18. *Caution is appropriate in interpreting these results as they represent only a portion of the actual narratives provided to AHCA.* Consistent with findings above, the most commonly mentioned details were around perinatal events, followed by surgical events. The majority of the available narrative on the analysis conducted yielded little information. A modified content analysis yielded the results in Table 17. Of the 331 records with this field available, the majority were the beginning of a narrative description of the event. Only 14.8% included any description of the action taken, whether this was a root cause analysis having been initiated or conducted or other analyses. Of note is that Root Cause Analyses – a critical component of a learning organization and a safety culture – were only noted as having been done or being currently conducted in 5.7% of the reports (19). Types of other analyses mentioned included thorough investigations, chart reviews, medical examiner reports, and peer review conferences. In over 20% of reports, the cause of the event was recorded as unknown or with analysis pending. In examining the potential contributing factors that were noted in this abbreviated segment of the narrative, equipment related factors were noted in 23% of the reports. These included mentions of person based misuse of equipment (e.g. misplacements or dislodgements of endotracheal tubes, misplacements of various central or other lines) as well as equipment failures. Several reports (10.9%) commented on the complexity or severity of the patient's underlying condition as contributing, or that the event was a "known complication" of the type of diagnosis or procedure. Communication challenges (both oral and written), a root cause of many medical errors and a majority of the sentinel events reported to JCAHO (Croteau, 2005) was noted in 8.2% of the reports (27). Interestingly, a number of reports specifically noted that either a physician or a nurse was implicated in the event (8.2% and 3.3% respectively). Patients were also mentioned as contributing to the event (e.g. mother moving, or

ineffective pushing during labor, or patient failed to follow instructions) in 3.9% of cases. Over eight percent of the events referred to either another institution as the location of the event. Nearly 8% of extracts alluded to a failure of existing policies or procedures, such as "failure to institute chain of command", "not following policy and procedure for the counting of sponges", or "label not checked prior to feeding infant".

Table 17: Hospitals with the greatest number of reports by type of report, Florida, 2000-2005.

Description of Analysis of Pediatric Code 15 Cases		
	N	%
Action		
Analysis Pending/Unknown	74	22.4%
Other analysis/conference or actions	30	9.1%
Root Cause Analysis initiated or conducted	19	5.7%
Total	123	37.2%
	N	%
Contributing Factors Noted		
Equipment	77	23.3%
Known risk of condition or procedure	36	10.9%
Other institution involved	28	8.5%
Communication (written or oral)	27	8.2%
Physician related	27	8.2%
Failure to follow procedure or other failure	26	7.9%
Medication error	21	6.3%
Nurse related	11	3.3%
Patient related	13	3.9%
Timeliness/delays	7	2.1%
Total	**331**	100.0%

Table 18: Sample excerpts from Analysis Field:
"Invitro surgery to correct fetus with congenital anomalies conducted by physician not affiliated with [*institution*]"
"mother had been instructed several times about maintaining baby safety, per policy"
"RN took the wrong infant from a mother's room to the nursery to be circumcised"
"difficulty in assessing patient due to her presentation"
"although it has not been determined, the on call surgeon is of the belief that..."
"this incident items solely from an employee error"
"cesarean section was not indicated. Incorrect interpretation of ultrasound finding by the maternal fetal medicine attending physician"
"misconnection of tubing during trial off ECMO"
"electronic monitoring unit failed to detect and alert staff the cardiac arrest of a 2 months old neonatology patient"
"insertion of NG tube into right mainstream then administration of nutrition directly into the right lung"
"failure of physician to assure safety equipment was attached prior to applying"
"patient and family failed to follow up per discharge instructions"

Comparison to Pediatric Discharge Data and Pediatric Patient Safety Indicators

The 2000 – 2003 Florida State Inpatient Database (SID) was used to generate denominators for the total number of pediatric discharges in the State to establish age specific reporting rates for Code 15 events (Table 19) and overall state rates for the occurrence of patient safety events for pediatrics (Table 20). The overall rate of code 15 reports in children 0-18 years varied somewhat across years from a low of 1.51 reports per 10,000 pediatric discharges (0-18 years) in 2003 and a high of 1.73 reports per 10,000 pediatric discharges in 2002. More variation was evident by age group, with adolescents in each of the four years having the highest rate of Code 15 reports. The highest reporting rate (4.52 reports per 10,000 discharges) was for discharges for youth aged 15-18 years in 2001. The lowest reporting rates (0.00 and 0.56 reports per 10,000 discharges) were among discharges for children 5 – 9 years in 2001 and 1 – 4 years in 2002.

Given the differences in the epidemiology of pediatric patient safety noted above, AHRQ recently released a new set of specifications for pediatric patient safety indicators that have been revised and improved in response to clinical concerns and published articles about the limitations of the earlier specifications for pediatrics (Sedman, 2004). While the Pediatric Quality Indicators (PDIs) include 13 hospital level indicators, the lack of direct correlation between these new pediatric indicators and events reportable in the CODE 15 system does not allow a direct comparison as was possible among adults and a statewide and limited institutional level comparison is possible for only one indicator: Foreign Body Left During Procedure (PDI 3). The measure specifications for this PDI are included below. Contrary to the analysis in adults, the pediatric analysis revealed that there were a total of 16 PDI events in Florida during the period 2000-2003 and 19 Code 15 reports of removal of a foreign object (Table 20). The small number of these events precluded much analysis at the hospital level. Of note is the fact that one hospital that reported 1 such Code 15 event during the time period was found to have 2 events using the PDI 3 definition.

Table 19: Code 15 reporting rates, by age and year, Florida, 2000-2005.

	All Pediatric (0-18 years) Discharges		Code 15 Reports	Code 15 Reporting Rates
	No.	% of Total	No.	per 10,000 discharges
2000				
under 1 year	231,903	66.3	31	1.34
1 to 4 years	31,288	8.9	4	1.28
5 to 9 years	19,865	5.7	3	1.51
10 to 14 years	23,578	6.7	5	2.12
15 to 18 years	43,328	12.4	11	2.54
Total	349,962	100.0	54	1.54
2001				
under 1 year	236,414	65.8	25	1.06
1 to 4 years	33,656	9.4	8	2.38
5 to 9 years	20,501	5.7	0	0.00
10 to 14 years	24,565	6.8	4	1.63
15 to 18 years	44,266	12.3	20	4.52
Total	359,402	100.0	57	1.59
2002				
under 1 year	234,537	65.4	31	1.32
1 to 4 years	33,449	9.3	5	1.49
5 to 9 years	20,959	5.8	4	1.91
10 to 14 years	25,295	7.1	4	1.58
15 to 18 years	44,366	12.4	18	4.06
Total	358,606	100.0	62	1.73
2003				
under 1 year	243,511	65.7	33	1.36
1 to 4 years	35,593	9.6	2	0.56
5 to 9 years	21,288	5.7	1	0.47
10 to 14 years	25,548	6.9	7	2.74
15 to 18 years	44,810	12.1	13	2.90
Total	370,750	100.0	56	1.51

Definition: Foreign Body Left During Procedure (PDI 3)
Numerator:
Discharges with ICD-9-CM codes for foreign body left in during procedure in any secondary diagnosis field.
ICD-9-CM Foreign Body Left in During Procedure diagnosis codes:
9984 FOREIGN BODY ACCIDENTALLY LEFT DURING A PROCEDURE
9987 ACUTE REACTIONS TO FOREIGN SUBSTANCE ACCIDENTALLY LEFT DURING A PROCEDURE
Foreign body left in during:
E8710 SURGICAL OPERATION; E8711 INFUSION OR TRANSFUSION; E8712 KIDNEY DIALYSIS OR OTHER PERFUSION
E8713 INJECTION OR VACCINATION; E8714 ENDOSCOPIC EXAMINATION; E8715 ASPIRATION OF FLUID OR TISSUE, PUNCTURE, AND CATHETERIZATION; E8716 HEART CATHETERIZATION; E8717 REMOVAL OF CATHETER OR PACKING
E8718 OTHER SPECIFIED PROCEDURES; E8719 UNSPECIFIED PROCEDURE
Denominator:
All surgical and medical discharges under age 18 defined by specific DRGs
Surgical and Medical Discharge DRGs:
Exclude cases:
- with ICD-9-CM codes for foreign body left in during procedure in the principal diagnosis field
- normal newborn (DRG 391)
- newborns weighing less than 500 grams

Table 20: Numbers and Rates of Pediatric Foreign Body Left During Procedure, Statewide, Florida 2000-2003

FL 2000-03: All Hospitals, Age 0-17	Rate	Risk Pool	Number of PDIs
2000	0.8970	89,213	8
2001	0.5330	93,731	5
2002	0.1050	95,055	1
2003	0.2050	97,568	2
2000-03	0.4260	375,567	16
Total Number of Pediatric Code 15s for Removal of Foreign Object, 2000-2003			19

Pediatric Expert Panel Input

A national expert panel was convened from various backgrounds to assist with the analysis of the data and provide insight into the reporting system and process, including a review of the reporting form. A consultation was also conducted with Jeffery Gregg from the Florida Agency for Health Care Administration, facilitated our access to the Code 15 data. Several important comments are summarized below and helped to shape the analyses that are reported here.

- *Unclear definitions* - Several members of the panel commented on the non-specific nature of the reportable events and the likelihood that there must be significant clinical interpretation occurring. This is particularly concerning for the brain damage and spinal damage events as these may still be present at 15 days, but could improve significantly over months or years as children grow and develop. While overall training of the risk managers does occur at some level, the lack of training on the specific pediatric dimensions was also noted. For example, an event of a foreign body could be the tip of a VP shunt or guidewire being left behind, which is of minimal clinical significance, versus a surgical clamp. Another example was the reporting requirement around the location of the incident – was this where the event started (e.g. patient room/operative triage) or where it happened (wrong patient/site surgery).

- *Improvements to the form* - several aspects of the current mandated form were commented on including: that requiring license numbers of involved personnel only further emphasizes a punitive nature to the reporting, that the listing of locations might want to separate out neonatal intensive care units, that limiting reporting to principal diagnoses and procedures loses valuable information.
- *Additional suggested analyses* - given that Florida has a Birth-Related Neurological Injury Compensation Plan (NICA), it was suggested that a comparison of Code 15 reports with this dataset be made. In addition, a comparison with reports filed with JCAHO was recommended.

Limitations, Conclusions, and Suggestions for Next Steps

This pediatric sub-analysis serves as an initial window on the nature of pediatric patient safety events in Florida. It should be viewed with caution as the total number of cases is small and the amount of descriptive detail available was extremely limited. Conversations with the members of the pediatric expert panel revealed very similar concerns about the Code 15 system as those identified by the larger team on this project in their interviews with risk managers throughout the state.

Despite the dominance in the dataset of perinatal events in these results– not surprising given the list of reportable events – comparison of the numbers of Code 15 events to actual numbers of pediatric discharges using the HCUP data reveals that events in adolescents may be more frequently reported, which may or may not be (given the nature of reporting) indicative of

greater patient safety risk among adolescents as reported by Woods et al. Further investigation of the Code 15 system should better delineate the nature of these adolescent events.

Another key aspect of pediatric care that is raised by these reports is the degree to which care for newborns and children with complex, chronic conditions is regionalized and whether Code 15 events occur at similar rates in community hospitals as in hospitals specializing in care for children and when children are cared for by adult specialists versus pediatric specialists. The volume/outcome relationship has been documented in pediatrics as it has in adults and regionalization of specialized services in Florida (e.g. through the Regional Perinatal Centers and Cardiac Surgery Designation) has existed for many years. Further analyses with additional years of data, as well as substantial additional qualitative analysis (both content analysis of full reports as well as interviews with hospital risk managers and families) are warranted. Specifically, investigation of the following dimensions would be appropriate:

- The relationship of code 15 events to the volume of pediatric services provided by an institution;
- The relationship of code 15 events among children to the pediatric qualifications of the managing team;
- The degree to which risk managers and others involved in the analysis of Code 15 events in pediatrics have specific knowledge of the unique dimensions of pediatric care; and
- Mapping of Code 15 events to related cases in hospital discharge datasets to better understand which occurrences are reported and how they differ from all others.

Content Analysis

We performed a substantive review and content analysis of the text and related data points within the detailed Code 15 data documents. In virtually all other hazardous industries, the utility of safety reporting systems depends mostly on content analyses of the narrative descriptions of events and hazards, and not on accounting review of numbers and trends [9,13-17]. Even when well-tuned and accepted by the reporting parties, tracking sets of accidents is inadequate for answering important questions about the safety of complex socio-technical systems [4], for several reasons. First, the information is obtained after the fact, and rare but calamitous events may not occur with enough frequency to give adequate statistical power for inference [17]. More importantly, a major problem is that incident and accident databases are organized, indexed, cataloged and reported *only in the language of the domain.* This means that they capture only the external expression, the *phenotype* of erroneous actions, as opposed to the *genotype* of factors that give rise to them [18]. Thus accumulating or trending, although superficially attractive, becomes problematic because the particularity of circumstance is necessarily lost. Despite numerous warnings about the sorts of problems this approach creates [19,20], it remains dominant in medical thinking.

To avoid this pitfall in evaluating the adverse event reporting system, we examined the narrative content of Code 15 reports in two ways. First, we reviewed all reports in the computer database for the calendar year 2004. Second, we conducted a more detailed analysis on a subset of 47 reports from 2004 that were chosen by AHCA as particularly responsive.

There were 862 reports in calendar year 2004. Since there are roughly 2 million hospital admissions per year in the state, the rate of reporting is extraordinarily low (~ 0.04%). Based on the lower bound estimates of adverse events from chart review studies in New York [21], Colorado, and Utah [22], we would expect on the order of 65,000 adverse events per year in Florida. In the studies cited, roughly 15% of adverse events led to permanent disability or death, which would project to roughly such 10,000 events per year in Florida. Although the methods and definitions of these studies are substantially different from the reporting requirements under the 'Code 15' statute, it seems clear that there is substantial under-reporting of events, by roughly one order of magnitude.

The Code 15 reporting form asks for three separate categories of narrative: a description of the circumstances of the event; an investigation and analysis; and a statement of corrective and improvement actions. Our review of actual texts indicates that reports in this category are generally very terse. The results of our content analyses may be underestimations due to truncation of texts in a few cases. The average length of texts for reviewed reports was: 35 words. 30% of the analysis narratives and 38% of the actions narratives contained less than 25 words. Many reports appear to be carefully crafted to comply with the reporting requirement in a minimalist way to meet the letter of the law, but not to support patient safety improvement, or learning about risk and hazard.

Examination of these short narratives suggests a strong focus on the 'person' model of accidents, and an emphasis on discipline and education as solutions. To wit: comments note that practitioners involved were counseled, removed, transferred, re-educated, and will be tracked

and trended in the future. Many of the reports contained protective or defensive language (*e.g.*, "This is the first incident for a well-respected surgeon ..."). A substantial proportion of the action plans noted that a root cause analysis had not yet been completed, suggesting that the 15 day deadline for reporting may not be easily met by many institutions.

Because the brevity of the narratives precluded any sort of reasonable examination of content, a more detailed analysis of 47 reports selected from 2004 for their responsiveness, was performed. These selected cases gave substantially greater detail, containing 500 – 1000 words or more. (Because of confidentiality concerns, these cases were not provided in machine readable form, so manual word counts were used). The narratives of these cases were examined to determine the sophistication of the analysis, assessed by whether a human error was used as the starting or stopping point of the investigation, and the strength of the actions taken, assessed by an ordinal ranking of the effectiveness of interventions suggested by the Veterans' Health Administration [16] (warnings and labels are least effective, followed by policy changes, training, work procedural changes, work environment or tool changes, and interlocks or forcing functions most effective).

Unfortunately, despite the greater level of detail, and the obvious attempt to be thorough in the analysis, most of these reports contained superficial analyses that stopped when they identified a human 'error' and failed to explore the preceding causes of the offending action (or omission). Many of the analyses use negative descriptors (*i.e.*, failure to follow a procedure," or "failure to act") that are not actionable, and would not be considered sufficient as root causes. Of the 47 reports reviewed, 31 stopped at this first level of analysis. Of the remainder, 7 provided only a

detailed description of events without any further analysis, 3 stated they were unable to find any causes, and 6 went at least one step beyond in attempting to examine the underlying causes for apparently erroneous behavior. Most of these attempts were still fairly simplistic (*e.g.* noting high workload only), and only two of these reached a reasonable level of thoroughness.

The emphasis on the "person model" of adverse events is undoubtedly reinforced by three aspects of the Code 15 system. First, the statute requires the identification (and the license numbers) of all the involved clinicians. This identification clearly implies to the reporting party that an identifiable human being on whom responsibility (and blame) can be placed is an essential part of the process. Second, the short, 15 day reporting period may encourage rapid and superficial investigations. Third, Code 15 reports are prepared by organizational risk managers, who by history and training tend to have a legalistic approach to these events and are interested in establishing accountability (or the lack thereof) rather than learning. And finally adverse event reports prepared by management tend to focus on operator errors [15, pg 243] (in contrast to reports by operators, who tend to focus on technical and equipment failures).

All the analyses assumed a "chain-of-events" model of accident causation. While chain-of-events models do have some explanatory power, safety scientists in areas other than healthcare have found them wanting [23-25] because they tend to be overly deterministic, focusing more on triggering events and paying less attention to deeper, more fundamental hazards that can be subject to effective long term control.

The corrective actions taken in these 47 reports were similarly limited in scope and tended to be narrowly focused on offending individuals or groups. Almost all of the reports relied, in whole or in part, on relatively weak interventions (education, warning labels, policies to encourage vigilance) or counter-productive measures (remedial education, discipline). Five reports included some sort of substantive change to work processes, and two included changes in tools or working conditions. Many reports pointed out that the adverse event was a known complication, so no action was necessary, but single report stood out in this regard. In a case where it reasonably appeared that the outcome was due to the natural course of the patient's disease and not associated with any aspects of care, one institution used this incident to conduct a thorough analysis of their emergency and rescue procedures, and discovered and addressed several potential risks in the process.

Again, the nature of the Code 15 process seems to affect the types of actions taken. Given the short time frame available from an event until a report is due, the easiest actions that organizations can take are discipline, warning, and education. The action plans occasionally give one the sense of Brownian motion – a whirl of activity without much direction.

In summary, the content analysis of these reports gives a very mixed picture. Although there are notable bright spots, most reports seem to be perfunctory, aimed at satisfying the legal requirement to report, and providing just enough information to avoid provoking a field investigation from AHCA, but not too much information (which might also provoke an investigation). The reports do not seem to be the independent, informed, evaluative analyses envisioned, but rather are carefully crafted social narratives aimed at a specific audience, with a

distinct purpose – to show that the management of the organization has things well under control. In this sense they might be considered a variety of the 'fantasy documents' described by Clarke [26].

Findings

The findings of this study are presented under three headings: reporting, analysis, and actions.

Under-reporting. Under-reporting within the Florida Code 15 program is pervasive. This is due to several factors:

1. Reporting is perceived by clinicians and administrators as a trigger for punishment especially if it might lead to an ACHA a field investigation.
2. Within healthcare organizations, the emphasis on reporting the identity of involved practitioners is viewed as punitive. Risk managers are sometimes pressured to find ways not to have to report. The risk managers are generally not well-supported or strategically placed in healthcare organizations and thus have difficulty effectively resisting such pressures.
3. Reporting appears to be ineffective. Since no information on risks, hazards, and how they might be managed is routinely reported by the state or shared with healthcare organizations, reporters gain nothing from reporting. Therefore, compliance meets the basic reporting requirements, at best.

Analysis. Berwick has criticized patient safety activity in the US as being obsessed with reporting, at the expense of analysis [1]. Our findings support this criticism. The analyses of adverse events contained in the Code 15 system are largely superficial. They are based on

"person" models of adverse events [2,3] and tend to stop when an 'error' is discovered, rather than taking the 'error' as the starting point for investigation [4-8]. Adverse event investigations are currently being conducted primarily by hospital risk managers who have little training in the safety sciences, are conflicted and pressured by being members of the institutions under investigation, and are not provided with resources and time to perform a thorough investigation. Because the quality of the analyses submitted is so poor, and because resources provided by the State to manage, analyze and report about these data are so limited, AHCA has not prioritized analysis and reporting. Contributing to poor and sparse reporting are:

4. The requirement to specifically identify the individuals involved in adverse events;
5. The short time frame required from event to report which encourages rapid turn around and simplistic analyses;
6. Little time and resources for use by risk managers in investigation and analysis.
7. Risk managers have little training in the safety sciences and investigation for understanding, as opposed to investigation for accountability.
8. What indexing and categorization occurs is not very useful since it is based in the language of the domain, not the language of human performance. Even so, the coding scheme used (such as the ICD-9 codes) are often ambiguous, difficult to apply, and not helpful for improvement.
9. The premise of the reporting system is based on the accounting model, emphasizing case definitions, categorization, summarization and trending. This "counting" model has not proven useful in safety activities in other hazardous domains, where it has been dropped in favor of a more qualitative model emphasizing the context of the incident and the narratives surrounding it.

10. Resources to support the investigative and analytic functionality of the reporting system are conspicuously absent. Neither the hospitals nor the Agency have the staff of persons skilled in accident investigation that would be necessary to perform the analysis required for learning from these events.

Corrective actions. With respect to patient safety improvement, data indicate that the actions taken are relatively weak and unlikely to be effective.

1. Again, the short time horizon of the reporting requirement encourages interventions that can be put into motion rapidly, such as remedial education or discipline. These interventions give the appearance of action but there is no evidence of substantive improvement.
2. The relatively disempowered position of risk managers within healthcare organizations limits the opportunities for assertive, proactive interventions.

Recommendations

The recommendations in this section are based on the findings above and knowledge of successful adverse event reporting schemes in other hazardous industries. The recommendations are presented around three major themes: making reporting safe; making analysis informed and independent; and making reporting effective. We discuss each with a set of specific supporting actions and justifications.

Make reporting safe. Berwick has commented that no scheme of inspection and reporting is sufficiently robust to withstand the fear of those being examined [27], and Leape has noted that

in the long run, all reporting is voluntary [11]. Charles Billings, the architect of the highly regarded Air Safety Reporting System at NASA, notes that there are two major impediments to reporting: fear, and ineffectiveness [9,10]. As long as the reporting institutions perceive a risk in reporting, it will be in their interest to report as little as they can. Therefore, the success of adverse event reporting in Florida will be critically dependent on making reporting safe for the reporters. To this end, we build upon the recommendations of our 2004 report as follows:

1. The reporting system should be separated from the regulatory system to reduce the perception that reporting adverse events might lead to punitive actions. This has been a critical factor in the well documented success with aviation safety, where the regulatory agency (the Federal Aviation Administration) is separate from the adverse event investigating body (the National Transportation Safety Board), and from the "near miss" reporting system (NASA – Ames Research Center). Even if a regulatory agency such as AHCA tried very hard to be non-punitive, it is inevitable that, in the face of a celebrated case, they would come under intense pressure to "do something" or appear ineffective. Removing the ability to issue regulations or sanctions will greatly reduce the perception that reporting risks punitive action. The Florida Patient Safety Corporation might be a natural host for an improved reporting system, particularly if it could be constituted as a Patient Safety Organization under Federal law (the Patient Safety and Quality Improvement Act of 2005). It is clear that such a move would require major changes in the staffing and funding of the FPSC.
2. Develop ironclad confidentiality protections for reporting bodies and individuals involved in adverse events. A major theme repeated by hospital risk managers was the fear that Code 15 reports would ultimately lose their confidentiality protection. This

anticipated fear leads to a certain coyness in the reports that are filed, and a general reluctance to report if any technical reason for not meeting the letter of the legal requirement can be found. A recurring theme is that these data need to be exempted from access by attorneys, journalists or others.

3. Eliminate the requirement to report specific identifiers (*eg*, license or Social Security numbers) for those involved in adverse incidents. Anonymity offers strong, although never complete, assurance against punitive actions and should elicit greater cooperation from those involved.
4. Move the responsibility for adverse event reporting within health care institutions to higher, administrative levels, such as the board of trustees of the CEO. Risk managers relate frequent stories of pressure to not report events for a variety of reasons. Because they are not strategically placed in the organization, they have difficulty resisting these pressures, and because they are charged with the reporting responsibility, they can easily be blamed (and dismissed) when failure to report becomes an issue.

Make analysis informed and independent. The data currently being provided to the system are inappropriately focused on the 'person model' of accident causation, and show little evidence of being informed by the advances in the science of human performance from the past 25 years. In addition, the investigations suffer from conflict of interest in two respects. First, hospital employees are investigating their own institutions and (as noted above) are occasionally subject to pressure that might limit their scope of inquiry and reporting. Second, a regulatory body is just as much a part of the socio-technical system of healthcare as is an operating body [28], and safety regulations have sometimes played contributory roles in accidents [29]. Finally, the

scientific model underlying the current approach to the data seems misdirected, as it is based on an accounting model that has not proven useful in advancing safety in hazardous industries. Until these issues are addressed, the information gathered cannot become useful for learning. To this end, we recommend the following:

1. Establish the independence of the reporting system from the larger regulatory system, as outlined in item 1, above. The body responsible for the system should be an advocate for safety *and only for safety*. While we recognize that there are conflicting demands on any system, having a clear voice for safety and safety improvement will help make the necessary tradeoffs more informed and explicit.
2. Ensure that risk managers and accident investigation staff acquire expertise in accident investigation and analysis that can be brought to bear in important cases.
3. Abandon the person model of accident causation. This could be done by dropping the requirement for personal identification, as noted above, and could be extended by having the reporting system reject as inadequate analyses that identify "human error", "mental lapses", "failure to follow procedure", *etc* as causes of adverse events.
4. Abandon the accounting perspective for the design and operation of the reporting system. While the collection and trending of large numbers of cases seems superficially attractive, the effect of massive under-reporting and the inevitable loss of information that occurs with aggregation inevitably makes this approach ineffective. Instead of aiming at acquiring a large number of relatively superficial reports, the goal should be changed to acquire a smaller number of truly insightful reports. The objective should shift from breadth to depth.

5. One specific mechanism by which such a change could be explored would be to develop a pilot project for accident investigation similar to that of the National Transportation Safety Board. In such a system, a group of expert analysts would travel to the site of an incident very shortly after it occurred and work with local investigators to develop an in-depth understanding of the hazards and conditions that led to the accident. This project would likely begin with only voluntary participation by a relatively small group of hospitals, and would need to resolve issues of triage (deciding which situations warranted the time and effort of an in-depth study) as part of its goals. At least one such project (MedCAS, *Medical Case Analysis System*) has been started in critical care medicine, so it might be feasible to partner with this project.
6. The time frame required for reporting is too short for meaningful analysis to be completed. It should either be extended, or could be broken into two phases. For example, notification of a potential incident might still be required in 15 days, with a definitive report to follow at some other interval (say, 90 days)..
7. Finally, the analytic function of the reporting system should be funded and supported adequately. It is beyond the scope of this report to develop specific funding recommendations, but it is appropriate to note that "you get what you pay for".

Make reporting useful. Incentives must be found to improve the quality of the reporting and the analyses conducted by the institutional reporters and state analysts. [9,10]. There is currently no feedback from the system to reporters in particular, to health care organizations or professionals in general. Thus, an output path is needed to complement the current input path from the point

of view of the providers and their organizations. To this end, we have the following recommendations:

1. The entity charged with operating the reporting system should report to the community of healthcare organizations and practitioners at regular intervals (for example, quarterly) on the nature of threats, hazards, and other risks to patient safety identified in the reports and analyses, and on potential methods of minimizing or mitigating those hazards.

Major changes are required for the Code 15 system to achieve its potential for systematic learning and improvement of patient safety in Florida.

References

1. Berwick DM. Patient safety: lessons from a novice. *Focus on Patient Safety* 2001;4(3):3.
2. Reason J. Human error: models and management. *BMJ* 2000;320(7237):768-770.
3. Wears RL. The science of safety. In: Zipperer L, ed. *Lessons in Patient Safety*. Chicago, IL: National Patient Safety Foundation; 2001:1 - 6.
4. Woods DD. *Behind Human Error: Cognitive Systems, Computers and Hindsight.* Dayton, OH: Crew Systems Ergonomic Information and Analysis Center, Wright Patterson Air Force Base; 1994.
5. Woods DD, Cook RI. Nine steps to move forward from error. *Cognition, Technology & Work* 2002;4:137-144.
6. Vincent C, Taylor-Adams S, Chapman EJ, *et al.* How to investigate and analyze clinical incidents: clinical risk unit and association of litigation and risk management protocol. *BMJ* 2000;320(7237):777-781.
7. Vincent C, Taylor-Adams S, Stanhope N. Framework for analyzing risk and safety in clinical medicine. *BMJ* 1998;316(7138):1154-1157.
8. Dekker S. *The Field Guide to Human Error Investigations*. Aldershot, UK: Ashgate; 2002.
9. Billings CE. The NASA aviation safety system: lessons learned from voluntary incident reporting. In: *Proceedings of the Second Annenberg Conference on Enhancing Patient Safety and Reducing Errors in Health Care*. Rancho Mirage, CA: National Patient Safety Foundation at the AMA; 1998:97-100.
10. Billings CE. Some hopes and concerns regarding medical event-reporting systems: lessons from the NASA Aviation Safety Reporting System. *Arch Pathol Lab Med* 1998;122(3):214-215.
11. Leape LL. Reporting of medical errors: time for a reality check. *Qual Saf Health Care* 2000;9(3):144-145.
12. Leape LL. Why should we report adverse incidents? *J Eval Clin Pract* 1999;5(1):1-4.
13. Bagian JP, Gosbee J, Lee CZ, *et al.* The Veterans Affairs root cause analysis system in action. *Jt Comm J Qual Improv* 2002;28(10):531-545.
14. Billings CE, Woods DD. Human error in perspective. The patient safety movement. *Postgrad Med* 2001;109(1):13-17.
15. Leveson NG. *Safeware: System Safety and Computers*. Boston: Addison-Wesley; 1995.

16. Bagian JP, Lee C, Gosbee J, *et al.* Developing and deploying a patient safety program in a large health care delivery system: you can't fix what you don't know about. *Jt Comm J Qual Improv* 2001;27(10):522-532.
17. March JG, Sproull LS, Tamuz M. Learning from samples of one or fewer. *Qual Saf Health Care* 2003;12(6):465-471.
18. Hollnagel E. The phenotype of erroneous actions. *International Journal of Man-Machine Studies* 1993;39(1):1 - 32.
19. Sutcliffe KM. Defining and classifying medical error: lessons for learning. *Qual Saf Health Care* 2004;13(1):8-9.
20. Tamuz M, Thomas EJ, Franchois KE. Defining and classifying medical error: lessons for patient safety reporting systems. *Qual Saf Health Care* 2004;13(1):13-20.
21. Brennan TA, Leape LL, Laird NM, *et al.* Incidence of adverse events and negligence in hospitalized patients. Results of the Harvard Medical Practice Study I. *N Engl J Med* 1991;324(6):370-376.
22. Thomas EJ, Studdert DM, Burstin HR, *et al.* Incidence and types of adverse events and negligent care in Utah and Colorado. *Med Care* 2000;38(3):261-271.
23. Leveson N. A new accident model for engineering safer systems. *Safety Science* 2004;42(4):237 - 270.
24. Hollnagel E. *Barriers and Accident Prevention*. Aldershot, UK: Ashgate; 2004.
25. Hollnagel E, Woods DD, Levenson N, eds. *Resilience Engineering*. Aldershot, UK: Ashgate; 2006.
26. Clarke L. *Mission Improbable: Using Fantasy Documents to Tame Disaster*. Chicago, IL: University of Chicago Press; 1999.
27. Berwick DM. Taking action to improve safety: how to increase the odds of success. In: Scheffler AL, Zipperer LA, eds. *Proceedings of the Second Annenberg Conference on Enhancing Patient Safety and Reducing Errors in Health Care*. Rancho Mirage, CA: National Patient Safety Foundation at the AMA; 1998:1-10.
28. Rasmussen J. Risk management in a dynamic society. *Safety Science* 1997;27(2/3):183 - 213.
29. Langewiesche W. The lessons of ValuJet 592. *Atlantic Monthly* 1998;281(3):81-98.

APPENDIX 1

FLORIDA STATUTES THAT LICENSED RISK MANAGERS ARE ROUTINELY EXPECTED TO BE FAMILIAR WITH ON A DAILY WORKING BASIS:

1. 765.202 f.s.
Score: 91.15%
Abstract: (2) The person designated as surrogate shall not act as witness to the execution of the document designating the health care surrogate. (3) A document designating a health care surrogate may also designate an alternate surrogate provided the designation is explicit. However, unless the document designating the health care surrogate expressly states otherwise, the court shall assume that the health care surrogate authorized to make health care decisions under this chapter is also the ...

2. 872.04 f.s.
Score: 81.69%
Abstract: (2) Unless otherwise authorized by statute, no autopsy shall be performed without the written consent by the health care surrogate, as provided in s. When two or more persons assume custody of the body for such purposes, then the consent of any one of them shall be sufficient to authorize the autopsy. (3) Any such written consent may be given by telegram, and any telegram purporting to have been sent by a person authorized to give such consent will be presumed to have been sent by such ...

3. 765.101 f.s.
Score: 81.69%
Abstract: (c) The right of access to all records of the principal reasonably necessary for a health care surrogate to make decisions involving health care and to apply for benefits. (6) "Health care facility" means a hospital, nursing home, hospice, home health agency, or health maintenance organization licensed in this state, or any facility subject to part I of chapter 394. (16) "Surrogate" means any competent adult expressly designated by a principal to make health care decisions on behalf of the ...

4. 394.4598 f.s.
Score: 81.69%
Abstract: If the court finds that a patient is incompetent to consent to treatment and has not been adjudicated incapacitated and a guardian with the authority to consent to mental health treatment appointed, it shall appoint a guardian advocate. (2) A facility requesting appointment of a guardian advocate must, prior to the appointment, provide the prospective guardian advocate with information about the duties and responsibilities of guardian advocates, including the information about the ethics of ...

5. 765.512 f.s.
Score: 79.67%
Abstract: An anatomical gift made by an adult donor and not revoked by the donor as provided in s. A family member, guardian, representative ad litem, or health care surrogate of an adult donor who has made an anatomical gift pursuant to subsection (2) may not modify, deny, or prevent a donor's wish or intent to make an anatomical gift from being made after the donor's death. (5) The person authorized by subsection (3) may make the gift after the decedent's death or immediately before the decedent's ...

6. 765.305 f.s.
Score: 79.67%
Abstract: (1) In the absence of a living will, the decision to withhold or withdraw life-prolonging procedures from a patient may be made by a health care surrogate designated by the patient pursuant to part II unless the designation limits the surrogate's authority to consent to the withholding or withdrawal of

life-prolonging procedures. (a) The patient does not have a reasonable medical probability of recovering capacity so that the right could be exercised by the patient. (b) The patient has an end...

7. 765.203 f.s.
Score: 79.67%
Abstract: I fully understand that this designation will permit my designee to make health care decisions, except for anatomical gifts, unless I have executed an anatomical gift declaration pursuant to law, and to provide, withhold, or withdraw consent on my behalf; to apply for public benefits to defray the cost of health care; and to authorize my admission to or transfer from a health care facility. I further affirm that this designation is not being made as a condition of treatment or admission to a ...

8. 765.201 f.s.
Score: 79.67%
Abstract: 765.201 Short title. --Sections 765.202-765.205 may be cited as the "Florida Health Care Surrogate Act." 3, ch.

9. 765.107 f.s.
Score: 79.67%
Abstract: 766.103, the Florida Medical Consent Law. For all purposes, the Florida Medical Consent Law shall be considered an alternative to provisions of this section. (2) Procedures provided in this chapter permitting the withholding or withdrawal of life-prolonging procedures do not apply to a person who never had capacity to designate a health care surrogate or execute a living will.

10. 394.4625 f.s.
Score: 79.67%
Abstract: (f) Within 24 hours after admission of a voluntary patient, the admitting physician shall document in the patient's clinical record that the patient is able to give express and informed consent for admission. A voluntary patient or a relative, friend, or attorney of the patient may request discharge either orally or in writing at any time following admission to the facility. If the request for discharge is made by a person other than the patient, the discharge may be conditioned upon the ...

Score: 79.67% placement, or when a petition for involuntary placement is filed, the names, addresses, and telephone numbers of the patient's guardian or guardian advocate, or representative if the patient has no guardian, and the patient's attorney shall be entered in the patient's clinical record. (e) A licensed professional providing services to the patient under this part, an employee of a facility providing direct

381.028 f.s.
Score: 79.67%
Abstract: (k) "Representative of the patient" means a parent of a minor patient, a court-appointed guardian for the patient, a health care surrogate, or a person holding a power of attorney or notarized consent appropriately executed by the patient granting permission to a health care facility or health care provider to disclose the patient's health care information to that person. --Patients have a right to have access to any records made or received in the course of business by a health care ...

765.522 f.s.
Score: 77.42%
Abstract: 765.522 Duty of certain hospital administrators; liability of hospital administrators, organ procurement organizations, eye banks, and tissue banks. (6) The hospital administrator or a designee shall, at or near the time of death of a potential organ donor, directly notify the affiliated Health Care Financing Administration designated organ procurement organization of the potential organ donor. This notification must not be made to a tissue bank or eye bank in lieu of the organ procurement ...

765.204 f.s.
Score: 77.42%
Abstract: (2) If a principal's capacity to make health care decisions for herself or himself or provide informed consent is in question, the attending physician shall evaluate the principal's capacity and, if the physician concludes that the principal lacks capacity, enter that evaluation in the principal's medical record. If the attending physician has a question as to whether the principal lacks capacity, another physician shall also evaluate the principal's capacity, and if the second physician ...

765.1103 f.s.
Score: 77.42%
Abstract: (2) Health care providers and practitioners regulated under chapter 458, chapter 459, or chapter 464 must, as appropriate, comply with a request for pain management or palliative care from a patient under their care or, for an incapacitated patient under their care, from a surrogate, proxy, guardian, or other representative permitted to make health care decisions for the incapacitated patient. Facilities regulated under chapter 395 or chapter 400 must comply with the pain management or ...

709.08 f.s.
Score: 77.42%
Abstract: --A durable power of attorney is a written power of attorney by which a principal designates another as the principal's attorney in fact. The durable power of attorney is exercisable as of the date of execution; however, if the durable power of attorney is conditioned upon the principal's lack of capacity to manage property as defined in s. 1. Affiant is the attorney in fact named in the Durable Power of Attorney executed by (principal) ("Principal") on (date) .

415.102 f.s.
Score: 77.42%
Abstract: (2) "Alleged perpetrator" means a person who has been named by a reporter as the person responsible for abusing, neglecting, or exploiting a vulnerable adult. (3) "Capacity to consent" means that a vulnerable adult has sufficient understanding to make and communicate responsible decisions regarding the vulnerable adult's person or property, including whether or not to accept protective services offered by the department. (20) "Protective services" means services to protect a vulnerable adult ...

401.45 f.s.
Score: 77.42%
Abstract: (3)(a) Resuscitation may be withheld or withdrawn from a patient by an emergency medical technician or paramedic if evidence of an order not to resuscitate by the patient's physician is presented to the emergency medical technician or paramedic. (4) Any licensee or emergency medical technician or paramedic who in good faith provides emergency medical care or treatment within the scope of their employment and pursuant to oral or written instructions of a medical director shall be deemed to be...

400.4075 f.s.
Score: 77.42%
Abstract: --An assisted living facility that serves three or more mental health residents must obtain a limited mental health license. (4) A facility with a limited mental health license may enter into a cooperative agreement with a private mental health provider. For purposes of the limited mental health license, the private mental health provider may act as the case manager.

456.013 f.s.
Score: 81.69%
Abstract: (2) Before the issuance of any license, the department shall charge an initial license fee as determined by the applicable board or, if there is no board, by rule of the department. (c) In considering applications for licensure, the board, or the department when there is no board, may require a personal appearance of the applicant. The department shall adopt rules for administering continuing education requirements adopted by the boards or the department if there is no board.

456.031 f.s.
Score: 81.69%
Abstract: (1)(a) The appropriate board shall require each person licensed or certified under chapter 458, chapter 459, part I of chapter 464, chapter 466, chapter 467, chapter 490, or chapter 491 to complete a 1-hour continuing education course, approved by the board, on domestic violence, as defined in s. (b) In lieu of completing a course as required by subsection (1), a person licensed under chapter 466 who has completed an approved domestic-violence education course in the immediately preceding 2

APPENDIX 2

Code 15 Florida Statute

Adverse events are defined in Florida Statute 395.0197(5) as follows:

"5) For purposes of reporting to the agency pursuant to this section, the term "adverse incident" means an event over which health care personnel could exercise control and which is associated in whole or in part with medical intervention, rather than the condition for which such intervention occurred, and which:

(a) Results in one of the following injuries:

1. Death;

2. Brain or spinal damage;

3. Permanent disfigurement;

4. Fracture or dislocation of bones or joints;

5. A resulting limitation of neurological, physical, or sensory function which continues after discharge from the facility;

6. Any condition that required specialized medical attention or surgical intervention resulting from non-emergency medical intervention, other than an emergency medical condition, to which the patient has not given his or her informed consent; or

7. Any condition that required the transfer of the patient, within or outside the facility, to a unit providing a more acute level of care due to the adverse incident, rather than the patient's condition prior to the adverse incident;

(b) Was the performance of a surgical procedure on the wrong patient, a wrong surgical procedure, a wrong-site surgical procedure, or a surgical procedure otherwise unrelated to the patient's diagnosis or medical condition;

(c) Required the surgical repair of damage resulting to a patient from a planned surgical procedure, where the damage was not a recognized specific risk, as disclosed to the patient and documented through the informed-consent process; or

(d) Was a procedure to remove unplanned foreign objects remaining from a surgical procedure."

Code 15s are defined by Florida Statute 395.0197(7) as:

"7) Any of the following adverse incidents, whether occurring in the licensed facility or arising from health care prior to admission in the licensed facility, shall be reported by the facility to the agency within 15 calendar days after its occurrence:

(a) The death of a patient;

(b) Brain or spinal damage to a patient;

(c) The performance of a surgical procedure on the wrong patient;

(d) The performance of a wrong-site surgical procedure;

(e) The performance of a wrong surgical procedure;

(f) The performance of a surgical procedure that is medically unnecessary or otherwise unrelated to the patient's diagnosis or medical condition;

(g) The surgical repair of damage resulting to a patient from a planned surgical procedure, where the damage is not a recognized specific risk, as disclosed to the patient and documented through the informed-consent process; or

(h) The performance of procedures to remove unplanned foreign objects remaining from a surgical procedure."

APPENDIX 3

Current Code 15 Reporting Form

Confidential
Code 15 Report

Hospital and Outpatient Services Unit
2727 Mahan Drive • Mail Stop #31
Tallahassee, Florida 32308
Phone: (850) 487-2717; Fax: (850) 921-5459

I. Facility Information (Form Must Be Typed)

Name of Facility or Campus

Risk Manager

Address | City | Title

State | Zip Code | County | 55 License Number

Telephone Number | Fax Number | E-mail Address

II. Patient Information

Patient Name | Age | Sex | ☐ Medicaid ☐ Medicare

Patient Identification Number | Date of Admission

Patient Address | County | Admitting Diagnosis

City | State | Zip Code | ICD-9 Code for Admit Diagnosis

III. Incident Information

Incident Date | Time

Location of Incident:

Facility Unit:
☐ Blood Bank
☐ CCU
☐ Endoscopy
☐ Emergency Room
☐ ICU
☐ Labor/Delivery
☐ Facility Campus
☐ Laboratory
☐ Operating Room
☐ Outpatient Services
☐ Patient Room
☐ Radiology
☐ Recovery Room
☐ Other

Other Health Care Provider:
☐ Abortion Clinic
☐ Ambulatory Surgical Center
☐ Assisted Living Facility
☐ Doctor's Office
☐ Home Health
☐ Nursing Home
☐ Name of Other Provider

Note: If the incident involved a death, was the Medical Examiner notified? ☐ Yes ☐ No

Confidential
Code 15 Report

Was an autopsy performed? ☐ Yes ☐ No

Name and contact number of the Medical Examiner

Name _____ Telephone Number _____

A) Describe circumstances of the incident (narrative) (Use additional sheets as necessary for complete response)

B) ICD-9-CM Codes

Surgical, diagnostic, or treatment procedure being performed at time of incident **(ICD-9 Codes 01-99.9)**	Accident, event, circumstances, or specific agent that caused the injury or event. **(ICD-9 E-Codes)**	Resulting injury **(ICD-9 Codes 800-999.9)**

C) List any equipment used if directly involved in the incident

D) Outcome of Incident (Please check)

- ☐ Death
- ☐ Fetal death
- ☐ Brain damage
- ☐ Spinal damage
- ☐ Surgical procedure performed on the wrong site
- ☐ Surgical procedure performed on the wrong patient
- ☐ Wrong surgical procedure performed
- ☐ Surgical procedure unrelated to the patient's diagnosis
- ☐ Surgical procedure to remove foreign objects remaining from a surgical procedure
- ☐ Surgical repair of injuries from a planned surgical procedure

Confidential
Code 15 Report

E) List license numbers of personnel and the capacity in which they were directly involved with this incident, i.e., ER physician, attending physician, surgeon, etc. (List social security numbers and capacity of unlicensed personnel)

F) List license numbers of witnesses (List social security numbers and capacity of unlicensed personnel)

2.

3.

a. Analysis and Corrective Action

A) Analysis (apparent cause) of this incident (Use additional sheets as necessary for complete response)

B) Describe corrective or proactive action(s) taken (Use additional sheets as necessary for complete response)

b.
c.
d.

Signature of Risk Manager **Title** **Date**

Team Membership

Robert L Wears, MD, MS	Team Leader
Nir Menachemi, MPH, PhD	Co-Coordinator
Lisa Simpson, MB, MPH	
D Lynn Glass, BSN, JD, LHRM	
Shawna J Perry, MD	
Nik Gravenstein, MD	
Jay Wolfson, DrPH, JD	
Paul Barach, MD, MPH	

Florida Tobacco Education and Use Prevention Community Youth and Cessation Request For Proposal Awardees County by County as of January 31, 2008

	Community	Community Awardee	Programmatic Contact Person	Amount	Contract Length	Memorandum of Understanding capable to be renewed for 2 additional years.	Deliverables of reports are standardized, but specific measurements are set in accordance with each program.	Program Report Approved	Expenditure Report Approved?	Fixed Capital Outlay project	Fixed Captiol Outlay (FCO)funding
1	Alachua	County Health Depatment	Dave Garison	$150,000.00	9 months	Yes	Quarterly Programmatic Report & Quarterly Expenditure Report	Yes - January 15th	No		
2	Baker	County Health Depatment	Dave Garison	$93,750.00	9 months	Yes	Quarterly Programmatic Report & Quarterly Expenditure Report	Yes - January 15th	Yes		
3	Bay	County Health Depatment	Ron Davis	$140,000.00	9 months	Yes	Quarterly Programmatic Report & Quarterly Expenditure Report	Yes - January 15th	Yes		
4	Brevard	PREVENT! of Brevard	Donna Washington	$150,000.00	9 months	Yes	Contract Specific and Quarterly Report	Yes - January 15th	Yes		
5	Broward	County Health Depatment	Jennifer Harris	$149,833.00	9 months	Yes	Quarterly Programmatic Report & Quarterly Expenditure Report	Yes - January 15th	Yes	Tobacco Ed - New Building	$447,100.00
6	Calhoun	County Health Depatment	Ron Davis	$62,493.00	6 months	Yes	Quarterly Programmatic Report & Quarterly Expenditure Report	New Award - May	New Award - May		
7	Charlotte	County Health Depatment	Laura Corbin	$99,580.00	9 months	Yes	Quarterly Programmatic Report & Quarterly Expenditure Report	Yes - January 15th	Yes		
8	Citrus	County Health Depatment	Dave Garison	$100,000.00	9 months	Yes	Quarterly Programmatic Report & Quarterly Expenditure Report	Yes - January 15th	No		
9	Clay	County Health Depatment	Dave Garison	$62,164.00	9 months	Yes	Quarterly Programmatic Report & Quarterly Expenditure Report	Yes - January 15th	Yes		
10	Collier	County Health Depatment	Jennifer Harris	$100,000.00	9 months	Yes	Quarterly Programmatic Report & Quarterly Expenditure Report	Yes - January 15th	Yes		
11	Columbia	County Health Depatment	Dave Garison	$62,500.00	6 months	Yes	Quarterly Programmatic Report & Quarterly Expenditure Report	New Award - May	New Award - May		
12	Desoto	County Health Depatment	Laura Corbin	$93,750.00	9 months	Yes	Quarterly Programmatic Report & Quarterly Expenditure Report	Yes - January 15th	Yes		
13	Dixie	Quit Doc	TBA	$62,500.00	6 months	Yes	Contract Specific and Quarterly Report	New Award - May	New Award - May		
14	Duval	County Health Depatment	Dave Garison	$150,000.00	9 months	Yes	Quarterly Programmatic Report & Quarterly Expenditure Report	Yes - January 15th	Yes		
15	Escambia	County Health Depatment	Ron Davis	$150,000.00	9 months	Yes	Quarterly Programmatic Report & Quarterly Expenditure Report	Yes - January 15th	Yes		
16	Flagler	Focus on Flagler Youth Coalition	Sam Samlal	$93,750.00	9 months	Yes	Contract Specific and Quarterly Report	Yes - January 15th	Yes		

	Community	Community Awardee	Programmatic Contact Person	Amount	Contract Length	Memorandum of Understanding capable to be renewed for 2 additional years.	Deliverables of reports are standardized, but specific measurements are set in accordance with each program.	Program Report Approved	Expenditure Report Approved?	Fixed Capital Outlay project	Fixed Captiol Outlay (FCO)funding
17	Franklin	County Health Depatment	Ron Davis	$62,500.00	6 months	Yes	New Award	New Award - May	New Award - May		
18	Gadsden	Boys and Girls Club of the Big Bend	TBA	$62,500.00	6 months	Yes	Contract Specific and Quarterly Report	New Award - May	New Award - May		
19	Gilchrist	Quit Doc	TBA	$62,500.00	6 months	Yes	Contract Specific and Quarterly Report	New Award - May	New Award - May		
20	Glades	Drug Free Charlotte -	Sam Samlal	$93,750.00	9 months	Yes	Contract Specific and Quarterly Report	Yes - January 15th	Yes		
21	Gulf	County Health Depatment	Ron Davis	$93,750.00	9 months	Yes	Quarterly Programmatic Report & Quarterly Expenditure Report	Yes - January 15th	Yes		
22	Hamilton	Hamilton County Board of County Commissioners	TBA	$62,500.00	6 months	Yes	Contract Specific and Quarterly Report	New Award - May	New Award - May		
23	Hardee	County Health Depatment	Laura Corbin	$93,750.00	9 months	Yes	Quarterly Programmatic Report & Quarterly Expenditure Report	Yes - January 15th	Yes		
24	Hendry	Drug Free Charlotte -	Sam Samlal	$93,750.00	9 months	Yes	Contract Specific and Quarterly Report	Yes - January 15th	Yes		
25	Hernando	Hernando County Community Anti Drug Coalition	Donna Washington	$100,000.00	9 months	Yes	Contract Specific and Quarterly Report	Yes - January 15th	Yes		
26	Highlands	County Health Depatment	Laura Corbin	$100,000.00	9 months	Yes	Quarterly Programmatic Report & Quarterly Expenditure Report	Yes - January 15th	Yes		
27	Hillsborough	County Health Depatment	Laura Corbin	$150,000.00	9 months	Yes	Quarterly Programmatic Report & Quarterly Expenditure Report	Yes - January 15th	Yes	LAB Tobacco Ed - Addition	$638,500.00
28	Holmes	County Health Depatment	Ron Davis	$93,750.00	9 months	Yes	Quarterly Programmatic Report & Quarterly Expenditure Report	Yes - January 15th	Yes		
29	Indian River	Substance Abuse Council of Indian River County	Donna Washington	$100,000.00	9 months	Yes	Contract Specific and Quarterly Report	Yes - January 15th	Yes		
30	Jackson	County Health Depatment	Ron Davis	$93,750.00	9 months	Yes	Quarterly Programmatic Report & Quarterly Expenditure Report	Yes - January 15th	Yes		

	Community	Community Awardee	Programmatic Contact Person	Amount	Contract Length	Memorandum of Understanding capable to be renewed for 2 additional years.	Deliverables of reports are standardized, but specific measurements are set in accordance with each program.	Program Report Approved	Expenditure Report Approved?	Fixed Capital Outlay project	Fixed Captiol Outlay (FCO)funding
31	Jefferson	County Health Depatment	Ron Davis	$62,500.00	6 months	Yes	Quarterly Programmatic Report & Quarterly Expenditure Report	New Award - May	New Award - May		
32	Lafayette	Suwannee Valley Youth Advocacy Partnership - Lafayette	Sam Samlal	$93,750.00	9 months	Yes	Contract Specific and Quarterly Report	Yes - January 15th	Yes		
33	Lake	County Health Depatment	Laura Corbin	$100,000.00	9 months	Yes	Quarterly Programmatic Report & Quarterly Expenditure Report	Yes - January 15th	Yes		
34	Lee	Lee County Coalition for a Drug Free Southwest Florida/ with the CHD	Donna Washington	$150,000.00	9 months	Yes	Contract Specific and Quarterly Report	Yes - January 15th	Yes		
35	Leon	County Health Depatment	Ron Davis	$66,666.50	6 months	Yes	Quarterly Programmatic Report & Quarterly Expenditure Report	New Award - May	New Award - May	Tobacco Ed-Addition	$638,500.00
36	Levy	County Health Depatment	Dave Garrison	$93,750.00	9 months	Yes	Quarterly Programmatic Report & Quarterly Expenditure Report	Yes - January 15th	Yes		
37	Liberty	County Health Depatment	Ron Davis	$62,493.00	6 months	Yes	Quarterly Programmatic Report & Quarterly Expenditure Report	New Award - May	New Award - May		
38	Madison	County Health Depatment	Ron Davis	$62,500.00	6 months	Yes	Quarterly Programmatic Report & Quarterly Expenditure Report	New Award - May	New Award - May		
39	Manatee	County Health Depatment	Laura Corbin	$97,510.00	9 months	Yes	Quarterly Programmatic Report & Quarterly Expenditure Report	Yes - January 15th	Yes		
40	Marion	County Health Depatment	Dave Garrison	$149,964.01	9 months	Yes	Quarterly Programmatic Report & Quarterly Expenditure Report	Yes - January 15th	Yes		
41	Martin	Quit Doc	TBA		6 months	Yes	Contract Specific and Quarterly Report	New Award - May	New Award - May		
42	Miami-Dade	County Health Depatment	Jennifer Harris	$150,000.00	9 months	Yes	Quarterly Programmatic Report & Quarterly Expenditure Report	Yes - January 15th	Yes		
43	Monroe	County Health Depatment	Jennifer Harris	$93,470.00	9 months	Yes	Quarterly Programmatic Report & Quarterly Expenditure Report	Yes - January 15th	Yes		
44	Nassau	County Health Depatment	Dave Garrison	$93,750.00	9 months	Yes	Quarterly Programmatic Report & Quarterly Expenditure Report	Yes - January 15th	No		
45	Okaloosa	County Health Depatment	Ron Davis	$100,000.00	9 months	Yes	Quarterly Programmatic Report & Quarterly Expenditure Report	Yes - January 15th	Yes		

	Community	Community Awardee	Programmatic Contact Person	Amount	Contract Length	Memorandum of Understanding capable to be renewed for 2 additional years.	Deliverables of reports are standardized, but specific measurements are set in accordance with each program.	Program Report Approved	Expenditure Report Approved?	Fixed Capital Outlay project	Fixed Captiol Outlay (FCO)funding
46	Okeechobee	County Health Depatment	Jennifer Harris	$60,905.00	6 months	Yes	Quarterly Programmatic Report & Quarterly Expenditure Report	New Award - May	New Award - May		
47	Orange	Center for Multicultural Wellness and Prevention	Donna Washington	$149,325.00	9 months	Yes	Contract Specific and Quarterly Report	Yes - January 15th	Yes		
48	Osceola	County Health Depatment	Laura Corbin	$52,618.52	9 months	Yes	Quarterly Programmatic Report & Quarterly Expenditure Report	Yes - January 15th	Yes		
49	Palm Beach	County Health Depatment	Jennifer Harris	$150,000.00	9 months	Yes	Quarterly Programmatic Report & Quarterly Expenditure Report	Yes - January 15th	No		
50	Pasco	County Health Depatment	Laura Corbin	$100,000.00	9 months	Yes	Quarterly Programmatic Report & Quarterly Expenditure Report	No	No	Tobacco Ed-Addition	$668,800.00
51	Pinellas	County Health Depatment	Laura Corbin	$150,000.00	9 months	Yes	Quarterly Programmatic Report & Quarterly Expenditure Report	Yes - January 15th	Yes		
52	Polk	Drug Prevention Resource Center -	Donna Washington	$150,000.00	9 months	Yes	Contract Specific and Quarterly Report	Yes - January 15th	Yes		
53	Putnam	County Health Depatment	Dave Garison	$81,660.00	9 months	Yes	Quarterly Programmatic Report & Quarterly Expenditure Report	Yes - January 15th	No		
54	Santa Rosa	County Health Depatment	Ron Davis	$99,999.00	9 months	Yes	Quarterly Programmatic Report & Quarterly Expenditure Report	Yes - January 15th	Yes		
55	Sarasota	County Health Depatment	Laura Corbin	$149,567.72	9 months	Yes	Quarterly Programmatic Report & Quarterly Expenditure Report	Yes - January 15th	Yes	Tobacco Ed-Addition	$668,800.00
56	Seminole	County Health Depatment	Laura Corbin	$100,000.00	9 months	Yes	Quarterly Programmatic Report & Quarterly Expenditure Report	Yes - January 15th	Yes		
57	St. Johns	County Health Depatment	Dave Garison	$100,000.00	9 months	Yes	Quarterly Programmatic Report & Quarterly Expenditure Report	Yes - January 15th	Yes		
58	St. Lucie	County Health Depatment	Jennifer Harris	$100,000.00	9 months	Yes	Quarterly Programmatic Report & Quarterly Expenditure Report	Yes - January 15th	Yes		
59	Sumter	County Health Depatment	Dave Garrison	$93,717.32	9 months	Yes	Quarterly Programmatic Report & Quarterly Expenditure Report	Yes - January 15th	Yes		
60	Suwannee	Suwannee Valley Youth Advocacy Partnership - Suwannee	Sam Samlal	$93,750.00	9 months	Yes	Contract Specific and Quarterly Report	Yes - January 15th	Yes		
61	Taylor	County Health Depatment	Ron Davis	$62,500.00	6 months	Yes	Quarterly Programmatic Report & Quarterly Expenditure Report	New Award - May	New Award - May		

	Community	Community Awardee	Programmatic Contact Person	Amount	Contract Length	Memorandum of Understanding capable to be renewed for 2 additional years.	Deliverables of reports are standardized, but specific measurements are set in accordance with each program.	Program Report Approved	Expenditure Report Approved?	Fixed Capital Outlay project	Fixed Captiol Outlay (FCO)funding
62	Union & Bradford	County Health Depatment	Dave Garison	$187,500.00	9 months	Yes	Quarterly Programmatic Report & Quarterly Expenditure Report	Yes - January 15th	No		
63	Volusia	County Health Depatment	Dave Garison	$150,000.00	9 months	Yes	Quarterly Programmatic Report & Quarterly Expenditure Report	Yes - January 15th	Yes		
64	Wakulla	County Health Depatment	Ron Davis	$62,500.00	6 months	Yes	Quarterly Programmatic Report & Quarterly Expenditure Report	New Award - May	New Award - May		
65	Walton	Chautauqua Offices of Psychotherapy and Evaluation -	Sam Samlal	$93,750.00	9 months	Yes	Contract Specific and Quarterly Report	Yes - January 15th	Yes		
66	Washington	County Health Depatment	Ron Davis	$93,750.00	9 months	Yes	Quarterly Programmatic Report & Quarterly Expenditure Report	Yes - January 15th	Yes		
	Statewide FCO	Projects not yet determined								Not Determined	$510,000.00
	Statewide FCO -	Tobacco Education Equipment Sites and Minor Renovations								Equipment and minor renovation	$1,428,300.00
	Total			**$6,640,716.07**							**$5,000,000.00**

Florida Tobacco Education and Use Prevention Community Youth and Cessation Request For Proposal Awardees Summary County by County As of January 31, 2008

The information provided reflects each county's response to the Requests For Proposals (RFPs) to the Florida Department of Health for Community Youth and Cessation contracts.

Alachua County

Alachua County Health Department (ACHD) will strive to enhance an existing partnership in the fight against tobacco through specific activities including: 1) developing a community wide plan to reduce tobacco use among youth and adults, eliminate exposure to second hand smoke and address the issue of tobacco use on chronic disease; 2) educating and mobilizing the community for tobacco prevention, control and policy; 3) working to enforce and strengthen tobacco laws and ordinances, including clean indoor and outdoor environments, restricting access to tobacco products, monitoring youth access to tobacco and; 4) integrating tobacco prevention and control into interagency programs.

The youth component will include several strategies. School-based programs will encourage children and adolescents who have not experimented with tobacco to continue to abstain from use. For young people who have experimented with tobacco, or who are regular users, the programs will enable and encourage them to stop all use. The ACHD will expand its current role in school-based education by developing a comprehensive education program for K-12 with special emphasis on grades 6-9. In addition to the education component, the ACHD tobacco program will develop programs to help students develop skills in recognizing and refuting tobacco promotion messages from the media, adults and peers.

The chronic disease portion of the program will include three program services: 1) addressing tobacco use by pregnant women; 2) reducing exposure to second hand smoke by infants and; 3) working with the Tobacco Partnership to promote adoption and enforcement of policies related to second hand smoke in public places. We will address disease *management* with a service for pediatric asthma.

Our priority populations are: 1) youth, with an emphasis on those with demographics associated with tobacco use; 2) Pregnant smokers and their offspring and; 3) children with asthma.

Baker County

Baker County Health Department (BCHD) has developed a two-prong asthma education program. For the first component, we developed a peer-asthma education program for adolescents. The second component improves knowledge and attitudes concerning asthma in their peers. In addition to continuing this two-prong approach, BCHD is developing an Asthma Coalition. The Asthma Coalition will meet monthly. The coalition will provide direction to enhance every aspect of the program and to overcome any barriers encountered.

Bay County

Bay County Health Department (BCHD) will build a tobacco community partnership to advise the county and maximize resources. BCHD will reach its target populations through school based SWAT clubs and non-profit youth organizations, and through program directors for planned youth based activities and training. Community-based and faith-based organizations and agencies that deal with chronic diseases such as lung-cancer and diabetes and others will be contacted to partner with the BCHD on the quarterly seminars and a regional seminar. The regional chronic disease related seminar/training will encourage participation by health field

personnel and they will directly contact health departments in the surrounding counties and local medical and school facilities' staff. Faith-based organizations and agencies that deal in chronic diseases such as lung-cancer, asthma, diabetes, and others will be contacted to partner with the BCHD on the quarterly seminars and regional seminar. Comprehensive tobacco prevention and tobacco use related health education - Life Management Classes (6th grade students) and other classes (6-12) using CDC approved curriculum materials will be implemented. Quarterly Tobacco Prevention and Chronic Seminars will be organized at various locations and will target persons with the chronic diseases: diabetes, asthma, cardiovascular disease, stroke and lung disease. Students will research policies regarding sale of flavored tobacco, Tobacco-sponsored "prevention" materials and secondhand smoke; they will prepare an action plan; and the BCHD will promote Quit Line and cessation classes. A mass media campaign will promote smoke-free environment to youth and adults as well as promote cessation and secondhand smoke prevention.

Bradford County

See Union County.

Brevard County

Brevard County Health Department (BCHD) has one Tobacco Program Specialist (TPS) responsible for the coordination and delivery of all tobacco prevention and control interventions. The TPS is working with county hospitals and community colleges to implement smoke free campus policies. She is also partnering with day care centers throughout Brevard to begin a secondhand smoke education and prevention campaign. TPS is building and maintaining current school based SWAT programs. Their focus for the year will be advocating for smoke-free beaches and counter-marketing initiatives to expose current tobacco industry marketing tactics. The tobacco program is also coordinating smoking cessation counseling to occur at hospitals, colleges and other partnering venues. The tobacco program will train community partners to deliver cessation classes/counseling and require partners to conduct counseling sessions for community. The TPS also plans on advertising the FL Quit for Life cessation hotline on public transportation buses.

Broward County

Broward County Health Department (BCHD) will implement "I Decide" tobacco prevention and cessation program. Nearly half of the program award will be spent on a media campaign focused on preventing youth initiation with "Don't Start" media messages and encourage current tobacco users with "we can help you help yourself stop" media messages. The program will offer two cessation programs locally through the American Lung Association: N-O-T (Not on Tobacco) for teens and Freedom from Smoking® for adults.

Calhoun County

The Chamber of Commerce is large and proactive, with civic-minded members including churches, political incumbents, businesses, media partners and others who care deeply about the future of Calhoun County. The Children's Coalition, County Library System and the County Extension Service have maintained involvement with youth tobacco prevention and education programs, as have participants from schools, including teachers, coaches and youth mentors. They can be relied upon to return to the fold. Target population for this proposal will be all residents of Calhoun County, through the leadership of our youth population. Calhoun County is disparately-affected by tobacco use and as a result, many citizens suffer from chronic diseases caused or exacerbated by tobacco use. Our youth see themselves as invulnerable and are therefore at high risk for addiction, including tobacco addiction. They can be reached at the schools and at the health department, where many seek primary care for chronic illnesses

related to tobacco use and other risk taking behavior. Our second disparately-affected group is the growing but "invisible" Hispanic population. They do not appear on census data because many are transient or illegal. A review of products on local store shelves recognizes their presence by carrying and selling ethnic food and products targeted towards customers of Mexican heritage. This population can be reached through their use of the health department for primary care and through the schools their children attend. CDC's best practices clearly support a comprehensive community tobacco control program emphasizing the following components: community partnership to involve citizens in reducing tobacco use, emphasizing policy changes to reduce the incidence of chronic diseases caused or worsened by use of tobacco products and exposure to second hand smoke. The youth component will center on schools and churches, with enforcement of statutes by partnering with law enforcement. Tobacco cessation referrals will be provided by the Area Health Education Center. Strategies to help people quit smoking are clearly shown to provide health and economic benefits. Leadership roles of our youth will attract local media and reinforce statewide media campaigns. Evaluation is essential to ensure goals are met and we keep our eyes clearly on the long term goal of prevention of tobacco related chronic diseases.

Charlotte County

Charlotte County Health Department's (CCHD) Chronic Disease Prevention Coordinator is coordinating area hospital implementation of smoke free campus policies. The Office of Healthy Lifestyles (OHL) within the CCHD will address the Chronic Disease components of the tobacco grant by reducing the exposure of secondhand smoke to all populations—especially children, and people suffering chronic disease. The OHL will meet with community businesses to encourage the establishment of "breathe easy zones", and promote the importance of compliance with the Florida Clean Indoor Air Act. They will also collaborate with Charlotte County Public Schools to educate parents on the importance of protecting their children from secondhand smoke and encourage parents to adopt smoke-free homes and cars. The OHL will also work with local partners to educate them about cessation opportunities. They will be working with the Healthy Start Program, WIC and the CCHD Clinic staff to identify pregnant smokers to cessation services. Drug Free Charlotte County (DFCC) will be the coordinating agency for the youth tobacco prevention interventions at the community level. They will be responsible for providing the support necessary to increase communication and form a community partnership addressing youth tobacco use. They will develop a tri-county partnership with members from Charlotte, Hendry and Glades Counties to maximize communication and resources for the youth component. Teens in the tri-county area will have the opportunity to collaborate with one another to create an anti-tobacco social marketing campaign, and have the opportunity to communicate with one another in cyber space via MySpace blogs, and other electronic communication. Teens additionally will participate in tri-county meetings and a yearly youth summit.

Citrus County

Citrus County will enhance the existing community-based multi-agency coalition. The coalition will work in promoting campaigns and community actions to enforce policies and ordinances pertaining to underage access to tobacco products. Activities will focus on tobacco prevention, eliminating environmental secondhand smoke, youth prevention/cessation, educational/preventive efforts among pregnant women, limiting underage access to tobacco products, education among support groups, eliminating second-hand smoke at entrances of businesses and organizations, and providing comprehensive cessation efforts, to include promotion of Florida's Quitline and working closely with the Area Health Education Centers (AHEC). They will also educate and mobilize the community on how to change local and state tobacco and control policies and work to strengthen and increase enforcement of tobacco

control laws. Citrus County will prioritize engaging youth in their community to design interventions to develop leadership skills and the use of role models, promote youth activities that seek to create policy change, promote programs that work with law enforcement, and develop plans to implement parental involvement. Citrus County will provide comprehensive, integrated programs and interventions that ultimately reduce the burden of chronic disease, disability, and death due to tobacco use. Targeted activities include providing Freedom From Smoking classes for CHD clients and community. The Healthy Start Initiative works to reduce the number of pregnant women who smoke by also providing one-on-one counseling and support to pregnant women and new mothers. The health department sponsors the "Open Airways" program and the "Better Breathers" chronic lung disease support group.

Collier County

Collier County Health Department (CCHD) will rebuild their local tobacco-free partnership to implement a comprehensive tobacco prevention and control program. The department will work closely with partners to build up local cessation services and promote the FL Quitline to reduce tobacco use. To reduce and eliminate exposure to secondhand smoke, the department will create and distribute Smoke free car kits at various events to encourage parents to not smoke in their cars with children. Radio PSAs will be used to educate community members and parents on the dangers of secondhand smoke and encourage parents not to smoke in cars with children. To prevention youth initiation of tobacco use, the Tobacco-Free Partnership will assess effectiveness of current tobacco control policies in place for tobacco product placement, public school smoke-free campus policy, and work to establish smoke-free campuses on local college campuses. Finally, Collier County Health Department will recruit, train and mobilize youth 12-18 and 18-24 to actively participate in and lead tobacco awareness and policy campaigns.

Clay County

Clay County Health Department (CCHD) will support activities that are consistent with the 1999 Best Practices for Comprehensive Tobacco Control Programs for the Centers for Disease Control and Prevention (CDC). The CCHD will participate in trainings sponsored by the program. The CCHD will communicate and report program performance as established by the Program. The CCHD will collaborate with program evaluation. They will reduce the current tobacco use in high school and middle school students by 5%, Implement evidence based curricula, teacher training, presentations, parental involvement and cessation services, review and enhance the youth tobacco citation program in Clay County, and provide educational materials, professional presentations, videos, and resources to schools, community groups and at local events in Clay County. They will increase tobacco cessation messages in Clay County by 25% by implementing community interventions that link tobacco control interventions with cardiovascular disease prevention, using local media to educate and inform individuals on the dangers of tobacco use, and collaborating with the American Heart Association, developing and market an anti-tobacco television campaign, and distributing tobacco information and resources within our community. Clay County will increase the number of smoking cessation classes in Clay County by 25%, increase and develop media and promotional campaigns, and provide assistance and incentives to worksite wellness coordinators and human resource staff to assist in promoting cessation classes.

Columbia County

Year one will be capacity building and will include: the steps of identifying members, convening members, completing a community tobacco related needs assessment, completing a strategic plan with measurable goals and objectives from information obtained during the community needs assessment, and implementing the intervention and programs identified in the

strategic plan in years two and three. First, key stakeholders and gatekeepers in the community will be identified. These interested parties include audiences from community organizations, voluntary organizations, religious organizations, parent groups, businesses, civic groups, student groups, law enforcement officials, the health department, schools and higher education facilities, health care providers, daycare providers, and others. Specifically, it is proposed that the following institutions will be represented as members of the Columbia County Tobacco Free Partnership (partnership name will be determined by the convened entities): Columbia County School Board, Columbia County Parks and Recreation, Lake City Medical Center Seniors United, Mt. Pisgah African Methodist Episcopal Church, the Women's Club, the Rotary Club, Kiwanis, the School Resource Officer Program, School Health Nurses Program, Healthy Families, Healthy Start, Women, Infants, and Children (WIC), Lake City Community College, University of Florida Institute of Food and Agriculture Sciences, Shands at Lakeshore, Lake City Medical Center, businesses, Suwannee River Area Health Education Center, the North Central Area chapter of the American Cancer Society, the Lake City based chapter of the American Lung Association, the Gainesville based chapter of the American Heart Association, and student organizations like Students Working Against tobacco, 4-H chapters, and FFA chapters. These stakeholders will be instrumental in supporting the proposed partnership and promoting the tobacco prevention and control messages to the communities in Columbia County. The activities these stakeholders will engage in as members of the partnership will include but are not limited to: advocating for and protecting the partnership and its goals; speaking on behalf of the partnership; carrying and publicizing the program message to constituents; cosponsoring community programs and activities; developing programs that tie directly into tobacco control messages, and supporting local legislation and policies that contribute to reducing tobacco use.

Duval County

Duval County Health Department (DCHD) will include enhancing the Smoke-Free Jacksonville Coalition to change the community environment to discourage tobacco use; train and empower youth to change community attitudes and behavior about tobacco and de-normalize tobacco use; and educate the community about the health effects of tobacco use. The Smoke-Free Jacksonville Coalition will offer a wide range of prevention and leadership activities through this grant, including engaging youth in developing and implementing tobacco control interventions; developing partnerships with local organizations; conducting educational programs for young people, parents, enforcement officials, community and business leaders, health care providers, school personnel and others. The Smoke-Free Jacksonville Coalition will work to raise awareness of the clean indoor air act by encouraging businesses to develop and enforce smoke-free policies and develop employee wellness programs, where needed. Employees seeking cessation resources will be referred to the Quitline and local smoking cessation classes through our partner, the NE Florida AHEC. The coalition will work to educate higher learning institutions on how to implement a smoke free campus. The Duval County Health Department will integrate tobacco prevention and control programming into intra-agency program that will include health clinics [I4 clinics], WIC [6 sites], dental clinics [5], A New DEAL [Closing the Gap Diabetes], Community Cardiovascular Health Program (CDHPE-Step Up), immunization clinics, child safety classes and childcare center injury prevention trainings. DCHD will also integrate tobacco control programming with the Healthy Jacksonville Coalition programs and events, especially those coalitions that target chronic diseases like asthma, diabetes, and Referrals to the Quitline and cessation services through AHEC will be included in all tobacco prevention and control activities, with significant management and tracking of the success rate.

DeSoto County

DeSoto County Health Department (DCHD) will focus on youth prevention and chronic disease within at risk populations. DCHD will work to ensure that services and interventions currently offered by a variety of community coalitions are streamlined and coordinated to minimize gaps in services and duplication of services.

To address youth prevention of tobacco use a Students Working Against Tobacco (SWAT) chapter will be developed at the high school. Youth will participate in training that will enable and empower them to address youth tobacco issues in their community. They will learn social marketing concepts and how to apply those to the de-normalization of tobacco use by their peers. They will also apply those concepts to developing media messages targeting their peers. SWAT youth will engage in counter-marketing activities at school and community events. The youth tobacco prevention program will include tobacco education curriculum at the middle and high school, training 5th grade students in basic CPR and providing cessation and education interventions to youth tobacco offenders. The youth program will work with parent groups in educating parents on their role in preventing tobacco use.

The chronic disease component of the DCHD Tobacco Program will encourage and support businesses and faith based communities to adopt smoke-free campus policies. They will couple those policies with increased cessation support. The program will work with local AHEC to provide cessation counseling and training. They will be working with the Healthy Start Program, WIC and the DCHD Clinic staff to identify pregnant smokers to cessation services. They will be working with area health care providers to educate them on the Quit Line and how to adopt systematic policies to incorporate cessation referrals for smoking patients. The program will also use media ads to promote the FL Quit Line. They will work with SFY to identify tobacco related disparities and form a strategy with affected parties to address those disparate populations.

Dixie County

The *Quit Doc Research and Education Foundation* has developed five distinct programs that are suitable to present in a number of different venues, including classrooms, PTA meetings, church groups, Boy Scouts/Girl Scouts, and Big Brothers/Big Sisters. The five programs are:

- Never Take Tobacco from Strangers (Grades 1-4)
- Tobacco Advertising: The Promise versus The Reality (Grades 4-8)
- SmokeScreeners (Grades 8-12)
- Protecting Your Children from the Tobacco Industry (Adults)
- Quitters Always Win: How to Successfully Overcome Nicotine Addiction (Adults)

Escambia County

Escambia County Health Department (ECHD) will cultivate and sustain tobacco-free communities throughout Escambia County utilizing community partnerships to accomplish a force multiplier effect. ECHD will partner with West Florida AHEC to support cessation and the Quitline. The county will reduce the percentage of pregnant women and their household members in Escambia County who smoke utilizing partnerships and school health nurses in every school as an avenue to reach parents of children in daycare. The county will also promote and conduct "I Quit for you Baby" Program. The program will seek to reduce exposure to second-hand smoke through youth advocacy, social marketing campaigns and the promotion

of smoke-free workplaces. The number of teens initiating tobacco use will be reduced through the use of teen advocacy training and program development, a youth-driven media campaign, and peer-to-peer teen-teaching of tobacco prevention concepts. The program will increase the understanding of how to effectively manage asthma symptoms and associated health issues with asthmatic children and their families by expanding the Open Airways (asthma education) program for school children. Escambia will increase the number of youth who quit using tobacco by implementing the NOT on Tobacco Program in high schools and the TATU program in middle schools. The program will work to decrease the social acceptability of tobacco use through community education and policy change. ECHD will reduce the number of premature deaths attributed to tobacco use as a catalyst for chronic disease prevention over the term of the 3-year grant by educating the community regarding tobacco-related cancers, respiratory complications, and effects of secondhand smoke.

Franklin County

The Franklin County Health Department (FCHD) proposes to facilitate the establishment of community advisory groups as a method to reach the aforementioned target populations. The members that will be recruited will consist of diverse representatives of faith based, civic, recreational, and other community partners. The advisory groups will allow the education and the potential to enact anti-smoking policy recommendations. Secondly, the FCHD would facilitate the incorporation and implementation of school based intervention programs that empower students and promote change in the environment that supports tobacco free norms. This will be done in conjunction with a mass anti-tobacco media campaign. In addition, the FCHD proposes to strategize, develop and/or expand a linkage with existing chronic disease management programs and provide assistance to county employers in developing wellness programs which include the dangers of second hand smoke and chronic diseases. This effort will include utilization of Florida' Quit Line.

Gadsden County

The goal of our efforts is to reduce the prevalence of tobacco use among youth, adults, and pregnant women; reduce per capita tobacco consumption; and reduce exposure to environmental tobacco smoke by non-tobacco users, especially youth, pregnant women and people who suffer from chronic diseases.

The programming in this proposal successfully fulfills the purpose of the RFP by: enhancing already strong community relationships to promote tobacco free norms; providing anti-tobacco education to the 8-18 age population in grossly underserved populations; providing education to parents, families and community leaders; providing chronic disease education; increasing the promotion of the Florida Quitline and local AHEC cessation counseling services; and cutting edge research and evaluation techniques.

The proposal enhances the community coalition by a staff member working in partnership with the Gadsden County Health Department, Gadsden School Board, Governmental Agencies and existing community leaders to strengthen and build upon the Boys and Girls Club of the Big Bend partnerships. The organizer will educate decision makers about the effects of tobacco and ways that they can reduce tobacco use to help produce a healthier community. The organizer will help change policies that the staff is legally allowed to change, such as within work places, community organizations, and with local wellness programs.

The community organizer will work to reduce tobacco use and reduce exposure to secondhand smoke, resulting in a cost effective way to reduce chronic disease. Staff will work to advertise smoking cessation programs throughout the community—such as the Florida Quitline, and promotion of AHEC cessation counseling & other coalition member's programming and materials.

Glades County (Glades and Hendry Counties collaborate on services)

The Tobacco Prevention Specialist (TPS) for Hendry County also extends services to Glades County. These two counties coordinate interventions in many county health department programs as they do in tobacco. The TPS will utilize core funding to promote cessation, reduce exposure to secondhand smoke and prevent youth tobacco use. A minimum of six Freedom From Smoking classes will be offered throughout Hendry/Glades counties by June 30, 2008. The TPS will work with staff and management team in both Hendry and Glades CHD to encourage adoption of a smoke free campus policy. The TPS will educate health care providers on secondhand smoke dangers and how to use systematic changes to make Quit Line referrals for their patients. They will also work with parent organizations and through community events to encourage parents to adopt smoke free home and car policies. The TPS will continue to build and support SWAT chapters at the high schools in both Hendry and Glades counties. These youth will be trained in anti-tobacco messaging and effective youth prevention interventions targeting their peers.

Gilchrist County

The *Quit Doc Research and Education Foundation* has developed five distinct programs that are suitable to present in a number of different venues, including classrooms, PTA meetings, church groups, Boy Scouts/Girl Scouts, and Big Brothers/Big Sisters. The five programs are:

- Never Take Tobacco from Strangers (Grades 1-4)
- Tobacco Advertising: The Promise versus The Reality (Grades 4-8)
- SmokeScreeners (Grades 8-12)
- Protecting Your Children from the Tobacco Industry (Adults)
- Quitters Always Win: How to Successfully Overcome Nicotine Addiction (Adults)

Gulf County

Gulf County Health Department (GCHD) will enhance the existing community partnerships by implementing more evidence-based, data-driven programs to prevent both tobacco use and chronic disease. The program will develop leadership skills in youth for the purpose of promoting tobacco prevention / cessation and to create an empowerment among peers. The program will also conduct youth programs that are coordinated with media-campaigns in an effort to create tobacco-free social norms. Gulf County will create points of access within local community integrating tobacco prevention and cessation into employee wellness programs, safety meetings, and other community forums. The program will also implement an extensive Employee Wellness Program within the CHD to include a smoking cessation focus in order to reduce issues of chronic disease within the workplace. GCHD will also target patients / clients who are currently involved in Health Disparities Programs for chronic diseases who smoke. The program will integrate the existing Healthy Start education classes with the new tobacco prevention classes to expand classes on smoking cessation during pregnancy. Finally, the program will engage in a year long community out-reach, with and emphasis on those disparately effected by tobacco use and chronic disease.

Hardee County

The Hardee County Health Department (HCHD) Tobacco Program will target the community at large within the county as well as specific groups disparately affected by tobacco use such as youth, women, and minorities—especially African Americans and Hispanics. The current Teen Pregnancy Prevention Alliance and the Drug Prevention Coalition will also serve as the Tobacco Prevention and Control Community Partnership. The partnership along with

other county Youth Prevention Programs will work with staff to promote governmental and voluntary policies to eliminate exposure to secondhand smoke and restrict youth access to tobacco products. The Tobacco Prevention Specialist (TPS) will continue to build and support SWAT chapters at the middle and high schools. Youth will be involved in policy change initiatives that protect them from tobacco marketing and promote the adoption of smoke-free policies at public and private institutions. The TPS will also work to prevent Chronic Disease through promoting cessation services and the Florida Quit Line. The TPS will encourage businesses to adopt smoke free zones as well as educate them on compliance to the Florida Clean Indoor Air Act.

Hendry County (Hendry and Glades collaborate on services)

Hendry County Health Department (HCHD) has one Tobacco Program Specialist (TPS) responsible for the coordination and delivery of all tobacco prevention and control interventions. The TPS for Hendry County also extends services to Glades County. These two counties coordinate interventions in many CHD programs as they do in tobacco. The TPS will utilize core funding to promote cessation, reduce exposure to secondhand smoke and prevent youth tobacco use. A minimum of six Freedom From Smoking classes will be offered throughout Hendry/Glades counties by June 30, 2008. The TPS will work with staff and management team in both Hendry and Glades CHD to encourage adoption of a smoke free campus policy. The TPS will educate health care providers on secondhand smoke dangers and how to use systematic changes to make Quit Line referrals for their patients. They will also work with parent organizations and through community events to encourage parents to adopt smoke free home and car policies. The TPS will continue to build and support SWAT chapters at the high schools in both Hendry and Glades counties. The youth will be trained in anti-tobacco messaging and effective youth prevention interventions targeting their peers.

Hernando County

Hernando County Community Anti-Drug Coalition (Coalition) will establish a community-based system for tobacco prevention and control initiative in Brevard County. The Coalition will enhance existing partnerships and establish a youth component and chronic disease component. The programs will focus on the reduction of tobacco use and secondhand smoke exposure among youth, adults, pregnant women and infants in Hernando County. The partnership component (the Coalition) will mobilize the community, conduct capacity building activities and conduct a media campaign to raise awareness of tobacco use and prevention. The youth component will engage youth through the "Chill Smart" youth group. The Chill Smart youth group will serve as spokespeople and leaders to educate the community and other youth of the hazards of tobacco use. The chronic disease component will focus on the reduction of secondhand smoke exposure, promote cessation among individuals with chronic diseases and promote the quit line. Activities include establishing worksite wellness initiatives, physician referral network for cessation services and smoking cessation media campaigns.

Highlands County

The current Teen Pregnancy Prevention Alliance and the Community Health Improvement Planning Committee serve as the Tobacco Prevention and Control Community Partnership. The partnership along with other county Youth Prevention Programs will work with staff to promote governmental and voluntary policies to eliminate exposure to secondhand smoke and restrict youth access to tobacco products. To address youth tobacco prevention three youth advocacy groups will be established at high schools to implement both school and community based prevention strategies. These youth and their advisors will be trained in leadership skills needed to promote policy changes and serve as role models to their peers. They will be advocates for policy change that protect youth from tobacco and secondhand

smoke. They will also assist in creating programs that create tobacco free norms. The TPS will work to decrease the impact of Chronic Disease through promoting the FL Quit Line and other cessation services offered by AHEC to persons with chronic disease. They will also educate health care providers on how to use the Quit Line referral system when counseling patients who smoke. The TPS will work to promote smoke free zones in county buildings and encourage these policies be adopted by other businesses. The TPS will educate businesses on compliance with the Florida Clean Indoor Air Act.

Hillsborough County

Hillsborough County Health Department (HCHD) has one Tobacco Program Specialist (TPS) responsible for the coordination and delivery of all tobacco prevention and control interventions. The Health Together Community Partnership, which is a collaboration of county businesses, faith based groups, media and public health organizations, has taken the tobacco issue as one of its priorities and serves as the Tobacco Free Partnership for the county. Gary Stein, the TPS in Hillsborough, chairs the Advocacy Subcommittee of Health Together. School based SWAT teams have formed at 18 middle and high schools across the county with a goal of establishing 22 by June 30, 2008. These SWAT chapters will mobilize to increase advocacy efforts in changing local policies to denormalize tobacco use; reduce secondhand smoke through counter-marketing to youth and adults; and increase enforcement of existing ordinances by monitoring retail outlets and specialty restaurants like hookah bars. Youth will be trained in leadership skills and tobacco education/advocacy. Youth representatives will present to local government and businesses in efforts to gain their assistance and support in promoting policy changes created by the HCHD and Health Together. Youth will also be involved in developing media campaigns in support of tobacco control objectives that will reach their target audience(s). The Tobacco Program Office at the CHD also coordinates the county Youth Tobacco Offender's Classes through its STEP Grant. This monthly class reaches approximately 35-50 youth and parents. The TPS is working collaboratively with the University of South Florida's Health Campus faculty, students and staff to create and implement an effective smoke-free policy. The HCHD's Tobacco Program will implement strategies that reduce/prevent Chronic Disease through increased cessation and reduction in exposure to secondhand smoke. In-service trainings and new employee orientation will train staff to deliver anti-tobacco messages tailored to patients' risks and provide referrals for cessation services like the FL Quit Line. The Tobacco Free Partnership of Healthy Together will actively encourage the adoption of smoke free zones on college campuses and in public/private institutions. They will also work to develop a permanent exhibit at the Tampa Museum of Science and Industry that educates patrons on the negative effects of tobacco use on the human body along with strategies to quit.

Holmes County

Holmes County will implement a three Phase Program consisting of Community, Youth, and Chronic Disease components. The plan utilizes a number of tobacco prevention and control strategies. The first strategy is the development of the Holmes County Tobacco Free Partnership (HCTFP) which will pull community partners together to facilitate collaboration and advise the county in the implementation of the tobacco plan. The county will establish a Media and Marketing Campaign to target chronic disease, secondhand smoke and hazards to pregnant women. The county will develop initiatives to foster leadership and advocacy skills in youth, parents and community partners. The county will engage in tobacco policy, enforcement and environmental interventions spearheaded by the community partnership. The county will provide cessation opportunities for youth and adults with a special focus on pregnant women. The county will establish School Programs to decrease tobacco use and acceptance among youth, parents and significant adults.

Indian River County

The Substance Abuse Council of Indian River County (Council) will establish a community based system for tobacco prevention and control initiative in Indian River County. The Council will enhance existing partnerships and establish a youth component and chronic disease component. The programs will focus on the reduction of tobacco use and secondhand smoke exposure among youth, adults, pregnant women and infants in Indian River County. The partnership component (the Council) will utilize current and recruit new members to guide the tobacco prevention efforts in Indian River County. New members will be recruited from County Health Department, healthcare providers, county and city municipalities. The Council will focus on policies to eliminate exposure to secondhand smoke and restrict youth access to tobacco products. The youth component will be formed by involving the local community to include public and private schools, parks and recreation agencies, faith based organizations and clubs and organizations that serve youth. The youth component will focus on developing leadership skills and coordinating media campaigns. Activities include, participating in youth events such s Kick Butts Day, Brown Ribbon Events and Smoke Out Events. Conducting educational programs such as Lifeskills Training Programs in middle schools and conducting tobacco-free sports activities. The chronic disease component will focus on (1) tobacco use and individuals who suffer from diabetes, asthma, cardiovascular disease and stroke, (2) programs that promote cessation and reduction of secondhand smoke exposure in homes and cars and (3) interventions to eliminate exposure to secondhand smoke in infants, children, and pregnant women.

Jackson County

Jackson County Health Department (JCHD) will address the following three areas for intervention in their program model: Community Partnership, Youth Empowerment, and Chronic Disease with multiple tobacco prevention and control strategies. There will be a local tobacco prevention partnership in place that will support the development of a media and marketing campaign to target chronic disease, secondhand smoke and hazards to pregnant women that is specific to our county needs and highest indicators. The partnership will also help to evaluate and support the leadership and advocacy skills development programs for youth, parents, and community partners. They will also play a role in the evaluation of county culture and attitude to help plan programs that will be effective in reaching all county populations with our messages on the dangers of tobacco use. They will support the evaluation and implementation of cessation services, enforcement needs, and the establishment of school and community clubs in the county.

The major phases of the plan include, first, the re-establishment of the county community partnership which includes the election of officers and the development of a work plan. The second phase of the plan will incorporate the enhancement of youth led initiatives and the implementation of the first chronic disease focused outreach activity. In this phase great emphasis will be placed on the recruitment of minorities and the development of the minority and age specific task forces that will function within the overall tobacco prevention partnership. Phase three will deal with the implementation of partnership goals and objectives, implementation of policy and enforcement issues, and increasing compliance with local and state clean indoor act initiatives as well as "Breathe Easy Zones".

Lafayette County

The plan is a three component strategy consisting of a community partnership development, youth prevention initiative and chronic disease components. The community partnership component will work to enhance the local tobacco free partnership through collaborative efforts within the community. A one day spit tobacco academy will be held for

school and recreational coaches; Rick Bender is the keynote speaker. The youth component will be lead by a youth advocacy coordinator, a contracted youth leadership trainer to provide training, and an online tracking system that the youth will be trained to utilize. A cessation program facilitator and curricula will be utilized in the area High Schools and Middle School. The chronic disease component is being addressed by the hiring of two part time registered nurses to act as health educators at two faith based wellness programs catering to members of Lafayette County.

Lake County

Lake County will partner with an established coalition. They will strive to meet their goals by working through media advocacy, policy initiatives and the county's existing tobacco prevention programs. They will develop county-wide strategies to address: Youth Component by increasing knowledge of dangers of tobacco use, increasing knowledge of tobacco industry marketing strategies and tactics, increasing parental involvement, recruitment and retention strategies for the current county wide SWAT, training for Youth Advocacy and Leadership Skills, promoting activities to create policy change, increase access to youth tobacco prevention and cessation services, and strengthen enforcement of underage tobacco use; and Chronic Disease by development of chronic disease programming and venues, development of a secondhand smoke campaign with appropriate media outlays, improving access for tobacco cessation services, promoting smoke free policies, and strengthen compliance of Clean Indoor Air Act and local product placement ordinances. In general, all residents of Lake County will be targeted in the denormalization of tobacco use.

Lee County

The Lee County Coalition for a Drug Free Southwest Florida (Coalition) will establish a community based system for tobacco prevention and control initiative in Lee County. The Coalition will enhance existing partnerships and establish a youth component and chronic disease component. The programs will focus on the reduction of tobacco use and secondhand smoke exposure among youth, adults, pregnant women and infants in Lee County. The partnership component will enhance the existing partnership with Coalition and the County Health Department. The partnership will focus on recruiting additional members, develop educational programs to educate community on tobacco prevention, mobilize community and strengthen and enforce current ordinances The youth component will engage current SWAT teams and create new SWAT teams. The youth component will focus on developing leadership skills, promoting youth activities seeking to change policies, conduct youth programs to reduce tobacco use among youth and increase parental involvement in youth tobacco programs. Activities include participating in law enforcement "sting" operations, "Great American Smoke Out", developing media campaigns to counter market deceptive tobacco ads. The chronic disease component will focus on the negative effects of chronic diseases caused by tobacco use. The program will (1) increase awareness of tobacco's effect by developing educational materials, (2) promote dental counseling on oral cancer by providing dental offices with oral cancer and quit line information (3) disseminate anti-tobacco materials.

Leon County

The goal of the Leon County comprehensive tobacco program addressed in this proposal is to prevent initiation of use among youth and young adults, eliminate exposure to second hand smoke, and identify tobacco related disparities among population groups. Since most people start tobacco use before age 18, youth prevention is seen as a crucial part of a comprehensive tobacco program. The program will promote healthy life styles among youth, particularly a tobacco free lifestyle. The benefits to youth from developing positive developmental assets are far reaching.

SWAT will be structured to enable the students to conduct mass media education campaigns through traditional media. SWAT is present in nearly every middle and high school in Leon County and we propose to use SWAT as the youth advocacy voice of the program. SWAT will inform the partnership of current attitudes, perceptions of social norms, and trends in youth culture. SWAT will also be the medium used to carry the tobacco control message to parents, community, and decision makers.
The partnership will continue to support SWAT Clubs and their sponsors in each of the school based chapters. These groups will be responsible for coordinating and facilitating youth related events and activities, and also serve as a role model and mentor for the development of leadership skills among young people. The following strategies will be used: empowering youth to be advocates by providing them with prevention leadership skills, increasing their awareness of the dangers of tobacco use, increasing their awareness of deceptive tobacco industry marketing practices, and increasing their perception that tobacco use is not a community norm.

The Leon County program will attempt to change local policy by meeting expectations and guidelines set by the RFP and expanding upon required tasks. We will work to identify the current status of tobacco use in our community.

Levy County

A tobacco-free partnership will be created in Levy County, Florida. Examples of the activities that these partners will engage in shall include: advocating for and protecting the partnership and its goals; speaking on behalf of the partnership; carrying and publicizing the program message to constituents; cosponsoring community programs; developing programs that tie directly into tobacco control messages; and supporting local legislation and policies that contribute to reducing tobacco use. The strategic plan of action will be required to address the program goals of reducing tobacco use among youth and adults, eliminating exposure to secondhand smoke, and addressing the impact of tobacco use on chronic diseases. In addition, the partnership activities will focus on: educating the communities of Levy County on how to change local and state tobacco prevention and control policies; mobilizing communities to define and address tobacco prevention and control policy development; strengthening and increasing enforcement of tobacco control laws and ordinances including clean indoor air, smoke-free and tobacco-free outdoor environments, and restricting access to tobacco products; integrating tobacco prevention and control programming into inter-agency programs, healthcare systems, childcare settings, and other programs and services, particularly those that target populations disparately affected by tobacco use; promoting the Florida Quitline and other cessation services; and conducting local tobacco and secondhand smoke prevention and cessation activities in coordination and in support of statewide media campaigns.

Liberty County

Liberty County's Program goals will be to reduce the prevalence of tobacco use among all citizens, especially youth. The first step to be taken is to establish a community partnership with the purpose of promoting a healthier community through youth involvement for tobacco-free environment and lifestyles. Re-activating the former Tobacco Prevention community partnership will be addressed through involvement with existing community groups, including churches, political incumbents, businesses, media partners and others who care deeply about the future of Liberty County. The Children's Coalition, County Library system and the County Extension Service have maintained involvement with tobacco prevention programs, as have many former participants from Liberty County Schools, including teachers, coaches and youth mentors.

Manatee County

Manatee County Health Department (MCHD) has one Tobacco Program Specialist (TPS) responsible for the coordination and delivery of all tobacco prevention and control interventions. A local tobacco free community partnership will be formed to address community tobacco needs/issues and to consolidate community resources. The youth component will include the Manatee County Youth Activism Campaign. This campaign will consist of youth training in leadership skills, tobacco issue and policy development, as well as an online youth activism management system that standardizes youth-led projects. Another key component of the youth prevention program will be educating and engaging parents of their role in tobacco prevention. The youth prevention component will identify and implement evidence based curricula for tobacco education in elementary and middle schools along with providing teacher training in curricula delivery. Chronic disease prevention will specifically address cessation and secondhand smoke reduction. Key populations in chronic disease prevention component will be infants, children, pregnant women, low income populations without insurance and individuals with a chronic disease. They will be working with the Healthy Start Program, WIC and the MCHD Clinic staff to identify pregnant smokers to cessation services. These same partners will assist in educating families of the dangers of secondhand smoke and encouraging them to adopt smoke-free home/car policies. Another focus of the chronic disease component will be adoption of smoke free campus policies at hospitals and health care facilities. The MCHD will collaborate with AHEC and utilize cessation services offered by them.

Marion County

Marion County will reestablish the Tobacco Free Coalition. Programming and activities such as an active coalition, cessation classes, media campaigns, monitoring of tobacco placement and signage, and the establishment of smoke free zones in the county will be utilized. For pregnant women and children, direct programming will include cessation classes, asthma education and media campaigns. Youth will be provided leadership training, participate in monitoring of tobacco placement and signage, assist in (and benefit from) the development of media campaigns, and offered cessation classes. Youth groups will be trained as activists and leaders, establish multi-media campaigns, implement cessation classes throughout the county, provide chronic disease education/interventions and continue involvement in community outreach.

Martin County

The *Quit Doc Research and Education Foundation* has developed five distinct programs that are suitable to present in a number of different venues, including classrooms, PTA meetings, church groups, Boy Scouts/Girl Scouts, and Big Brothers/Big Sisters. The five programs are:

- Never Take Tobacco from Strangers (Grades 1-4)
- Tobacco Advertising: The Promise versus The Reality (Grades 4-8)
- SmokeScreeners (Grades 8-12)
- Protecting Your Children from the Tobacco Industry (Adults)
- Quitters Always Win: How to Successfully Overcome Nicotine Addiction (Adults)

Nassau County

Nassau County will create a local community partnership.

The youth component of this program includes: seeking to organize and grow anti tobacco youth empowerment clubs in all middle and high schools; additionally seek to educate club members on health effects of tobacco use, tobacco industry manipulation and deception,

increase awareness of tobacco advertising with youth populations and de-normalize tobacco use; create a plan to partner with the school system to teach public speaking to club members to develop and foster leadership skills; empower youth to the make the right decisions to avoid tobacco; utilize club members to assist local law enforcement agencies to discourage underage tobacco sales and invite youth groups to become involved in communities of faith. Our youth empowerment club will encourage adult participation in anti tobacco clubs. We seek to have parents of club members participate and attend club meetings and plan events. Anti tobacco club representatives will take an active roll in local policy change.

The chronic disease component of this effort will include incorporating 30 minute cessation education and Second Hand Smoke (SHS) prevention intervention in the quarterly diabetes, self management classes provided to the public by the NCHD. The chronic disease component also includes a partnership with heart and oncology doctors and their staff to incorporate Quitline referrals and introduce a cessation and SHS prevention component at all classes provided by the NCHD. A tobacco and secondhand smoke component will be added to any DOH stroke and cardiovascular disease education encounter with the community. Education on the dangers of exposure to secondhand smoke to pregnant women in cessation classes will be implemented. Education will be provided to all WIC personnel on dangers of secondhand smoke exposure to pregnant women. This will include distribution of secondhand smoke education to all WIC participants. The Chronic Disease focus will include education and encouragement to local business owners to adopt smoke free campuses or breathe easy zones to eliminate secondhand smoke exposure.

We seek to increase awareness of dangers to exposure of secondhand smoke.

Okeechobee County

Okeechobee County Health Department (OCHD) has maintained a long standing working partnership with the Okeechobee Shared Services Network, which consists of a Community Collaborative Council (CCC) and has a membership of over eighty organizations and agencies combined. The purpose of the CCC is to assist the community organizations with the mechanism for dialogue and community problem solving, encourage shared decision making and accountability at the policy level and maximized the use of available resources. These organizations are familiar with the health needs of the community and it is therefore more feasible for the OCHD to recruit members from this forum to establish a core committee to assist with addressing tobacco issues in the community. With this funding, it will allow additional collaboration with the CCC which will greatly enhance resources and information. It is at this forum that the OCHD will propose ideas and suggestions on how to address tobacco issues as well as obtain the necessary support to full fill the goals and objectives of the program. For year one and two and three the Program will continue to recruit new members and develop goals and objectives that will address tobacco use in the community. The CCC has been contacted and is eager to be included in the Program.

The chronic disease component will focus on promoting cessation services and increase referrals to the Florida Quitline. Chronic disease educational activities will be coordinated with the Healthy Communities Coordinator to address diabetes, asthma, cardiovascular disease and stroke, chronic obstructive pulmonary lung disease. The Program will also collaborate with its local AHEC to utilize its training programs for health care providers such as staff training in the 5 A's and 5 R's referral methods. For the first year, the chronic disease component will focus on promotion of educational materials, presentation and workshops. For year one and two the program will develop counter-marking campaigns on the effects of secondhand smoke in homes and cares, media service such billboards, radio and newspaper ads. Youth will collaborate with Partnership to help promote smoke-free policies in the community. The program will also collaborate with the College Nursing Division to develop a Tobacco Training for new students.

The youth component will begin in year one with the first part being spent educating youth on tobacco's history, culture, manipulation and politics. The health department will work with professional agencies that have several years of experience of working with youth to provide youth advocacy and leadership training which will include: public speaking, messaging, media literacy and advocacy, policy change, event planning tools and leadership skills. The training will be designed to develop leadership skills and invest energy in creating a core group of youth to build a community program that will collaborate on tobacco issues. The SWAT Coordinator and Advisors will ensure that youth participate in health fairs, local community events and table displays at movie theaters to promote and obtain media support for their activities.

Okaloosa County

The objectives of the Okaloosa County Tobacco Free Initiative (OCTFI) are to reduce the prevalence of tobacco use among youth, adults, and pregnant women, reduce exposure to secondhand smoke, and increase the number of calls to the Florida Quit-For-Life Line. There are two fundamental phases to the plan. Phase one, takes OCHD programs (WIC, Healthy Start, MomCare, OCHD Clinical Services) as the basic underpinning of coordinated service delivery for tobacco prevention and cessation services. The plan consists of several components. The first component is training all healthcare personnel and support staff within OCHD on the "Five A's and Five R's" method of smoking cessation intervention and then implementation of the intervention. The CHD will also conduct provider training for local medical professionals. The CHD will provide low-cost American Lung Association's Freedom From Smoking cessation classes. The CHD will promote use of the Florida Quit-For-Life Line. The CHD will provide Nicotine Replacement Therapy or other smoking cessation medications to clients. In Phase two, the plan expands to include a youth element and the formation of a Community Tobacco Coalition. The youth element conceives of two broad aims, education and media campaigns.

Osceola County

Osceola County Health Department (OCHD) has one Tobacco Program Specialist (TPS) responsible for the coordination and delivery of all tobacco prevention and control interventions. The Tobacco Program will establish and maintain its tobacco free partnership, the Osceola County Tobacco Prevention Advisory Council. This partnership will be instrumental in advocating for smoke-free campus policies at the community college, area businesses and governmental agencies. They will also assist in developing and delivering secondhand smoke education to parent groups, day cares, community events and health care facilities. Their efforts will result in more families adopting voluntary smoke-free home/car policies. The tobacco program along with the partnership will also promote AHEC cessation services to the community as well as offer Freedom From Smoking classes to targeted disparate groups. To further address chronic disease prevention, the tobacco program will educate health care providers on implementing systemic changes that result in referrals to the FL Quit Line. The tobacco program will utilize the youth empowerment model of SWAT to further decrease youth smoking rates. SWAT chapters will be recruited and maintained throughout county middle and high schools. Youth and their advisors will be trained in leadership skills needed to promote policy changes and serve as role models to their peers. They will be advocates for policy change that protect youth from tobacco and secondhand smoke. Their main objective will be policy that prohibits tobacco use on all Osceola County School Board campuses to include sports fields, cars and contracted vendors. They will also assist in creating programs that create tobacco free norms. Youth advocacy will be enhanced through newly established internet websites and social networking opportunities for SWAT advocates. The Tobacco Program will also pilot a college aged advocacy at one campus.

Orange County

The Center for Multicultural Wellness and Prevention (CMWP) will establish a community based system for tobacco prevention and control initiative in Orange County. CMWP will focus on tobacco prevention for African Americans, Haitians and Hispanics. The program will consist of two components, (1)Community Outreach and Tobacco Education and (2)Chronic Disease (Asthma). The Community Outreach and Tobacco Education component will establish a six member Community Tobacco Control Coalition. The Coalition will conduct six educational forums, host smoke free youth activities (soccer tournaments), host smoke free festivals in minority communities and establish three tobacco support groups within the communities. The Chronic Disease (Asthma) component will provide in home tobacco education and cessation for fifty persons who have asthma and are exposed to secondhand smoke in the home. In addition, the program will provide fifty in home air quality inspections.

Palm Beach County

Palm Beach County Health Department (PBCHD) will establish a stand-alone tobacco free partnership to engage local stakeholders in tobacco control efforts. The key objective of this partnership is to establish tobacco-free norms by advocating and promoting behaviors and attitudes that are consistent with a tobacco-free society. The program will develop intervention to prevent youth initiation and offer cessation to current youth users, work with reducing maternal smoking rates, work to establish smoke-free healthcare facilities, replace tobacco-industry sponsored materials in schools and health care facilities with other prevention and cessation materials from reputable sources. Additionally, the program will work to enforce current tobacco product placement ordinances, establish smoke-free college campus policies, implement N-O-T (Not on Tobacco) high school cessation program developed by American Lung Association, and Families Acting Collaboratively to Educate and Involve Teens (FACE IT) Program.

Pinellas County

Pinellas County Health Department (PCHD) has one Tobacco Program Specialist (TPS) responsible for the coordination and delivery of all tobacco prevention and control interventions. Pinellas County has an existing tobacco free partnership which will be enhanced through recruitment and training. This partnership will play a vital role in determining the needs, target populations and recommended interventions for the tobacco program. The youth tobacco prevention component will target youth through partnerships with schools, on campus intervention programs, city recreation teen programs, teen tobacco intervention clinics, after school programs and clubs, and Juvenile Detention Centers (at risk youth). The School Board will refer youth tobacco citations to the program to receive cessation intervention. The tobacco program will build upon community mobilization techniques to reduce youth access to tobacco and reduce youth exposure to tobacco marketing. They will promote tobacco-free policy change involving youth and adults in cooperative alliance, with an emphasis on parental involvement, to encourage tobacco free policies in schools, health care settings and private/public institutions. Youth advocating for comprehensive tobacco control policies will work with local decision makers to provide education to parents on negative consequences of smoking around youth.

Chronic Disease prevention activities will target adults with, or at risk for, chronic disease through partnerships with County free clinics, Community Health Centers, private walk in clinics, hospitals, practitioners, Grand Round events, and other interested partners. The program will educate health service providers on current tobacco information (i.e. FL Quit Line and available cessation services) so that they will have the tools to counsel their tobacco using patients. The tobacco free partnership along with the youth program will encourage adoption of voluntary

smoke free home and car policies. Interagency collaborations will target pregnant women and parents with young children with current tobacco resources and materials. The tobacco program will also assist in promoting cessation services offered by AHEC.

Polk County

Polk County Health Department (PCHD) has one Tobacco Program Specialist (TPS) responsible for the coordination and delivery of all tobacco prevention and control interventions. Although the community tobacco grant was awarded to a community based organization, the TPS will serve as the resource for all tobacco education and collaboration among partners. The tobacco program will train community partners to deliver cessation classes/counseling and require partners to conduct counseling sessions for community. The TPS is working with the Polk County Board of County Commission and the management team at the PCHD to implement a smoke-free campus policy at all PCHD worksites and clinics. To address the youth prevention component, a SWAT chapter has been established at Bartow High School. These youth and their adult advisor will be trained in leadership skills and the tobacco issue so that they can affectively advocate for comprehensive tobacco control policies. The Drug Prevention Resource Center will be responsible for establishing and maintaining additional youth advocates with a focus on policy change and partnering with existing SWAT chapters.

Putnam County

This agency's main objectives are (1) the creation of a Tobacco Prevention and Control Community Partnership; (2) development of SWAT as county-wide and school-based units to work with the schools and the community to educate about the dangers of tobacco products and their use; (3) development and implementation of school based curricula and programs in partnership with the School Board using CDC *Best Practices* as a guideline; and (4) working with Chronic Disease to reduce adult tobacco use among disparate populations. The Task List requires the formation of a tobacco prevention and control community partnership, a review of current community needs, implementing educational programs, disseminating tobacco prevention and control materials, partner with youth programs, promote the toll-free QuitLine and other cessation services, develop leadership skills in youth and promote youth activities, provide interventions to promote cessation and secondhand smoke prevention to persons with the diabetes, asthma, cardiovascular disease, stroke and chronic obstructive lung disease, and provide interventions to eliminate exposure to secondhand smoke in infants, children and pregnant women in order to prevent acquiring a chronic disease. All of these tasks are incorporated into our goals and objectives for the project.

Santa Rosa County

Santa Rosa County Health Department (SRCHD) and its community partners propose to enhance the existing Healthy Start community partnership to incorporate expanded tobacco prevention and control activities. Coalition agencies will serve as one forum for disseminating tobacco prevention and control materials to other organizations and to the public. The Coalition will serve as a vehicle to promote the tobacco quit line and other tobacco cessation services. The program will work with local youth to develop leadership skills, create a media campaign and pursue policy change to create tobacco-free social norms. Promote the adoption of smoke-free workplace policies in order to promote cessation and secondhand smoke prevention, particularly for pregnant women and persons suffering from tobacco-related chronic diseases. The coalition will promote adoption of workplace policies that prohibit tobacco use near the entrances to buildings and other places where persons could be exposed to secondhand smoke. The program will enhance community awareness of chronic diseases caused by tobacco and secondhand smoke through counter-marketing media campaign. SRCHD will

collaborate with students in the University of West Florida Communication Arts Program to design media campaign.

Sarasota County

Sarasota County Health Department (SCHD) has one Tobacco Program Specialist (TPS) responsible for the coordination and delivery of all tobacco prevention and control interventions. The tobacco program will establish and maintain a county tobacco free partnership. The partnership will have two committees that will address strategies to reduce the burden of chronic disease caused by tobacco and strategies to prevent youth initiation. The youth prevention component will focus on three categories: education, leadership and advocacy. Strategies will be used to implement tobacco use prevention education into existing curriculum making it easier and more applicable for teachers to incorporate into their instructional time. At the middle and high school level youth will receive leadership skills through trainings provided by the tobacco program. These trainings will also address tobacco issues, media advocacy, media literacy and policy development education. The trained youth will become advocates for a district policy prohibiting tobacco use on all campuses to include sporting facilities, contractors and cars. The youth program will also engage in a media campaign educating parents on the tobacco industry marketing tactics and how the industry targets youth.

The Chronic Disease component will focus on increasing cessation attempts and reducing exposure to secondhand smoke. The program will educate those affected with chronic disease of the benefits of quitting and direct toward available services. It will increase distribution points for information about cessation and the Florida Quit For Life Line. The chronic disease component with assistance from the partnership will develop and disseminate "workplace tobacco policy toolkits" for businesses to implement policies to reduce secondhand smoke. A mini grant system will be used to provide assistance to worksites planning to implement new smoke-free policies.

Seminole County

The previously existing, Tobacco-Free Partnership of Seminole County, will be re-established and enhanced. The TFPSC will serve as the core infrastructure to support and deliver tobacco prevention and control activities that involve youth, including programs for the prevention of smoking-related chronic diseases. Tobacco prevention and control initiatives will strive to change the community environment to discourage tobacco use, change community attitudes and behavior about tobacco use and educate the community about the health effects of tobacco use. The partnership will be guided by the primary objectives to reduce the prevalence of tobacco use among youth, adults and pregnant women; reduce per capita tobacco consumption; and reduce exposure to environmental tobacco smoke. The TFPSC will also focus on promotion of cessation services and secondhand smoke policies. The youth component will target middle and high school students. However, additional education efforts will include a school-based peer education program. Youth will become trained leaders, communicators and advocates in the fight against the tobacco industry. The TFPSC will work with the Area Health Education Centers and the American Lung Association (ALA) to coordinate and promote cessation resources to the community. Adult cessation and chronic disease management efforts will be available for all youth and adult smokers, regardless of background, and will include priority populations-specific materials for minority groups, low income populations, and young adults.

St. Lucie County

The St. Lucie County Health Department plans to rebuild a tobacco-free partnership that will recruit and engage societal organizations to change social norms about tobacco, promote

cessation and eliminate exposure to secondhand smoke. The local program will collaborate extensively with St. Lucie County schools to implement prevention and cessation programs within the schools that will reach both adults and youth. The following programs will be coordinated within the schools this fiscal year: *Life Skills,* American Lung Association's *Kids Against Tobacco* (KAT), FACE IT early intervention and prevention program, N-O-T (Not On Tobacco) high school cessation program developed by American Lung Association. Concerted efforts will be made to establish smoke free campuses, mobilize parent involvement, and encourage youth advocates to lead policy changes during this first funding cycle.

St Johns County

The St Johns County Health Department (SJCHD) will work to enhance the tobacco partnerships and collaborations. A primary goal of this partnership will be to utilize the insights gained from the 2008 Assessment to educate and inform the community about tobacco risks. Risk reduction strategies will include education to affect or influence policy change and development and regarding importance enforcing existing policies. A comprehensive media campaign will also be developed which will support statewide media campaigns and promote community tobacco intervention initiatives, including promotion of the Florida Quitline. There are several groups that this committee will target:

- Youth with interventions to engage economically disadvantaged and minority sub-groups with age specific education and activities at schools, community centers and health fairs.
- Individuals with chronic disease, in particular HIV/AIDS, diabetes, Chronic Obstructive Pulmonary Disease (COPD), cardiovascular disease, stroke and asthma, through health care providers, community agencies, and faith-based organizations.
- Individuals at risk for chronic illness, including pregnant women, infants and children, through community and day care centers, health care providers, WIC, and Healthy Start.

In addition to the community based efforts of the tobacco focused sub-committee of the SJHIC, the SJCHD will develop and initiate a unified approach to tobacco prevention and cessation to be utilized throughout SJCHD. This approach will include staff training, materials and support that will enable comprehensive clinical intervention, as well as, the competent provision of prevention and cessation messages by any staff member with client contact. The RN/Health Educator will engage, educate and support local health care providers in tobacco intervention efforts and, in concert with the Tobacco Prevention Specialist, provide a regular schedule of free community tobacco cessation classes to which clients can be referred. Finally, working with the RN/Health Educator, the Tobacco Prevention Specialist will partner with local schools and solicit the opinions of parents and students to aid in the development of enhanced classroom and after school tobacco prevention education and activities that will engage a diverse group of students and parents as SWAT participants.

Sumter County

Sumter County will participate in various community activities throughout Sumter County and provide literature on tobacco prevention at each and every event. We will work with the community partnership of the Sumter County School System and provide the tobacco prevention message to the youth of Sumter County. Sumter will also work with the community partnership of the Sumter County Library System and provide the tobacco prevention message to the residents of Sumter County. Our program will work with the community partnership of Sumter County Youth Centers and provide the tobacco prevention message to the youth and

their families that participate with the program. Work with the Department of Juvenile Justice in meeting with the youth involved with their program and providing information on tobacco prevention and related subject of secondhand smoke and chronic disease. We will participate in various community activities throughout Sumter County and provide literature on tobacco prevention at each and every event, work with the community partnership of the Sumter County School System and provide literature on the harmful affects of secondhand smoke to the youth of Sumter County, work with the community partnership of the Sumter County Library System and provide information on the harmful affects of secondhand smoke to the citizens of Sumter County. Another area covered will be working with the community partnership of Sumter County Youth Centers and provide information on the harmful affects of secondhand smoke to the youth and their families that participate with the program, provide secondhand smoke and tobacco prevention information through all licensed Day Care providers in Sumter County. Through our ongoing partnership with Leesburg Regional Medical Center provide information on the harmful affects of tobacco use and secondhand smoking while pregnant as well as the adverse effects of tobacco on secondhand smoke to the infant and other children in the home.

Suwannee County

Suwannee Valley Youth Advocacy Partnership (SVYP) has been a three component strategy consisting of a community partnership development, youth prevention initiative and chronic disease components. The community partnership component will work to enhance the local tobacco free partnership through collaborative efforts within the community. A one day spit tobacco academy will be held for school and recreational coaches; Rick Bender is the keynote speaker.

The youth component will be addressed by a youth advocacy coordinator, a contracted youth leadership trainer to provide training, and an online tracking system that the youth will be trained to utilize. A cessation program facilitator and curricula will also be utilized in the area High Schools and Middle School.

The chronic disease component is being addressed through two part time registered nurses acting as health educators at two faith based wellness programs catering to members of Suwannee County.

Partnership will be met by working through media advocacy, policy initiatives, and existing tobacco education and control programs. The youth component to prevent initiation of tobacco use will primarily be developed through anti-tobacco advocacy groups in local school-sponsored teams (SWAT). The Partnership will target the healthcare provider community with information for their patients regarding the health risks of tobacco use and the effects on their immediate and long term health, and information on health disparities with tobacco use among minorities. Target groups will be adults ages 18-44 and 45-64; African-American males; and high school students.

Union / Bradford Counties

Community partnerships in Union and Bradford Counties that take a leadership position in this initiative are essential to the success of Project Tobacco Prevention. This is a logical first step in bringing Project Tobacco Prevention to Union County, and the affiliation will facilitate program implementation and community acceptance. The Tobacco Prevention Community Partnership will enhance the efforts of the Be W.I.S.E. coalition of Union County. In Bradford County, the partnerships developed to provide prevention activities such as diabetes self management education classes, cardiovascular health, women's health have been very effective. The Tobacco Prevention Community Partnership will provide an ongoing opportunity for these groups to work together in a comprehensive and cohesive manner to target reduction and elimination of tobacco use among both the adult and youth population and provide chronic disease prevention information and activities in this community. Services will include education

about tobacco use, smoking cessation, the effects of secondhand smoke, and the elimination of environmental tobacco. Youth will be targeted through the CHD nurses in School Health Programs in the Union and Bradford Public Schools, and through the SWAT coordinators. In addition, SWAT coordinators will work closely with Cooperative Extension in Union and Bradford Counties to reach youth involved in 4-H programs. The adult population of tobacco users will require a multi-faceted approach to engage their participation in cessation activities. The Chronic Disease programs in Union and Bradford County have established close working alliances with the African-American churches and will utilize these contacts to expand the services to these populations.

Volusia County

The forming a renewed TFP-VC (tobacco-free partnership of Volusia County) will permit central comprehensive plans targeting tobacco in our community. A community awareness campaign will be established. The goals of the community partnership include: 1) the prevention of the initiation of tobacco use among youth; 2) the protection from environmental toxic smoke (ETS – secondhand); and 3) the reduction/elimination of disparities in tobacco use among minority populations. The goals of the Partnership will be met by working through media advocacy, policy initiatives, and existing tobacco education and control programs. The youth component to prevent initiation of tobacco use will primarily be developed through anti-tobacco advocacy groups in local school-sponsored teams (SWAT). The Partnership will target the healthcare provider community with information for their patients regarding the health risks of tobacco use and the effects on their immediate and long term health, and information on health disparities with tobacco use among minorities. Our target groups will be adults ages 18-44 and 45-64; African-American males; and high school students. See Appendix V for statistics on target groups. Outreach will be conducted through community organizations affiliated with these groups.

Wakulla County

The Tobacco Prevention staff will provide prevention education/information, and support for community efforts to create/sustain tobacco free environments in partnership with other organizations and county residents. This community partnership will be critical in conducting community needs assessments, and implementing policies and cultural changes within the county.

Walton County

The Walton County Prevention Coalition has generated a plan with a three component strategy consisting of a community partnership development, youth prevention initiative and chronic disease components. The community partnership component will be addressed through the following: the partnership will hire a Tobacco-Free Community Liaison to compile and review data, the Tobacco-Free Community Liaison in collaboration with the Walton County Health Department will conduct a needs assessment for reduction of tobacco use and the partnership will prioritize the needs identified, set goals, compare the program goals to the health department's work plan and develop a comprehensive plan of action. The Coalition will promote the DOH Quit-line on all advertisements for the tobacco prevention program in Walton County and work collaboratively with all other program-funded programs, such as AHEC. The Coalition will promote the adoption of smoke-free policies in schools and tobacco free policies in schools, hospitals, healthcare systems and other public and private institutions by educating key leadership within those organizations of the dangers of tobacco use and encourage them to participate of the tobacco prevention and control community partnership. The youth component plans are as follows: Begin organizing SWAT chapters and coordinating with existing SADD chapters and other youth organizations to train youth in social marketing and activism to

promote tobacco policy changes. Promotion of youth activities that seek to create policy change in the community, such as preparing presentations for local leadership that educate about the health effects of tobacco use and current tobacco issues. Collaboration with ABT (Division of Alcoholic Beverages and Tobacco) to have youth volunteers to help monitor retail compliance checks. Tobacco-Free Community Liaison will collaborate with local PTAs (Parent Teacher Associations) to educate parents on the negative consequences of smoking around youth and include this information in the media campaign for tobacco prevention. The chronic disease component includes a collaborative effort with the Tobacco Prevention Specialist and the Senior Health Educator at the Walton County Health Department to support, enhance and collaborate with their initiatives to promote cessation and secondhand smoke education to persons with chronic diseases, such as diabetes, asthma, cardiovascular disease, stroke and chronic obstructive lung disease.

Washington County

Washington County will implement a three Phase Program consisting of Community, Youth, and Chronic Disease components. The plan utilizes a number of tobacco prevention and control strategies. The first strategy is the development of the Washington County Tobacco Free Partnership (WCTFP) which will pull community partners together to facilitate collaboration and advise the county in the implementation of the tobacco plan. The county will establish a Media and Marketing Campaign to target chronic disease, second hand smoke and hazards to pregnant women. The county will develop initiatives to foster leadership and advocacy skills in youth, parents and community partners. The county will engage in tobacco policy, enforcement and environmental interventions spearheaded by the community partnership. The county will provide cessation opportunities for youth and adults with a special focus on pregnant women. The county will establish School Programs to decrease tobacco use and acceptance among youth, parents and significant adults.

PHYSICIAN WORKFORCE ASSESSMENT
AND DEVELOPMENT PROGRAM

Section 381.4018, F.S.

Physician Workforce

Assessment and Development

Select Year: 2007 Go

The 2007 Florida Statutes

Title XXIX PUBLIC HEALTH | Chapter 381 PUBLIC HEALTH: GENERAL PROVISIONS | View Entire Chapter

381.4018 Physician workforce assessment and development.--

(1) LEGISLATIVE INTENT.--The Legislature recognizes that physician workforce planning is an essential component of ensuring that there is an adequate and appropriate supply of well-trained physicians to meet this state's future health care service needs as the general population and elderly population of the state increase. The Legislature finds that items to consider relative to assessing the physician workforce may include physician practice status; specialty mix; geographic distribution; demographic information, including, but not limited to, age, gender, race, and cultural considerations; and needs of current or projected medically underserved areas in the state. Long-term strategic planning is essential as the period from the time a medical student enters medical school to completion of graduate medical education may range from 7 to 10 years or longer. The Legislature recognizes that strategies to provide for a well-trained supply of physicians must include ensuring the availability and capacity of quality graduate medical schools in this state, as well as using new or existing state and federal programs providing incentives for physicians to practice in needed specialties and in underserved areas in a manner that addresses projected needs for physician manpower.

(2) PURPOSE.--The Department of Health shall serve as a coordinating and strategic planning body to actively assess the state's current and future physician workforce needs and work with multiple stakeholders to develop strategies and alternatives to address current and projected physician workforce needs.

(3) GENERAL FUNCTIONS.--The department shall maximize the use of existing programs under the jurisdiction of the department and other state agencies and coordinate governmental and nongovernmental stakeholders and resources in order to develop a state strategic plan and assess the implementation of such strategic plan. In developing the state strategic plan, the department shall:

(a) Monitor, evaluate, and report on the supply and distribution of physicians licensed under chapter 458 or chapter 459. The department shall maintain a database to serve as a statewide source of data concerning the physician workforce.

(b) Develop a model and quantify, on an ongoing basis, the adequacy of the state's current and future physician workforce as reliable data becomes available. Such model must take into account demographics, physician practice status, place of education and training, generational changes, population growth, economic indicators, and issues concerning the "pipeline" into medical education.

(c) Develop and recommend strategies to determine whether the number of qualified medical school applicants who might become competent, practicing physicians in this state will be sufficient to meet the capacity of the state's medical schools. If appropriate, the department shall, working with representatives of appropriate governmental and nongovernmental entities, develop strategies and recommendations and identify best practice programs that introduce health care as a profession and strengthen skills needed for medical school admission for elementary, middle, and high school students, and improve premedical education at the precollege and college level in order to increase this state's potential pool of medical students.

(d) Develop strategies to ensure that the number of graduates from the state's public and private allopathic and osteopathic medical schools are adequate to meet physician workforce needs, based on the analysis of the physician workforce data, so as to provide a high-quality medical education to students in a manner that recognizes the uniqueness of each new and existing medical school in

this state.

(e) Pursue strategies and policies to create, expand, and maintain graduate medical education positions in the state based on the analysis of the physician workforce data. Such strategies and policies must take into account the effect of federal funding limitations on the expansion and creation of positions in graduate medical education. The department shall develop options to address such federal funding limitations. The department shall consider options to provide direct state funding for graduate medical education positions in a manner that addresses requirements and needs relative to accreditation of graduate medical education programs. The department shall consider funding residency positions as a means of addressing needed physician specialty areas, rural areas having a shortage of physicians, and areas of ongoing critical need, and as a means of addressing the state's physician workforce needs based on an ongoing analysis of physician workforce data.

(f) Develop strategies to maximize federal and state programs that provide for the use of incentives to attract physicians to this state or retain physicians within the state. Such strategies should explore and maximize federal-state partnerships that provide incentives for physicians to practice in federally designated shortage areas. Strategies shall also consider the use of state programs, such as the Florida Health Service Corps established pursuant to s. 381.0302 and the Medical Education Reimbursement and Loan Repayment Program pursuant to s. 1009.65, which provide for education loan repayment or loan forgiveness and provide monetary incentives for physicians to relocate to underserved areas of the state.

(g) Coordinate and enhance activities relative to physician workforce needs, undergraduate medical education, and graduate medical education provided by the Division of Medical Quality Assurance, the Community Hospital Education Program and the Graduate Medical Education Committee established pursuant to s. 381.0403, area health education center networks established pursuant to s. 381.0402, and other offices and programs within the Department of Health as designated by the [1]State Surgeon General.

(h) Work in conjunction with and act as a coordinating body for governmental and nongovernmental stakeholders to address matters relating to the state's physician workforce assessment and development for the purpose of ensuring an adequate supply of well-trained physicians to meet the state's future needs. Such governmental stakeholders shall include, but need not be limited to, the [1]State Surgeon General or his or her designee, the Commissioner of Education or his or her designee, the Secretary of Health Care Administration or his or her designee, and the Chancellor of the State University System or his or her designee from the Board of Governors of the State University System, and, at the discretion of the department, other representatives of state and local agencies that are involved in assessing, educating, or training the state's current or future physicians. Other stakeholders shall include, but need not be limited to, organizations representing the state's public and private allopathic and osteopathic medical schools; organizations representing hospitals and other institutions providing health care, particularly those that have an interest in providing accredited medical education and graduate medical education to medical students and medical residents; organizations representing allopathic and osteopathic practicing physicians; and, at the discretion of the department, representatives of other organizations or entities involved in assessing, educating, or training the state's current or future physicians.

(i) Serve as a liaison with other states and federal agencies and programs in order to enhance resources available to the state's physician workforce and medical education continuum.

(j) Act as a clearinghouse for collecting and disseminating information concerning the physician workforce and medical education continuum in this state.

History.--s. 1, ch. 2007-172.

[1]**Note.**--Chapter 2007-40 redesignated the Secretary of Health as the State Surgeon General.

The Physician Workforce Voluntary Survey

PHYSICIAN WORKFORCE QUESTIONNAIRE

The items below relate to very important questions regarding Florida's current and future physician workforce. Your responses will be instrumental in shaping Florida's health care and physician workforce policies. Secretary of the Department of Health, M. Rony François, M.D., M.S.P.H., Ph.D., and the Council of Florida Medical School Deans, Florida Graduate Medical Education Committee, Florida Medical Association and Florida Osteopathic Medical Association appreciate your time and effort in responding to the eight questions below.

Name: *FirstName MI. LastName* **License Number:** *ME 123456789*

1. Do you practice medicine at any time during the year in Florida?
   Note: If you check 'No' then please stop here. ◯ Yes ◯ No
2. How many months/year do you practice medicine in Florida?
   ◯ 1-4 Months ◯ 5-8 Months ◯ 9-12 Months
3. In what Florida counties do you practice?(may select up to 5 counties)
   Please note - County Names and Numeric Codes are listed on the **back side of the form.**
   Please print or type County Names and Numeric Codes below.

	County Name	Numeric Code	1-20 Hrs/Wk	21-40 Hrs/Wk	More than 40 Hrs/Wk
a.			◯	◯	◯
b.			◯	◯	◯
c.			◯	◯	◯
d.			◯	◯	◯
e.			◯	◯	◯

4. Is more than twenty percent (20%) of your practice non-clinical? (i.e. research, teaching, administration)
   ◯ Yes ◯ No
5. Are you a resident or fellow?
   ◯ Yes ◯ No
6. What is the primary specialty area(s) of your current clinical practice?(may select up to 5 different areas)
   Please note - Specialty Areas and Numeric Codes are listed on the **back side of the form.**
   Please print or type Specialty Areas and Numeric Codes below.

	Specialty Area	Numeric Code	1-20%	21-40%	41-60%	61-80%	81-100%
a.			◯	◯	◯	◯	◯
b.			◯	◯	◯	◯	◯
c.			◯	◯	◯	◯	◯
d.			◯	◯	◯	◯	◯
e.			◯	◯	◯	◯	◯

7. Do you plan to retire, relocate outside of the state of Florida, or significantly reduce the scope of your practice within the next five years?
   ◯ Yes ◯ No
8. Do you currently take emergency call or otherwise work clinically in a hospital emergency department or provide for the immediate, acute care of trauma patients?
   ◯ Yes ◯ No

ME0123456789

County Names and Numeric Codes (Reference for question # 3)

11 ALACHUA	25 DIXIE	39 HILLSBOROUGH	53 MARTIN	67 SANTA ROSA
12 BAKER	26 DUVAL	40 HOLMES	54 MONROE	68 SARASOTA
13 BAY	27 ESCAMBIA	41 INDIAN RIVER	55 NASSAU	69 SEMINOLE
14 BRADFORD	28 FLAGLER	42 JACKSON	56 OKALOOSA	70 SUMTER
15 BREVARD	29 FRANKLIN	43 JEFFERSON	57 OKEECHOBEE	71 SUWANNEE
16 BROWARD	30 GADSDEN	44 LAFAYETTE	58 ORANGE	72 TAYLOR
17 CALHOUN	31 GILCHRIST	45 LAKE	59 OSCEOLA	73 UNION
18 CHARLOTTE	32 GLADES	46 LEE	60 PALM BEACH	74 VOLUSIA
19 CITRUS	33 GULF	47 LEON	61 PASCO	75 WAKULLA
20 CLAY	34 HAMILTON	48 LEVY	62 PINELLAS	76 WALTON
21 COLLIER	35 HARDEE	49 LIBERTY	63 POLK	77 WASHINGTON
22 COLUMBIA	36 HENDRY	50 MADISON	64 PUTNAM	78 UNKNOWN
23 DADE	37 HERNANDO	51 MANATEE	65 ST.JOHNS	79 OUT OF STATE
24 DESOTO	38 HIGHLANDS	52 MARION	66 ST.LUCIE	80 FOREIGN

Specialty Areas and Numeric Codes (Reference for question # 6)

000 NO CLINICAL PRACTICE
020 ALLERGY AND IMMUNOLOGY
040 ANESTHESIOLOGY
045 CRITICAL CARE MEDICINE
048 PAIN MEDICINE
042 PEDIATRIC ANESTHESIOLOGY
060 COLON AND RECTAL SURGERY
080 DERMATOLOGY
100 DERMATOPATHOLOGY
081 PROCEDURAL DERMATOLOGY
110 EMERGENCY MEDICINE
118 MEDICAL TOXICOLOGY
114 PEDIATRIC EMERGENCY MEDICINE
116 SPORTS MEDICINE
119 UNDERSEA AND HYPERBARIC MEDICINE
120 FAMILY MEDICINE
125 GERIATRIC MEDICINE
127 SPORTS MEDICINE
140 INTERNAL MEDICINE
141 CARDIOVASCULAR DISEASE
154 CLINICAL CARDIAC ELECTROPHYSIOLOGY
142 CRITICAL CARE MEDICINE
143 ENDOCRINOLOGY, DIABETES, AND METABOLISM
144 GASTROENTEROLOGY
151 GERIATRIC MEDICINE
145 HEMATOLOGY
155 HEMATOLOGY AND ONCOLOGY
146 INFECTIOUS DISEASE
152 INTERVENTIONAL CARDIOLOGY
148 NEPHROLOGY
147 ONCOLOGY
149 PULMONARY DISEASE
156 PULMONARY DISEASE AND CRITICAL CARE MEDICINE
150 RHEUMATOLOGY
157 SPORTS MEDICINE
130 MEDICAL GENETICS
190 MOLECULAR GENETIC PATHOLOGY
160 NEUROLOGICAL SURGERY
180 NEUROLOGY
185 CHILD NEUROLOGY
187 CLINICAL NEUROPHYSIOLOGY
183 NEUROMUSCULAR MEDICINE
186 NEURODEVELOPMENTAL DISABILITIES
181 PAIN MEDICINE
188 VASCULAR NEUROLOGY
200 NUCLEAR MEDICINE
220 OBSTETRICS AND GYNECOLOGY
240 OPHTHALMOLOGY
260 ORTHOPAEDIC SURGERY
261 ADULT RECONSTRUCTIVE ORTHOPAEDICS
262 FOOT AND ANKLE ORTHOPAEDICS
263 HAND SURGERY
270 MUSCULOSKELETAL ONCOLOGY
268 ORTHOPAEDIC SPORTS MEDICINE
267 ORTHOPAEDIC SURGERY OF THE SPINE
269 ORTHOPAEDIC TRAUMA
265 PEDIATRIC ORTHOPAEDICS
280 OTOLARYNGOLOGY
286 NEUROTOLOGY
288 PEDIATRIC OTOLARYNGOLOGY
300 PATHOLOGY-ANATOMIC AND CLINICAL
305 BLOOD BANKING/TRANSFUSION MEDICINE
306 CHEMICAL PATHOLOGY
307 CYTOPATHOLOGY
310 FORENSIC PATHOLOGY
311 HEMATOLOGY
314 MEDICAL MICROBIOLOGY
315 NEUROPATHOLOGY
316 PEDIATRIC PATHOLOGY
301 SELECTIVE PATHOLOGY
320 PEDIATRICS
321 ADOLESCENT MEDICINE
329 NEONATAL-PERINATAL MEDICINE
325 PEDIATRIC CARDIOLOGY
323 PEDIATRIC CRITICAL CARE MEDICINE
324 PEDIATRIC EMERGENCY MEDICINE
326 PEDIATRIC ENDOCRINOLOGY
332 PEDIATRIC GASTROENTEROLOGY
327 PEDIATRIC HEMATOLOGY/ONCOLOGY
335 PEDIATRIC INFECTIOUS DISEASES
328 PEDIATRIC NEPHROLOGY
330 PEDIATRIC PULMONOLOGY
331 PEDIATRIC RHEUMATOLOGY
333 PEDIATRIC SPORTS MEDICINE
336 DEVELOPMENTAL-BEHAVIORAL PEDIATRICS
340 PHYSICAL MEDICINE AND REHABILITATION
341 PAIN MEDICINE
346 PEDIATRIC REHABILITATION
345 SPINAL CORD INJURY MEDICINE
360 PLASTIC SURGERY
361 CRANIOFACIAL CURGERY
363 HAND SURGERY
380 PREVENTIVE MEDICINE
399 MEDICAL TOXICOLOGY
398 UNDERSEA AND HYPERBARIC MEDICINE
400 PSYCHIATRY
401 ADDICTION PSYCHIATRY
405 CHILD AND ADOLESCENT PSYCHIATRY
406 FORENSIC PSYCHIATRY
407 GERIATRIC PSYCHIATRY
402 PAIN MEDICINE
409 PSYCHOSOMATIC MEDICINE
420 RADIOLOGY DIAGNOSTIC
421 ABDOMINAL RADIOLOGY
429 CARDIOTHORACIC RADIOLOGY
422 ENDOVASCULAR SURGICAL NEURORADIOLOGY
426 MUSCULOSKELETAL RADIOLOGY
423 NEURORADIOLOGY
425 NUCLEAR RADIOLOGY
424 PEDIATRIC RADIOLOGY
427 VASCULAR AND INTERVENTIONAL RADIOLOGY
430 RADIATION ONCOLOGY
520 SLEEP MEDICINE
440 SURGERY-GENERAL
443 HAND SURGERY
445 PEDIATRIC SURGERY
442 SURGICAL CRITICAL CARE
450 VASCULAR SURGERY
460 THORACIC SURGERY
480 UROLOGY
485 PEDIATRIC UROLOGY
999 OTHER

The Physician Workforce Mandatory Survey

PHYSICIAN WORKFORCE SURVEY

Governor Charlie Crist, State Surgeon General Ana Viamonte Ros and the Florida Legislature recognize the importance of assessing Florida's current and future physician workforce. Critical legislation was passed last year that requires the Department of Health to evaluate the geographic distribution and specialty mix of active Florida physicians. Please refer to F.S. 381.4018 Physician workforce assessment and development. The questions in this physician workforce survey will be instrumental in shaping Florida's health care and physician workforce policies. Your time and effort in responding to the questions below is appreciated.

Instructions for completing the survey:

- Questions 1 - 12 apply to all physicians
- If you are an on-call specialist taking emergency call in an emergency department, please also answer questions 13 - 16
- If you provide only radiological services, please also answer questions 17 - 25
- If you provide obstetric services, please also answer questions 26 - 32

1. **Do you practice medicine at any time during the year in Florida?**
   - ○ Yes.
   - ○ No. Please stop here and review the Affirmation Statement on page 5.

2. **How many months per year do you practice in Florida?**
   - ○ 1-4 Months
   - ○ 5-8 Months
   - ○ 9-12 Months

3. **In what Florida County(ies) is your medical practice located? (May select up to 5 counties - See p. 5 for county codes) For each county selected: How many hours per week do you practice in each setting?**

County Name	Numeric Code	1-20 Hrs/Wk	21-40 Hrs/Wk	> 40 Hrs/Wk
		○	○	○
		○	○	○
		○	○	○
		○	○	○
		○	○	○

4. **Are you in a solo practice?**
   - ○ Yes
   - ○ No

5. **Which practice setting best describes where the <u>majority</u> of your time is spent? (Choose Only One)**
   - ○ Private Office Setting
   - ○ Federally Qualified Health Center
   - ○ Governmental Clinical Setting (for example: County Health Department)
   - ○ Federal Healthcare Facility (for example: military or VA)
   - ○ Hospital-Outpatient Department/Service
   - ○ Hospital-Inpatient
   - ○ Hospital Emergency Department
   - ○ Hospital Other (for example: hospital-based radiologist, pathologist, anesthesiologist or medical director)
   - ○ Nursing Home/Extended Care Facility
   - ○ Ambulatory Surgery Center/Free-Standing Imaging Diagnostic Center
   - ○ Other Setting

*TST-000000101

6. **Are you currently enrolled in an internship, residency program or fellowship program?**
   - ○ Yes
   - ○ No

7. **Does more than 20 percent of your practice include non clinical work (research, teaching, administration)?**
   - ○ Yes
   - ○ No

8. **List your primary specialty area, and any additional specialties, of your current clinical practice and the percentage of time you spend working in that area: (Select up to 5 Areas - See p. 6 for specialty codes)**

Specialty Area	Numeric Code	1-20%	21-40%	41-60%	61-80%	81-100%
		○	○	○	○	○
		○	○	○	○	○
		○	○	○	○	○
		○	○	○	○	○
		○	○	○	○	○

9. **Do you plan to retire, relocate outside of the State of Florida, or significantly reduce the scope of your practice within the next five years?**
   - ○ Yes
   - ○ No

10. **If you have changed the scope of your practice in the last two years, what are the reasons for the change (Choose All That Apply)?**
    - ○ Liability
    - ○ Reimbursement
    - ○ Regulatory and Administrative Burden
    - ○ Retirement
    - ○ Lifestyle Considerations, Other than Retirement
    - ○ Other

11. **Do you currently take emergency call or otherwise work clinically in a hospital emergency department or provide for the immediate, acute care of trauma patients?**
    - ○ Yes
    - ○ No
    - ○ Exempt Due to Medical Staff Bylaws

12. **If you take emergency call or otherwise work clinically in a hospital emergency department, are you**
    - ○ Full Time
    - ○ On-Call Specialty

For on-call specialists taking emergency call in an emergency department please answer questions 13 - 16

13. **At how many hospitals do you currently take emergency call?**
    - ○ One
    - ○ Two
    - ○ Three or greater

14. **How many days per month do you take call?**
    - ○ 1-4
    - ○ 5-9
    - ○ 10 or greater

15. **If you have taken hospital emergency department call during the past 2 years, has the number of emergency on-call hours that you work:**
    - ○ Increased
    - ○ Decreased
    - ○ Stayed the Same

16. **If you have decreased or plan to decrease or stop taking emergency department call, please check any reason that applies**
    - ○ Liability
    - ○ Reimbursement
    - ○ Lifestyle Considerations
    - ○ Impact to Private Practice
    - ○ Changing Practice Patterns
    - ○ Exemption
    - ○ Other

For physicians that provide only radiological services, please answer questions 17 - 25

17. **Do you read mammograms or other breast imaging exams?**
    - ○ Yes
    - ○ No

18. **If you do not read mammograms or other breast imaging exams, please choose the most important reason why:**
    - ○ Liability
    - ○ Reimbursement
    - ○ Uninteresting Field
    - ○ Too Stressful
    - ○ Too Much Regulation
    - ○ Other

If you read mammograms, please continue.
If you do not read mammograms, please skip to question 26.

19. **Do you read screening mammograms?**
    - ○ Yes
    - ○ No

20. **Do you read diagnostic mammograms and sonograms?**
    - ○ Yes
    - ○ No

21. **Do you perform BOTH ultrasound and stereotactic guided core biopsies?**
    - ○ Yes
    - ○ No

22. **Do you read breast MRIs?**
    - ○ Yes
    - ○ No

23. **Do you read breast MRIs AND perform MRI guided core biopsies?**
    - ○ Yes
    - ○ No

24. **In the next two years, will the number of mammograms you read change for any reason, including retirement:**
    - ○ Increase
    - ○ Decrease
    - ○ Stay the Same
    - ○ Discontinue

25. **Have you done a 6-month or greater breast imaging fellowship?**
    - ○ Yes
    - ○ No

For physicians that provide obstetric services only, please answer questions 26 - 32

26. **Do you deliver babies?**
    - ○ Yes
    - ○ No. Thank you for taking this survey. Please review the Affirmation Statement on page 5.

27. **How many routine deliveries per month?**
    - ○ None
    - ○ Low, < 10 per month
    - ○ Medium, 10-30 per month
    - ○ High, >30 per month

28. **How many high risk deliveries per month?**
    - ○ None
    - ○ Low, < 10 per month
    - ○ Medium, 10-30 per month
    - ○ High, >30 per month

29. **How many c-sections per month?**
    - ○ None
    - ○ Low, < 10 per month
    - ○ Medium, 10-30 per month
    - ○ High, >30 per month

30. **How many emergency room deliveries per month for patients having minimal or no "known" prenatal care?**
    - ○ None
    - ○ Low, < 10 per month
    - ○ Medium, 10-30 per month
    - ○ High, >30 per month

31. **How many assists or consultative services per month?**
    - ○ None
    - ○ Low, < 10 per month
    - ○ Medium, 10-30 per month
    - ○ High, >30 per month

32. **Are you planning to discontinue doing obstetric care for any reason, including retirement, in the next two years?**
    - ○ Yes
    - ○ No

AFFIRMATION STATEMENT:

I affirm that I have completed the survey to the extent that it is applicable to me. This information provided is true and accurate to the best of my knowledge and the submission does not contain any knowingly false information.

County Names and Numeric Codes (Reference for question # 3)

11	ALACHUA	25	DIXIE	39	HILLSBOROUGH	53	MARTIN	67	SANTA ROSA
12	BAKER	26	DUVAL	40	HOLMES	54	MONROE	68	SARASOTA
13	BAY	27	ESCAMBIA	41	INDIAN RIVER	55	NASSAU	69	SEMINOLE
14	BRADFORD	28	FLAGLER	42	JACKSON	56	OKALOOSA	70	SUMTER
15	BREVARD	29	FRANKLIN	43	JEFFERSON	57	OKEECHOBEE	71	SUWANNEE
16	BROWARD	30	GADSDEN	44	LAFAYETTE	58	ORANGE	72	TAYLOR
17	CALHOUN	31	GILCHRIST	45	LAKE	59	OSCEOLA	73	UNION
18	CHARLOTTE	32	GLADES	46	LEE	60	PALM BEACH	74	VOLUSIA
19	CITRUS	33	GULF	47	LEON	61	PASCO	75	WAKULLA
20	CLAY	34	HAMILTON	48	LEVY	62	PINELLAS	76	WALTON
21	COLLIER	35	HARDEE	49	LIBERTY	63	POLK	77	WASHINGTON
22	COLUMBIA	36	HENDRY	50	MADISON	64	PUTNAM	78	UNKNOWN
23	DADE	37	HERNANDO	51	MANATEE	65	ST.JOHNS	79	OUT OF STATE
24	DESOTO	38	HIGHLANDS	52	MARION	66	ST.LUCIE	80	FOREIGN

See reverse side for specialty codes.

Specialty Areas and Numeric Codes (Reference for question # 8)

000	**NO CLINICAL PRACTICE**
020	**ALLERGY AND IMMUNOLOGY**
040	**ANESTHESIOLOGY**
045	CRITICAL CARE MEDICINE
048	PAIN MEDICINE
042	PEDIATRIC ANESTHESIOLOGY
060	**COLON AND RECTAL SURGERY**
080	**DERMATOLOGY**
100	DERMATOPATHOLOGY
081	PROCEDURAL DERMATOLOGY
110	**EMERGENCY MEDICINE**
118	MEDICAL TOXICOLOGY
114	PEDIATRIC EMERGENCY MEDICINE
116	SPORTS MEDICINE
119	UNDERSEA AND HYPERBARIC MEDICINE
120	**FAMILY MEDICINE**
125	GERIATRIC MEDICINE
127	SPORTS MEDICINE
140	**INTERNAL MEDICINE**
141	CARDIOVASCULAR DISEASE
154	CLINICAL CARDIAC ELECTROPHYSIOLOGY
142	CRITICAL CARE MEDICINE
143	ENDOCRINOLOGY, DIABETES, AND METABOLISM
144	GASTROENTEROLOGY
151	GERIATRIC MEDICINE
145	HEMATOLOGY
155	HEMATOLOGY AND ONCOLOGY
146	INFECTIOUS DISEASE
152	INTERVENTIONAL CARDIOLOGY
148	NEPHROLOGY
147	ONCOLOGY
149	PULMONARY DISEASE
156	PULMONARY DISEASE AND CRITICAL CARE MEDICINE
150	RHEUMATOLOGY
157	SPORTS MEDICINE
130	**MEDICAL GENETICS**
190	MOLECULAR GENETIC PATHOLOGY
160	**NEUROLOGICAL SURGERY**
180	**NEUROLOGY**
185	CHILD NEUROLOGY
187	CLINICAL NEUROPHYSIOLOGY
183	NEUROMUSCULAR MEDICINE
186	NEURODEVELOPMENTAL DISABILITIES
181	PAIN MEDICINE
188	VASCULAR NEUROLOGY
200	**NUCLEAR MEDICINE**
220	**OBSTETRICS AND GYNECOLOGY**
240	**OPHTHALMOLOGY**
260	**ORTHOPAEDIC SURGERY**
261	ADULT RECONSTRUCTIVE ORTHOPAEDICS
262	FOOT AND ANKLE ORTHOPAEDICS
263	HAND SURGERY
270	MUSCULOSKELETAL ONCOLOGY
268	ORTHOPAEDIC SPORTS MEDICINE
267	ORTHOPAEDIC SURGERY OF THE SPINE
269	ORTHOPAEDIC TRAUMA
265	PEDIATRIC ORTHOPAEDICS
280	**OTOLARYNGOLOGY**
286	NEUROTOLOGY
288	PEDIATRIC OTOLARYNGOLOGY
300	**PATHOLOGY-ANATOMIC AND CLINICAL**
305	BLOOD BANKING/TRANSFUSION MEDICINE
306	CHEMICAL PATHOLOGY
307	CYTOPATHOLOGY
310	FORENSIC PATHOLOGY
311	HEMATOLOGY
314	MEDICAL MICROBIOLOGY
315	NEUROPATHOLOGY
316	PEDIATRIC PATHOLOGY
301	SELECTIVE PATHOLOGY
320	**PEDIATRICS**
321	ADOLESCENT MEDICINE
329	NEONATAL-PERINATAL MEDICINE
325	PEDIATRIC CARDIOLOGY
323	PEDIATRIC CRITICAL CARE MEDICINE
324	PEDIATRIC EMERGENCY MEDICINE
326	PEDIATRIC ENDOCRINOLOGY
332	PEDIATRIC GASTROENTEROLOGY
327	PEDIATRIC HEMATOLOGY/ONCOLOGY
335	PEDIATRIC INFECTIOUS DISEASES
328	PEDIATRIC NEPHROLOGY
330	PEDIATRIC PULMONOLOGY
331	PEDIATRIC RHEUMATOLOGY
333	PEDIATRIC SPORTS MEDICINE
336	DEVELOPMENTAL-BEHAVIORAL PEDIATRICS
340	**PHYSICAL MEDICINE AND REHABILITATION**
341	PAIN MEDICINE
346	PEDIATRIC REHABILITATION
345	SPINAL CORD INJURY MEDICINE
360	**PLASTIC SURGERY**
361	CRANIOFACIAL CURGERY
363	HAND SURGERY
380	**PREVENTIVE MEDICINE**
399	MEDICAL TOXICOLOGY
398	UNDERSEA AND HYPERBARIC MEDICINE
400	**PSYCHIATRY**
401	ADDICTION PSYCHIATRY
405	CHILD AND ADOLESCENT PSYCHIATRY
406	FORENSIC PSYCHIATRY
407	GERIATRIC PSYCHIATRY
402	PAIN MEDICINE
409	PSYCHOSOMATIC MEDICINE
420	**RADIOLOGY DIAGNOSTIC**
421	ABDOMINAL RADIOLOGY
429	CARDIOTHORACIC RADIOLOGY
422	ENDOVASCULAR SURGICAL NEURORADIOLOGY
426	MUSCULOSKELETAL RADIOLOGY
423	NEURORADIOLOGY
425	NUCLEAR RADIOLOGY
424	PEDIATRIC RADIOLOGY
427	VASCULAR AND INTERVENTIONAL RADIOLOGY
430	**RADIATION ONCOLOGY**
520	**SLEEP MEDICINE**
440	**SURGERY-GENERAL**
443	HAND SURGERY
445	PEDIATRIC SURGERY
442	SURGICAL CRITICAL CARE
450	VASCULAR SURGERY
460	**THORACIC SURGERY**
480	**UROLOGY**
485	PEDIATRIC UROLOGY
999	**OTHER**

Workforce Surveys: Project Status Update

Reported on
January 23, 2008
Florida Department of Health

Workforce Surveys Available

- Physician Workforce
  - Offered to both allopathic and osteopathic physicians
  - Used to assess Florida's current and future physician workforce
  - Required by SB770; must complete prior to next renewal
  - Included paper survey insert in the renewal notices
  - Offered online and incorporated into the renewal process
  - Provide survey response data to DHAT for analysis and reporting
- Nursing Workforce
  - Developed by the Florida Center for Nursing (FCN) as a voluntary survey
  - Available to RNs, LPNs, and ARNPs
  - Offered online only and incorporated into the renewal process
  - Replaced previous survey that was external to the DOH website and had a response rate of less than 6%
  - Provide survey response data to FCN for analysis and reporting

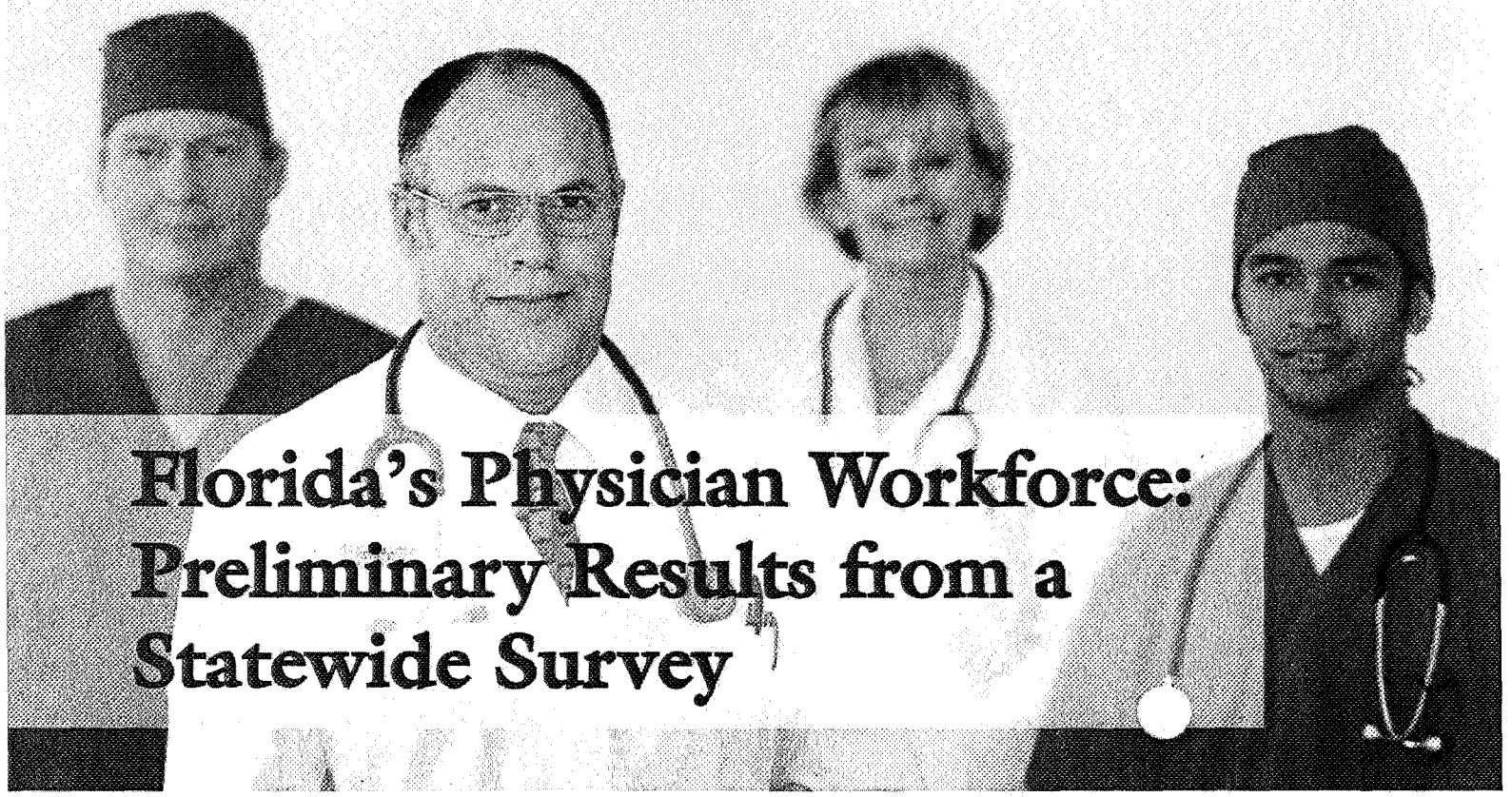
Project Status

Survey Type	Survey Released	Survey End Date	Current Response*	Data Provided
Allopathic Physicians (27,000)	10/15/07	9/30/08	91%	2/28/08 and as requested
Osteopathic Physicians (5,150)	12/03/07	11/30/08	78%	4/30/08 and as requested
Nurses (133,200)	12/19/07	12/31/08	92%	Monthly

*Percent of practitioners who renewed and completed the survey.

Non-Disciplinary Citations

- Mail non-disciplinary citation notices 90 days after expiration date.
  - April 30, 2008 - Allopathic Physicians
  - June 30, 2008 - Osteopathic Physicians
- Mail non-renewal notification letter 150 days prior to next renewal cycle



Florida's Physician Workforce: Preliminary Results from a Statewide Survey

Robert G. Brooks, MD, MBA
Nir Menachemi, PhD, MPH

As each practicing physician knows, quality of care for patients includes the need for well-trained physicians who are available to meet the unique medical requirements of patients in their local communities. Similarly, from the patient's standpoint, the availability of qualified doctors, who can meet their needs in a timely way, is crucial to their success in the maintenance of a healthy life and in receipt of excellent care when disease occurs. Despite the obvious need for access to physician services, national predictions about the current and future physician workforce suggest that an actual net decrease in the number of practicing medical doctors may occur over the next 10 years unless changes are made in policies at the medical school, residency, and practice levels.

The medical workforce in Florida is challenged by a unique situation where mounting pressures on physicians is occurring as a result of multiple factors. With major concerns about medical liability, new constitutional amendments that threaten the fabric of the physician-patient relationship, and declining financial incentives, the current situation in our state requires timely action by policy makers. Unfortunately, Florida has not traditionally had an accurate picture of its physician workforce because data has been scarce. At times this has been noted as a glaring gap in critical information such as during the legislative and social debates surrounding medical liability and, more recently, during the discussions about adding two new medical schools to the state's educational landscape.

Fortunately, the lack of information on the Florida physician workforce is about to change for two reasons. First, in 2006, the Florida Department of Health (FDOH), with the urging of then-Governor Jeb Bush, developed a voluntary survey of physicians which was included in the re-licensure application materials sent to physicians for their January, 2007 renewal. In Florida, approximately one-half of all Florida allopathic physicians renew their licenses in any given year. >>>

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Thus, the data collected in early 2007 represents the largest set of information about the Florida physician workforce collected in our state's history. Secondly, in the Spring of 2007, the Florida Legislature passed legislation which will require the FDOH to develop, in conjunction with input from health care groups (including the Florida Medical Association), a formal, mandatory survey of Florida's physicians beginning with the 2008 renewal cycle. Both of these new changes will be of help in analyzing the composition, practice patterns, and services of currently practicing doctors. In this paper, we will present and discuss some of the early results from the voluntary survey collected from physicians renewing their licenses in January of 2007.

Methods

The survey instrument was included in the mailing for licensure renewal to the approximately 50 percent of Florida allopathic physicians who were required to renew their license by January 31, 2007. Physician participants could respond through a Web site or by return mail. The survey process did not include physicians applying for initial licensure.

The survey itself was developed by the FDOH it conjunction with multiple partners including the Florida Medical Association, medical specialty societies, the Council of Medical School Deans, the Graduate Medical Education Committee, and other health care groups. The survey consisted of eight questions that inquired about the physician's duration of practice in a given year, their county of practice, medical specialty, level of training (resident, fellow, practicing), coverage of emergency departments, and plans to retire, relocate, or reduce their work within the next five years.

In our current analysis, we excluded physicians who did not have a practice address within Florida, those whose answer to the question on specialty-type suggested they were not in clinical practice, and those who were currently in a residency or fellowship program. Physicians who did not answer the question about training (n=313 or 2.1 percent), however, were retained since it is possible they are currently in practice. Since more than one specialty could be chosen by physician respondents, for purposes of this study, we used the specialty marked which had the highest allotment of time (usually 81-100 percent, but occasionally 61-80 percent). Using this method, we also categorized all medical specialists, all pediatric subspecialists, and all surgical specialists into unique groups. Lastly, since less than three percent of physicians answered they only worked 1 – 4 months per year in Florida the analysis includes physicians who indicated they worked in Florida for any length of time (1 – 4, 5 – 8, or 9 – 12 months).

Results

The overall response rate was 22,035 of 24,840 physicians (88.7 percent). Exclusions included: practice address not in Florida - 5,151 (23.4 percent), residents or fellows – 664 (4.1percent), and specialty code indicating no clinical practice – 70 (<1 percent). The remaining 15,518 physicians are included in the following analyses.

Table 1 *(See Tables at end of article)* shows the overall characteristics of the physician respondents. By frequency, medical specialists (14.2 percent) were the largest represented group, followed by general internal medicine (14.1 percent), surgical specialists (13.8 percent), and family medicine (11.5 percent) physicians. Overall, the mean age of respondents was 51.43 years. Approximately 78 percent were male, and the majority were White (64.6 percent). Of note, only 4.6 percent of respondents were Black, 10.9 percent Asian, and 15.0 percent indicated Hispanic ethnicity. The majority of physicians (55.5 percent) worked more than 40 hours per week in clinical care. In addition, 30.4 percent worked from 21 – 40 hours per week, and 14.1 percent worked 20 or fewer hours in their medical practice (data not shown).

Table 2 *(See Tables at end of article)* displays the number of physician respondents in medical, pediatric, and surgical specialties. As with all numbers presented in this article, it should be noted that this number represents an 88.7 percent response for one-half of the total number of licensed physicians. It is therefore difficult to extrapolate the numbers, particularly where a specialty has only a few respondents, to calculate the total number of physicians in that specialty in the state.

Table 3 *(See Tables at end of article)* shows the distribution of Florida physicians by county for the 10 largest counties (by population) in Florida. The data in this table is particularly useful when examining the relative distribution of each specialty and how it differs around the state. For example, whereas family physicians make-up 5.9 percent of doctors in Palm Beach county, there are proportionately twice as many (12.7 percent) family physicians in Miami-Dade county.

Coverage of emergency departments by physicians, by clinical specialty, is shown in Table 4. *(See Tables at end of article)* As expected, the highest percent is noted for emergency medicine physicians (88.9 percent). Of interest, among 10 clinical groups that typically take emergency calls, pediatrics (13.3 percent), and family medicine (13.5 percent) had the lowest coverage rates statewide. In the 10 large counties displayed in Table 4, the rates of emergency room coverage ranged from zero percent (0/6) for pediatric specialists in Brevard, to 100 percent (21/21) for emergency medicine doctors in Polk county. From the county standpoint, rates for emergency room coverage for these 10 clinical groups ranged from 24.9 percent in Miami-Dade, to 43.6 percent in Brevard.

Lastly, we reviewed the percent of physicians planning to leave, or significantly reduce, practice within five years (Table 5). *(See Tables at end of article)* When looking at state level data, the rates ranged from 8.4 percent for pediatric sub-specialists, >>>

to 17.8 percent for general surgeons. From a county standpoint, rates varied from 10.6 percent for Hillsborough, to 14.6 percent for Pinellas county. Individual specialty groups varied widely by county with certain specialties having no physicians indicating an intention to leave practice within five years (e.g., general surgery in Lee – 0/6; pediatric sub-specialists in Palm Beach – 0/23, Duval – 0/39, Polk – 0/6, Brevard – 0/6, and Lee – 0/6), while in other areas more than 25 percent of physicians responding to the survey suggested they will be leaving practice within five years (e.g., general surgery in Broward – 9/36, Orange - 5/20; emergency medicine in Palm Beach - 10/39, Hillsborough - 11/40).

Discussion

Information about the physician workforce is important if we, as a state, are to maximally cover the multitude of patients and their medical conditions requiring timely and complete attention. Florida has been handicapped by not having current data about the nature of the physicians practicing in the state including where they are located, what their practice type entails, the services they offer, and their future plans (e.g. retirement or decrease in clinical activity). With the passing of new legislation, this information will now be accessible in the years to come. In the interim, the voluntary physician survey that targeted those getting re-licensed in 2007 provides a glimpse into some of these important practice patterns.

Although an almost 90 percent response rate to this voluntary survey is excellent, it must be noted that the data represent an approximate 50 percent sample, not the entire population of Florida physicians. While we believe the survey provides valuable information, not previously available, we would also caution about its uses, particularly where the number of physicians in a given specialty or geographic area are small. In these cases, one cannot assume that one-half of that population was sampled. However, for larger groups and for an overall view of the physician workforce in the state several trends can be observed.

For example, the data suggest the total number of allopathic physicians who are actively practicing clinical medicine in the state is probably in the range of 34,000. This number excludes the many physicians who hold a Florida license, but do not appear to have a practice address in the state. It also excludes residents and fellows in training programs.

The mean age of the respondent physician was slightly greater than 51 years. This important demographic characteristic should be tracked over time. Over 78 percent of the practicing physicians in the study were male, a number which will likely be changing given the fact the majority of entering students in many medical schools are now female. Also noteworthy is the fact that in this study 15 percent of physicians were of Hispanic origin, but only 4.6 percent were Black physicians. Asian physicians made up almost 11 percent of the study respondents.

Much discussion has occurred around the question as to whether Florida has an adequate number of a variety of specialist physicians to meet its needs. This has been particularly true of "high-risk" specialties such as neurosurgery, trauma surgery, obstetrics, etc., since the 2003 debate on medical malpractice. Given the nature of the sampling it is difficult to know if the respondents in these specific specialties represent one-half of the total number of these much-needed specialties in Florida, and whether the estimated total number would be adequate to meet patient needs. When a similar survey is administered in the 2008 re-licensure cycle, those data can be combined with the current data to help resolve the issue about total numbers, hours worked per week in clinical practice, etc.

The same issue holds true when trying to assess the basic medical coverage needs in smaller counties and emergency rooms. While these figures show larger counties where very few physicians in particular specialties are covering emergency departments, it is hard to know whether that equates to gaps in coverage in those geographic areas. As the mandatory survey data begin to be collected yearly beginning in 2008, however, we should be able to better answer this question more accurately.

Similarly, it will be important to follow the trends related to future plans to leave or reduce practice as noted in this study. Physician respondents in certain specialties (e.g., general surgery, obstetrics/gynecology) were more than twice as likely to say they were likely to retire (or leave practice for other reasons) within five years, than others such as medical or pediatric specialists. Tracking these trends over time will be valuable to policymakers and educational leaders, particularly given the length of time, often eight or more years, needed in training to replace these physicians.

In summary, we believe the findings from this voluntary survey of Florida's physician workforce offers valuable new information that will assist leaders in the state to better plan for the needs of patients and doctors. When combined with the mandatory survey which is being planned for implementation in 2008 and beyond, these data will provide a framework upon which policymakers, educators, and professional societies such as the Florida Medical Association, can work to maximize quality care for patients.●

Table: 1 Descriptive characteristics of physicians responding to the survey

				Race/Ethnicity					
	Frequency (%)	Mean Age	% male	% White	% Hispanic	% Asian	% Black	% Native Am.	% Other
Medical specialties	2,197 (14.2%)	51.05	87.9	61.2	17.0	13.6	1.8	0.2	6.3
Internal Medicine	2,185 (14.1%)	49.57	75.6	49.1	18.5	17.4	6.3	0.1	8.5
Surgical specialties	2,162 (13.9%)	52.57	93.0	82.1	7.7	5.0	2.8	0	2.4
Family Medicine	1,779 (11.5%)	53.86	72.7	58.6	18.5	12.9	6.3	0.2	8.5
Pediatrics	1,002 (6.5%)	49.20	49.6	51.1	21.8	14.2	8.0	0.1	4.7
Anesthesiology	898 (5.8%)	49.32	79.6	66.9	14.0	9.6	4.1	0.2	5.2
Radiology	775 (5.0%)	50.96	79.7	78.3	9.9	6.6	2.1	0	3.2
Psychiatry	732 (4.7%)	55.81	71.5	60.3	17.8	13.8	3.8	0	4.4
Obstetrics/ Gynecology	720 (4.6%)	51.71	71.2	68.9	13.1	4.9	9.7	0.3	3.7
Emergency Medicine	731 (4.7%)	47.42	82.6	70.4	11.5	6.4	7.8	0.3	3.6
General Surgery	377 (2.4%)	53.78	90.4	68.9	16.9	8.3	3.1	0	2.8
Pathology	364 (2.3%)	52.91	70.5	71.9	12.6	9.3	3.1	0.3	2.8
Pediatric sub-specialty	362 (2.3%)	50.03	69.0	53.3	24.4	11.6	4.5	0	6.2
Neurology	309 (2.0%)	52.72	83.0	66.6	14.7	11.4	1.7	0.3	5.4
Dermatology	275 (1.8%)	48.96	67.8	86.6	5.2	4.4	1.8	0.4	1.8
Other	650 (4.2%)	53.84	77.3	70.7	11.4	9.5	4.3	0.3	3.8
Total	**15,518 (100%)**	**51.43**	**78.3**	**64.6**	**15.0**	**10.9**	**4.6**	**0.2**	**4.7**

Eponym trivia provided by funtrivia.com. Answers: 1. Brucellosis 2. hygiene 3. insomnia 4. arachnophobia 5. Apgar score

Table: 2 | Numbers of select medical, pediatric, and surgical specialists who responded to the survey

Medical Specialty	Survey (N=)
Cardiology	
General	621
Interventional	40
Electrophsiology	18
Gastroenterology	350
Pulmonary Diseases & critical care medicine	154
Pulmonary Medicine	81
Critical Care Medicine	43
Hematology and Oncology	188
Oncology only	47
Hematology only	23
Nephrology	159
Infectious Diseases	146
Endocrine	116
Geriatrics	101
Rheumatology	95

Pediatric Specialty	Survey (N=)
Neonatalogy	94
Adolescent Med.	38
Endocrine	35
Cardiology	34
Critical Care	34
Hematology and Oncology	29
Neurology	20
Gastroenterology	19
Nephrology	15
Infectious Diseases	13
Pulmonary	12
Developmental/ Behavioral	9
Rheumatology	3

Surgical Specialty	Survey (N=)
Opthalmology	508
Orthopedics	310
Sports Medicine	54
Adult reconst.	40
Spine	34
Hand	31
Pediatric	18
Trauma	14
Foot and ankle	5
Musculoskeletal	2
Urology	278
Plastics	249
Hand	9
Craniofacial	5
Otolaryngology	196
Neurosurgery	126
Thoracic	107
Vascular	78
Colon and rectal	33
Pediatric	24
Critical Care	12
Hand	7

Table: 3 Distribution of Florida physician respondents by county

	Top 10 Florida counties by population									
	Miami Dade	Broward	Palm Beach	Hills-borough	Pinellas	Orange	Duval	Polk	Brevard	Lee
Medical specialties	341 (13.8%)	218 (13.6%)	200 (17.0%)	160 (13.8%)	142 (16.5%)	121 (13.9%)	145 (17.7%)	38 (12.4%)	49 (11.7%)	41 (10.9%)
Internal Medicine	345 (14.0%)	237 (14.8%)	197 (16.7%)	168 (14.5%)	136 (15.8%)	108 (12.4%)	89 (10.5%)	48 (15.6%)	73 (17.4%)	61 (16.3%)
Surgical specialties	305 (12.4%)	238 (14.9%)	181 (15.4%)	157 (13.5%)	121 (14.0%)	141 (16.2%)	108 (12.7%)	37 (21.1%)	63 (15.0%)	59 (15.7%)
Family Medicine	314 (12.7%)	123 (7.7%)	69 (5.9%)	95 (8.2%)	86 (10.0%)	109 (12.5%)	103 (12.1%)	32 (10.4%)	51 (12.2%)	35 (9.3%)
Pediatrics	190 (7.7%)	99 (6.2%)	62 (5.3%)	79 (6.8%)	51 (5.9%)	66 (7.6%)	67 (7.9%)	19 (6.2%)	15 (3.6%)	26 (6.9%)
Anesthesiology	150 (6.1%)	111 (6.9%)	64 (5.4%)	83 (7.2%)	46 (5.3%)	23 (2.6%)	45 (5.3%)	19 (16.2%)	25 (6.0%)	25 (6.7%)
Radiology	100 (4.1%)	84 (5.3%)	70 (5.9%)	39 (3.4%)	49 (5.7%)	22 (2.5%)	47 (5.5%)	14 (4.6%)	19 (4.5%)	15 (4.0%)
Psychiatry	130 (5.3%)	70 (4.4%)	53 (4.5%)	65 (5.6%)	32 (3.7%)	36 (4.1%)	20 (2.4%)	17 (5.5%)	16 (3.8%)	15 (4.0%)
Obstetrics/ Gynecology	112 (4.5%)	79 (4.9%)	66 (5.6%)	63 (5.4%)	35 (4.1%)	55 (6.3%)	46 (5.4%)	12 (3.9%)	16 (3.8%)	16 (4.3%)
Emergency Medicine	86 (3.5%)	65 (4.1%)	42 (3.6%)	44 (3.8%)	44 (5.1%)	49 (5.6%)	44 (5.2%)	22 (7.2%)	25 (6.0%)	25 (6.7%)
Pediatric sub-specialty	82 (3.3%)	63 (3.9%)	20 (1.7%)	37 (3.2%)	14 (1.6%)	34 (3.9%)	23 (2.7%)	5 (1.6%)	6 (1.4%)	5 (1.3%)
General Surgery	71 (2.9%)	36 (2.3%)	24 (2.0%)	35 (3.0%)	15 (1.7%)	21 (2.4%)	15 (1.8%)	10 (3.3%)	8 (1.9%)	6 (1.6%)
Pathology	39 (1.6%)	45 (2.8%)	20 (1.7%)	45 (3.9%)	24 (2.8%)	21 (2.4%)	21 (2.5%)	8 (2.6%)	8 (1.9%)	7 (1.9%)
Neurology	48 (1.9%)	34 (2.1%)	23 (2.0%)	26 (2.2%)	17 (2.0%)	14 (1.6%)	27 (3.2%)	6 (2.0%)	9 (2.1%)	5 (1.3%)
Dermatology	40 (1.6%)	22 (1.4%)	39 (3.3%)	20 (1.7%)	17 (2.0%)	9 (1.0%)	15 (1.8%)	6 (2.0%)	6 (1.4%)	13 (3.5%)
Other	112 (4.5%)	76 (4.8%)	48 (4.1%)	44 (3.8%)	34 (3.9%)	41 (4.7%)	33 (3.9%)	14 (4.6%)	30 (7.2%)	21 (5.6%)
Total	**2465 (100%)**	**1600 (100%)**	**1178 (100%)**	**1160 (100%)**	**863 (100%)**	**870 (100%)**	**848 (100%)**	**307 (100%)**	**419 (100%)**	**375 (100%)**

Table: 4 Percent of physician respondents who indicated they cover an emergency department

	Top 10 Florida counties by population										
	Miami Dade	Broward	Palm Beach	Hills-borough	Pinellas	Orange	Duval	Polk	Brevard	Lee	State Total
Emergency Medicine	80.2%	87.7%	73.8%	90.9%	86.4%	91.7%	95.5%	100%	96.0%	92.0%	88.9
General Surgery	37.1%	58.3%	45.8%	57.1%	53.3%	65.0%	60.0%	50.0%	87.5%	66.7%	57.2
Surgical specialties	47.0%	54.4%	56.4%	59.2%	54.2%	61.0%	61.8%	59.5%	61.9%	50.0%	56.5
Medical specialties	19.4%	18.9%	17.6%	19.1%	33.3%	25.6%	28.7%	35.1%	53.1%	30.0%	25.7
Obstetrics/Gynecology	25.2%	24.1%	34.8%	19.0%	42.9%	21.8%	47.8%	33.3%	37.5%	43.8%	34.1
Pediatric sub-specialty	28.4%	33.3%	50.0%	32.4%	35.7%	31.3%	21.7%	40.0%	0	60.0%	29.5
Internal Medicine	15.2%	16.6%	19.3%	16.7%	21.3%	17.0%	23.0%	20.8%	30.6%	13.3%	20.3
Psychiatry	14.0%	14.3%	15.1%	18.5%	28.1%	8.3%	20.0%	18.8%	12.5%	6.7%	14.5
Family Medicine	13.7%	10.6%	8.7%	9.5%	5.8%	13.8%	12.6%	15.6%	15.7%	11.4%	13.5
Pediatrics	10.1%	14.1%	12.9%	6.3%	7.8%	14.1%	9.0%	21.1%	40.0%	19.2%	13.3
Average for above	**24.8%**	**29.7%**	**29.8%**	**29.0%**	**33.5%**	**32.9%**	**34.6%**	**37.8%**	**43.6%**	**33.6%**	--

Table: 5 | Percent of physician respondents planning to leave or significantly reduce practice within next five years

	Top 10 Florida counties by population										
	Miami Dade	Broward	Palm Beach	Hills-borough	Pinellas	Orange	Duval	Polk	Brevard	Lee	State Total
General Surgery	7.1	25.0	20.8	8.6	13.3	25.0	13.3	22.2	12.5	0	17.8
Obstetrics/Gynecology	15.3	15.2	21.2	21.0	17.1	11.3	13.0	8.3	6.3	12.5	16.9
Psychiatry	17.7	18.6	13.2	9.2	18.8	8.3	5.0	5.9	31.3	26.7	16.7
Emergency Medicine	9.5	17.5	24.4	29.5	11.4	8.3	14.0	4.5	12.0	12.0	15.7
Pathology	18.4	11.1	10.0	11.1	25.0	20.0	4.8	25.0	12.5	14.3	15.5
Family Medicine	14.3	20.8	7.2	12.6	14.0	13.9	13.6	12.5	14.0	20.0	14.9
Surgical specialties	18.1	11.3	15.5	6.4	14.3	18.4	17.0	22.9	13.1	12.3	14.2
Radiology	17.3	8.5	10.1	12.8	14.6	0	14.9	7.1	15.8	26.7	14.2
Neurology	10.4	8.8	18.2	3.8	17.6	7.1	18.5	16.7	0	0	13.3
Anesthesiology	11.4	8.3	12.5	15.7	22.2	4.3	13.3	21.1	20.0	12.0	13.1
Dermatology	10.0	27.7	10.3	25.0	17.6	11.1	20.0	16.7	16.7	0	11.3
Internal Medicine	13.4	14.0	8.6	8.9	15.6	7.4	8.0	2.1	5.5	8.3	10.4
Pediatrics	13.8	8.1	8.1	6.3	5.9	9.4	11.9	5.3	6.7	3.8	10.0
Medical specialties	9.7	8.8	9.0	3.8	13.5	9.1	6.2	5.3	10.2	10.0	8.8
Pediatric sub-specialty	9.9	4.8	0	13.5	14.3	3.0	0	0	0	0	8.1
Other	13.5	18.7	20.8	13.6	8.8	15.0	12.1	28.6	10.3	9.5	15.8
Total % per column	**13.5**	**12.8**	**12.3**	**10.6**	**14.6**	**11.4**	**11.5**	**11.2**	**11.6**	**11.6**	**12.9**