and includes several measures that grant parity with the other Armed Services. There are also many provisions requested by the administration regarding Law Enforcement, Marine Safety, and Environmental Protection which allow the Coast Guard to better accomplish its many missions.

This conference report was crafted in a bi-partisan fashion and it provides the Coast Guard with a solid foundation to do its job. I thank all of the Members who have actively participated in its development. I am proud to give the Coast Guard my full support, and the resources it needs to carry out its many essential missions.

Mr. MCCONNELL. Mr. President, I ask unanimous consent that the conference report be agreed to, the motion to reconsider be laid upon the table, and any statements relating to the conference report be printed in the RECORD.

The PRESIDING OFFICER. Without objection, it is so ordered.

The conference report was agreed to.

PRESERVING THE ABILITY OF THE FEDERAL HOUSING ADMINISTRATION TO INSURE MORTGAGES

Mr. MCCONNELL. Mr. President, I ask unanimous consent that the Banking Committee be discharged from further consideration of S. 2712 and the Senate then proceed to its consideration.

The PRESIDING OFFICER. Without objection, it is so ordered. The clerk will report the bill by title.

The legislative clerk read as follows:

A bill (S. 2712) to preserve the ability of the Federal Housing Administration to insure mortgages under sections 238 and 519 of the National Housing Act.

There being no objection, the Senate proceeded to consider the bill.

Mr. MCCONNELL. Mr. President, I ask unanimous consent that the bill be read a third time, passed, the motion to reconsider be laid upon the table, and that any statements relating to the bill be printed in the RECORD, without intervening action or debate.

The PRESIDING OFFICER. Without objection, it is so ordered.

The bill (S. 2712) was read the third time and passed, as follows:

S. 2712

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. AMENDMENT TO GENERAL AND SPECIAL RISK PROGRAM ACCOUNT.

Under the heading ''FEDERAL HOUSING ADMINISTRATION—GENERAL AND SPECIAL RISK PROGRAM ACCOUNT'' in title II of Division G of the Consolidated Appropriations Act, 2004 (Public Law 108–199), in the first proviso, strike ''$25,000,000,000'' and insert ''$29,000,000,000''.

Mr. MCCONNELL. Mr. President, I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The legislative clerk proceeded to call the roll.

Mr. FRIST. Mr. President, I ask unanimous consent the order for the quorum call be rescinded.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. FRIST. Mr. President, we have actually a lot of business that we are doing and wrapping up for the night. In fact, we are going on recess for the conventions for the next several weeks. Most of the business has been completed, but there will be a lot of very important business that we will be conducting over the next several hours, but we will get it done tonight.

This particular piece of business has to do with patient safety. For me, it means a lot because I can see up close both the importance of this legislation, and have watched it legislatively as it has traveled through its various iterations. So to be able to propound this unanimous consent request is something that we can briefly comment on shortly.

PATIENT SAFETY AND QUALITY IMPROVEMENT ACT OF 2003

Mr. FRIST. Mr. President, I ask unanimous consent the Senate now proceed to consideration of Calendar No. 387, S. 720.

The PRESIDING OFFICER. The clerk will report the bill by title.

The legislative clerk read as follows:

A bill (S. 720) to amend title IX of the Public Health Service Act to provide for the improvement of patient safety and to reduce the incidence of events that adversely affect patient safety.

There being no objection, the Senate proceeded to consider the bill which had been reported from the Committee on Health, Education, Labor, and Pensions, with an amendment to strike all after the enacting clause and insert in lieu thereof the following:

(Strike the part shown in black brackets and insert the part shown in italic.)

S. 720

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

[SECTION 1. SHORT TITLE.

[This Act may be cited as the ''Patient Safety and Quality Improvement Act''.

[SEC. 2. FINDINGS AND PURPOSES.

[(a) FINDINGS.—Congress makes the following findings:

[(1) In 1999, the Institute of Medicine released a report entitled To Err is Human that described medical errors as the eighth leading cause of death in the United States, with as many as 98,000 people dying as a result of medical errors each year.

[(2) To address these deaths and injuries due to medical errors, the health care system must identify and learn from such errors so that systems of care can be improved.

[(3) In their report, the Institute of Medicine called on Congress to provide legal protections with respect to information reported for the purposes of quality improvement and patient safety.

[(4) The Health, Education, Labor, and Pensions Committee of the Senate held 4 hearings in the 106th Congress and 1 hearing in the 107th Congress on patient safety where experts in the field supported the recommendation of the Institute of Medicine for congressional action.

[(5) Myriad public and private patient safety initiatives have begun. The Quality Interagency Coordination Taskforce has recommended steps to improve patient safety that may be taken by each Federal agency involved in health care and activities relating to these steps are ongoing.

[(6) The research on patient safety unequivocally calls for a learning environment, rather than a punitive environment, in order to improve patient safety.

[(7) Voluntary data gathering systems are more supportive than mandatory systems in creating the learning environment referred to in paragraph (5) as stated in the Institute of Medicine's report.

[(8) Promising patient safety reporting systems have been established throughout the United States and the best ways to structure and use these systems are currently being determined, largely through projects funded by the Agency for Healthcare Research and Quality.

[(9) The Department of Health and Human Services has initiated several patient safety projects. The Joint Commission on Accreditation of Healthcare Organizations issued a patient safety standard that went into effect on July 1, 2001, and the peer review organizations are conducting ongoing studies of clinical performance measurement of care delivered to beneficiaries under the medicare program under title XVIII of the Social Security Act.

[(10) Many organizations currently collecting patient safety data have expressed a need for legal protections that will allow them to review protected information so that they may collaborate in the development and implementation of patient safety improvement strategies. Currently, the State peer review protections provide inadequate conditions to allow the sharing of information to promote patient safety.

[(11) In 2001, the Institute of Medicine released a report entitled Crossing the Quality Chasm that found that the United States health care system does not consistently deliver high quality care to patients.

[(b) PURPOSES.—It is the purpose of this Act to—

[(1) encourage a culture of safety and quality in the United States health care system by providing for legal protection of information reported voluntarily for the purposes of quality improvement and patient safety; and

[(2) ensure accountability by raising standards and expectations for continuous quality improvements in patient safety through the actions of the Secretary of Health and Human Services.

[SEC. 3. AMENDMENTS TO PUBLIC HEALTH SERVICE ACT.

[Title IX of the Public Health Service Act (42 U.S.C. 299 et seq.) is amended—

[(1) in section 912(c), by inserting '', in accordance with part C,'' after ''The Director shall'';

[(2) by redesignating part C as part D;

[(3) by redesignating sections 921 through 928, as sections 931 through 938, respectively;

[(4) in section 938(1) (as so redesignated), by striking ''921'' and inserting ''931''; and

[(5) by inserting after part B the following:

["PART C—PATIENT SAFETY IMPROVEMENT

["SEC. 921. DEFINITIONS.

[''In this part:

[''(1) NON-IDENTIFIABLE INFORMATION.—The term 'non-identifiable information' means information that is presented in a form and manner that prevents the identification of any provider, patient, and the reporter of patient safety data.

[''(2) PATIENT SAFETY DATA.—The term 'patient safety data' means—

[''(A) any data, reports, records, memoranda, analyses, deliberative work, statements, root cause analyses, or quality improvement processes that could result in improved patient safety or health care quality, that are—

[''(i) collected or developed by a provider for the purpose of reporting to a patient safety organization;

[''(ii) reported to a patient safety organization for patient safety or quality improvement processes;

[''(iii) requested by a patient safety organization (including the contents of such request);

[''(iv) reported to a provider by a patient safety organization;

[''(v) collected or developed by a patient safety organization; or

[''(vi) reported among patient safety organizations, after obtaining authorization; or

[''(B) information related to corrective actions taken in response to patient safety data;

for the purpose of improving patient safety, health care quality, or health care outcomes.

[''(3) PATIENT SAFETY ORGANIZATION.—The term 'patient safety organization' means a private or public organization or component thereof that performs the following activities (which are deemed to be necessary for the proper management and administration of such organization or component thereof):

[''(A) The conduct, as its primary activity, of efforts to improve patient safety and the quality of health care delivery.

[''(B) The collection and analysis of patient safety data that are voluntarily submitted by a provider.

[''(C) The development and dissemination of information to providers with respect to improving patient safety, such as recommendations, protocols, or information regarding best practices.

[''(D) The utilization of patient safety data to carry out activities under this paragraph and for the purposes of encouraging a culture of safety and of providing direct feedback and assistance to providers to effectively minimize patient risk.

[''(E) The maintenance of confidentiality with respect to individually identifiable health information.

[''(F) The provision of appropriate security measures with respect to patient safety data.

[''(G) The certification to the Agency that the patient safety organization satisfies the criteria of this paragraph for the period in which the organization is carrying out such duties.

[''(4) PROVIDER.—The term 'provider' means—

[''(A) a provider of services (as defined in section 1861(u) of the Social Security Act) and a person furnishing any medical or other health care services (as defined in section 1861(s)(1) and (2) of such Act) through, or under the authority of, such a provider of services;

[''(B) a physician (as defined in section 1861(r) of such Act);

[''(C) any other person, including a pharmacist, who is engaged in the delivery of medical or other health services (as defined in section 1861(s)(1) and (2) of such Act) in a State and who is required by State law or regulation to be licensed or certified by the State to engage in the delivery of such services in the State;

[''(D) a renal dialysis facility, ambulatory surgical center, pharmacy, physician or health care practitioner's office, long term care facility, behavioral health residential treatment facility, or clinical laboratory; or

[''(E) any other person or entity specified in regulations by the Secretary after public notice and comment.

[''SEC. 922. CONFIDENTIALITY AND PEER REVIEW PROTECTIONS.

[''(a) IN GENERAL.—Notwithstanding any other provision of law, and subject to this section, patient safety data shall be privileged and confidential.

[''(b) SCOPE OF PRIVILEGE.—Subject to the provisions of subsection (c), patient safety data to which subsection (a) applies shall not be—

[''(1) subject to a civil, criminal, or administrative subpoena;

[''(2) subject to discovery in connection with a civil, criminal, or administrative proceeding;

[''(3) disclosed pursuant to section 552 of title 5, United States Code (commonly known as the Freedom of Information Act) or any other similar Federal or State law;

[''(4) admitted as evidence or otherwise disclosed in any civil, criminal, or administrative proceeding; or

[''(5) utilized in an adverse employment action or in the evaluation of decisions made in relation to accreditation, certification, credentialing or licensing of an individual, that is based on such individual's participation in the development, collection, reporting, or storage of patient safety data in accordance with this part.

[''(c) DISCLOSURE REQUIREMENTS.—Nothing in this section shall be construed to prohibit one or more of the following disclosures (which are deemed to be necessary for the proper management and administration of the patient safety organization):

[''(1) Disclosures by a provider in complying with authorized requests for the provision of information to which subsection (a) applies (such as a patient's medical record or other relevant information) that is in the control of such a provider and that has been developed, maintained, or exists separately from the process by which the provider collects or develops information for reporting to a patient safety organization.

[''(2) Disclosures by a provider or patient safety organization of patient safety data as part of a disciplinary proceeding relating to a provider, or a criminal proceeding, if such a disclosure of such patient safety data is—

[''(A) material to the proceeding;

[''(B) within the public interest; and

[''(C) not available from any other source.

[''(3) Disclosures by a provider or patient safety organization of relevant information to the Food and Drug Administration, or to a person that is subject to the jurisdiction of such Administration, with respect to an Administration-regulated product or activity for which that entity has responsibility, for the purposes of activities related to the quality, safety, or effectiveness of such Administration-regulated product or activity, subject to section 520(c) of the Federal Food, Drug, and Cosmetic Act.

[''(4) Disclosures by a provider or patient safety organization of information to which subsection (a) applies to carry out activities described in paragraph (2)(A) (i) through (vi) or (3) of section 921.

[''(d) TRANSFER OF INFORMATION.—The transfer of any patient safety data by a provider to a patient safety organization shall not be treated as a waiver of any privilege or protection established under this part or established under State law.

[''(e) PENALTY.—Except as provided in subsection (c) and as otherwise provided for in this section, it shall be unlawful for any person to disclose any patient safety data described in subsection (a). Any person violating the provisions of this section shall, upon conviction, be fined in accordance with section 934(d).

[''(f) NO LIMITATION OF OTHER PRIVILEGES.—Nothing in this section shall be construed to limit other privileges that are available under Federal or State laws that provide greater peer review or confidentiality protections than the peer review and confidentiality protections provided for in this section.

[''(g) RULE OF CONSTRUCTION.—Nothing in this section shall be construed to alter or affect the implementation of any provision of section 264(c) of the Health Insurance Portability and Accountability Act of 1996 (Public Law 104–191; 110 Stat. 2033) or any regulation promulgated under such section.

[''SEC. 923. NATIONAL DATABASE.

[''(a) AUTHORITY.—

[''(1) IN GENERAL.—In conducting activities under this part, the Secretary may provide for the establishment and maintenance of a database to receive relevant non-identifiable patient safety data, or may designate entities to collect relevant non-identifiable patient safety data, that is voluntarily reported by patient safety organizations upon the request of the Secretary.

[''(2) USE OF DATA.—Data reported to any database established or designated under paragraph (1) shall be used to analyze regional variations and national statistics related to patient safety and health care quality. The information resulting from such analyses may be included in the annual quality reports prepared under section 913(b)(2).

[''(b) STANDARDS.—In developing or designating a database under subsection (a)(1), the Secretary may determine common formats for the voluntary reporting of non-identifiable patient safety data, including necessary data elements, common and consistent definitions, and a standardized computer interface for the processing of such data. To the extent practicable, such standards shall be consistent with the administrative simplification provisions of part C of title XI of the Social Security Act.

[''(c) CONFIDENTIALITY.—Any non-identifiable patient safety data that is transferred to the database under this section shall be privileged and confidential.

[''SEC. 924. TECHNICAL ASSISTANCE.

[''The Secretary, acting through the Director, may provide technical assistance to patient safety organizations. Such assistance shall include annual meetings for patient safety organizations to discuss methodology, communication, data collection, or privacy concerns.

[''SEC. 925. PROMOTING THE INTEGRATION OF HEALTH CARE INFORMATION TECHNOLOGY SYSTEMS.

[''(a) DEVELOPMENT.—Not later than 36 months after the date of enactment of the Patient Safety and Quality Improvement Act, the Secretary shall develop or adopt voluntary national standards that promote the integration of health care information technology systems.

[''(b) UPDATES.—The Secretary shall provide for the ongoing review and periodic updating of the standards developed under subsection (a).

[''(c) DISSEMINATION.—The Secretary shall provide for the dissemination of the standards developed and updated under this section.

[''SEC. 926. AUTHORIZATION OF APPROPRIATIONS.

[''There is authorized to be appropriated such sums as may be necessary to carry out this part.''.

[SEC. 4. STUDIES AND REPORTS.

[(a) MEDICAL TECHNOLOGIES AND THERAPIES.—

[(1) IN GENERAL.—The Secretary of Health and Human Services shall enter into a contract with an appropriate research organization for the conduct of a study to assess the impact of medical technologies and therapies on patient safety, patient benefit, health

care quality, and the costs of care as well as productivity growth. Such study shall determine—

[(A) the extent to which the current health care system's use of labor versus the use of technology has contributed to increases in the share of the gross domestic product that is devoted to health care and the impact of medical technologies and therapies on such increases;

[(B) the extent to which early and appropriate introduction and integration of innovative medical technologies and therapies may affect the overall productivity and quality of the health care delivery systems of the United States; and

[(C) the relationship of such medical technologies and therapies to patient safety, patient benefit, health care quality, and cost of care.

[(2) REPORT.—Not later than 18 months after the date of enactment of this Act, the Secretary of Health and Human Services shall prepare and submit to the appropriate committees of Congress a report containing the results of the study conducted under paragraph (1).

[(b) STATE LAWS RELATING TO PATIENT SAFETY PEER REVIEW SYSTEMS.—

[(1) SURVEY.—The Attorney General shall conduct a survey of State laws that relate to patient safety data peer review systems, including laws that establish an evidentiary privilege applicable to data developed by such systems, and shall review the manner in which such laws have been interpreted by the courts.

[(2) REPORT.—Not later than 9 months after the date of enactment of this Act, the Attorney General shall prepare and submit to the Committee on Health, Education, Labor, and Pensions of the Senate and the Committee on Energy and Commerce of the House of Representatives, a report concerning the results of the survey conducted under paragraph (1).]

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Patient Safety and Quality Improvement Act of 2003''.

SEC. 2. FINDINGS AND PURPOSES.

(a) FINDINGS.—Congress makes the following findings:

(1) In 1999, the Institute of Medicine released a report entitled To Err is Human that described medical errors as the eighth leading cause of death in the United States, with as many as 98,000 people dying as a result of medical errors each year.

(2) To address these deaths and injuries due to medical errors, the health care system must identify and learn from such errors so that systems of care can be improved.

(3) In their report, the Institute of Medicine called on Congress to provide legal protections with respect to information reported for the purposes of quality improvement and patient safety.

(4) The Health, Education, Labor, and Pensions Committee of the Senate held 4 hearings in the 106th Congress and 1 hearing in the 107th Congress on patient safety where experts in the field supported the recommendation of the Institute of Medicine for congressional action.

(5) Myriad public and private patient safety initiatives have begun. The Quality Interagency Coordination Taskforce has recommended steps to improve patient safety that may be taken by each Federal agency involved in health care and activities relating to these steps are ongoing.

(6) The research on patient safety unequivocally calls for a learning environment, rather than a punitive environment, in order to improve patient safety.

(7) Voluntary data gathering systems are more supportive than mandatory systems in creating the learning environment referred to in paragraph (6) as stated in the Institute of Medicine's report.

(8) Promising patient safety reporting systems have been established throughout the United States and the best ways to structure and use these systems are currently being determined, largely through projects funded by the Agency for Healthcare Research and Quality.

(9) Many organizations currently collecting patient safety data have expressed a need for legal protections that will allow them to review protected information and collaborate in the development and implementation of patient safety improvement strategies. Currently, the State peer review protections are inadequate to allow the sharing of information to promote patient safety.

(b) PURPOSES.—It is the purpose of this Act to—

(1) encourage a culture of safety and quality in the United States health care system by providing for legal protection of information reported voluntarily for the purposes of quality improvement and patient safety; and

(2) ensure accountability by raising standards and expectations for continuous quality improvements in patient safety.

SEC. 3. AMENDMENTS TO PUBLIC HEALTH SERVICE ACT.

Title IX of the Public Health Service Act (42 U.S.C. 299 et seq.) is amended—

(1) in section 912(c), by inserting '', in accordance with part C,'' after ''The Director shall'';

(2) by redesignating part C as part D;

(3) by redesignating sections 921 through 928, as sections 931 through 938, respectively;

(4) in 934(d) (as so redesignated), by striking the second sentence and inserting the following: ''Penalties provided for under this section shall be imposed and collected by the Secretary using the administrative and procedural processes used to impose and collect civil money penalties under section 1128A of the Social Security Act (other than subsections (a) and (b), the second sentence of subsection (f), and subsections (i), (m), and (n)), unless the Secretary determines that a modification of procedures would be more suitable or reasonable to carry out this subsection and provides for such modification by regulation.'';

(5) in section 938(1) (as so redesignated), by striking ''921'' and inserting ''931''; and

(6) by inserting after part B the following:

''PART C—PATIENT SAFETY IMPROVEMENT

''SEC. 921. DEFINITIONS.

''In this part:

''(1) NON-IDENTIFIABLE INFORMATION.—

''(A) IN GENERAL.—The term 'non-identifiable information' means information that is presented in a form and manner that prevents the identification of a provider, a patient, or a reporter of patient safety data.

''(B) IDENTIFIABILITY OF PATIENT.—For purposes of subparagraph (A), the term 'presented in a form and manner that prevents the identification of a patient' means, with respect to information that has been subject to rules promulgated pursuant to section 264(c) of the Health Insurance Portability and Accountability Act of 1996 (42 U.S.C. 1320d–2 note), that the information has been de-identified so that it is no longer individually identifiable health information as defined in such rules.

''(2) PATIENT SAFETY DATA.—

''(A) IN GENERAL.—The term 'patient safety data' means—

''(i) any data, reports, records, memoranda, analyses (such as root cause analyses), or statements that could result in improved patient safety or health care quality or health care outcomes, that are—

''(I) collected or developed by a provider for reporting to a patient safety organization, provided that they are reported to the patient safety organization within a reasonable period of time;

''(II) requested by a patient safety organization (including the contents of such request);

''(III) reported to a provider by a patient safety organization; or

''(IV) collected from a provider or patient safety organization or developed by a patient safety organization; or

''(ii) any deliberative work or process or oral communications with respect to any patient safety data described in clause (i).

''(B) LIMITATION.—The term 'patient safety data' shall not include information (including a patient's medical record) that is collected or developed separately from and that exists separately from patient safety data. Such separate information or a copy thereof submitted to a patient safety organization shall not itself be considered as patient safety data.

''(3) PATIENT SAFETY ORGANIZATION.—The term 'patient safety organization' means a private or public organization or component thereof that performs all of the following activities (which are deemed to be necessary for the proper management and administration of such organization or component thereof), and that is currently listed by the Secretary as a patient safety organization pursuant to section 924(c):

''(A) The conduct, as its primary activity, of efforts to improve patient safety and the quality of health care delivery.

''(B) The collection and analysis of patient safety data that are submitted by more than one provider.

''(C) The development and dissemination of information to providers with respect to improving patient safety, such as recommendations, protocols, or information regarding best practices.

''(D) The utilization of patient safety data for the purposes of encouraging a culture of safety and of providing direct feedback and assistance to providers to effectively minimize patient risk.

''(E) The maintenance of a process to preserve confidentiality with respect to the information that is not non-identifiable.

''(F) The provision of appropriate security measures with respect to patient safety data.

''(G) The submittal to the Secretary of a certification pursuant to section 924.

''(4) PROVIDER.—The term 'provider' means—

''(A) a person licensed or otherwise authorized under State law to provide health care services, including—

''(i) a hospital, nursing facility, comprehensive outpatient rehabilitation facility, home health agency, hospice program, renal dialysis facility, ambulatory surgical center, pharmacy, physician or health care practitioner's office, long term care facility, behavior health residential treatment facility, clinical laboratory, or health center; or

''(ii) a physician, physician assistant, nurse practitioner, clinical nurse specialist, certified registered nurse anesthetist, certified nurse midwife, psychologist, certified social worker, registered dietitian or nutrition professional, physical or occupational therapist, pharmacist, or other individual health care practitioner; or

''(B) any other person specified in regulations promulgated by the Secretary.

''SEC. 922. PRIVILEGE AND CONFIDENTIALITY PROTECTIONS.

''(a) PRIVILEGE.—Notwithstanding any other provision of Federal, State, or local law, patient safety data shall be privileged and, subject to the provisions of subsection (c), shall not be—

''(1) subject to a Federal, State, or local civil, criminal, or administrative subpoena;

''(2) subject to discovery in connection with a Federal, State, or local civil, criminal, or administrative proceeding;

''(3) disclosed pursuant to section 552 of title 5, United States Code (commonly known as the Freedom of Information Act) or any other similar Federal, State, or local law;

''(4) admitted as evidence or otherwise disclosed in any Federal, State, or local civil, criminal, or administrative proceeding; or

''(5) utilized in a disciplinary proceeding against a provider.

''(b) CONFIDENTIALITY.—Notwithstanding any other provision of Federal, State, or local law, and subject to the provisions of subsections (c) and (d), patient safety data shall be confidential and shall not be disclosed.

''(c) EXCEPTIONS TO PRIVILEGE AND CONFIDENTIALITY.—Nothing in this section shall be construed to prohibit one or more of the following uses or disclosures:

''(1) Disclosure by a provider or patient safety organization of relevant patient safety data for use in a criminal proceeding only after a court makes an in camera determination that such patient safety data contains evidence of an intentional act to directly harm the patient.

''(2) Voluntary disclosure by a provider or patient safety organization of information to the Food and Drug Administration, or to a person that is subject to the jurisdiction of the Food and Drug Administration, with respect to a Food and Drug Administration-regulated product or activity for which that entity has responsibility, for the purposes of activities related to the quality, safety, or effectiveness of a Food and Drug Administration-regulated product or activity or a Food and Drug Administration proceeding.

''(3) Voluntary disclosure of non-identifiable patient safety data by a provider or a patient safety organization.

''(4) Voluntary disclosure by a provider of patient safety data to the Centers for Disease Control and Prevention for public health surveillance, investigation, or other public health activities.

''(d) PROTECTED DISCLOSURE AND USE OF INFORMATION.—Nothing in this section shall be construed to prohibit one or more of the following uses or disclosures:

''(1) Disclosure by a provider or patient safety organization of information to which subsections (a) or (b) applies to carry out activities described in paragraph (2) or (3) of section 921.

''(2) Use or disclosure by a provider or patient safety organization of patient safety data in connection with providing treatment, improving patient safety, health care quality or administrative efficiency, or any other customary activity of the provider or in obtaining payment.

''(3) Disclosure of patient safety data among patient safety organizations.

''(4) Disclosure of patient safety data by a provider or patient safety organization to grantees or contractors carrying out patient safety research, evaluation, or demonstration projects authorized by the Director.

''(5) Disclosure of patient safety data by a provider to an accrediting body that accredits that provider.

''(e) CONTINUED PROTECTION OF INFORMATION.—Patient safety data used or disclosed in accordance with subsection (d) shall continue to be privileged and confidential in accordance with subsections (a) and (b) and shall not be disclosed—

''(1) by an entity that possessed such information before such use or disclosure; or

''(2) by an entity to which the information was disclosed;

unless such additional disclosure is permitted under subsection (d).

''(f) LIMITATION ON ACTIONS.—

''(1) PATIENT SAFETY ORGANIZATIONS.—Except as provided in subsection (c), no action may be brought or process served against a patient safety organization to compel disclosure of information collected or developed under this part whether or not such information is patient safety data.

''(2) PROVIDERS.—An accrediting body shall not take an accrediting action against a provider based on the good faith participation of the provider in the collection, development, reporting, or maintenance of patient safety data in accordance with this part. An accrediting body may not require a provider to reveal its communications with any patient safety organization established in accordance with this part.

''(g) DISCLOSURE OR USE OF INFORMATION.—

''(1) IN GENERAL.—Except with respect to the specific patient safety data that is used or disclosed, the disclosure or use of any patient safety data in accordance with subsection (c) or (d) shall not be treated as a waiver of any privilege or protection established under this part.

''(2) INADVERTENT DISCLOSURE OR USE.—The inadvertent disclosure or use of patient safety data shall not waive any privilege or protection established under this part with respect to such data.

''(h) REPORTER PROTECTION.—

''(1) IN GENERAL.—A provider may not take an adverse employment action, as described in paragraph (2), against an individual based upon the fact that the individual in good faith reported information—

''(A) to the provider with the intention of having the information reported to a patient safety organization; or

''(B) directly to a patient safety organization.

''(2) ADVERSE EMPLOYMENT ACTION.—For purposes of this subsection, an 'adverse employment action' includes—

''(A) loss of employment, the failure to promote an individual, or the failure to provide any other employment-related benefit for which the individual would otherwise be eligible; or

''(B) an adverse evaluation or decision made in relation to accreditation, certification, credentialing, or licensing of the individual.

''(i) ENFORCEMENT.—

''(1) PROHIBITION.—Except as provided in subsections (c) and (d) and as otherwise provided for in this section, it shall be unlawful for any person to negligently or intentionally disclose any patient safety data described in subsection (a) and any such person shall, upon adjudication, be assessed in accordance with section 934(d).

''(2) RELATION TO HIPAA.—The penalty provided for under paragraph (1) shall not apply if the defendant would otherwise be subject to a penalty under the regulations promulgated under section 264(c) of the Health Insurance Portability and Accountability Act of 1996 (42 U.S.C. 1320d–2 note) or under section 1176 of the Social Security Act (42 U.S.C. 1320d–5) for the same disclosure.

''(3) EQUITABLE RELIEF.—Without limiting remedies available to other parties, a civil action may be brought by any aggrieved individual to enjoin any act or practice that violates subsection (h) and to obtain other appropriate equitable relief (including reinstatement, back pay, and restoration of benefits) to redress such violation.

''(4) ACTIONS AGAINST STATE EMPLOYEES.—Notwithstanding subsection (a), with respect to a State employer, the privilege described in such subsection shall not apply to such employer unless the employer consents, in advance, to be subject to a civil action under paragraph (3).

''(j) RULE OF CONSTRUCTION.—Nothing in this section shall be construed to—

''(1) limit other privileges that are available under Federal, State, or local laws that provide greater confidentiality protections or privileges than the privilege and confidentiality protections provided for in this section;

''(2) limit, alter, or affect the requirements of Federal, State, or local law pertaining to patient-related data that is not privileged or confidential under this section;

''(3) alter or affect the implementation of any provision of section 264(c) of the Health Insurance Portability and Accountability Act of 1996 (Public Law 104–191; 110 Stat. 2033), section 1176 of the Social Security Act (42 U.S.C. 1320d–5), or any regulation promulgated under such sections;

''(4) limit the authority of any provider, patient safety organization, or other person to enter into a contract requiring greater confidentiality or delegating authority to make a disclosure or use in accordance with subsection (c) or (d); and

''(5) prohibit a provider from reporting crime to law enforcement authorities.

"SEC. 923. PATIENT SAFETY NETWORK OF DATABASES.

''(a) IN GENERAL.—The Secretary shall maintain a patient safety network of databases that provides an interactive evidence-based management resource for providers, patient safety organizations, and other persons. The network of databases shall have the capacity to accept, aggregate, and analyze nonidentifiable patient safety data voluntarily reported by patient safety organizations, providers, or other persons.

''(b) NETWORK OF DATABASE STANDARDS.—The Secretary may determine common formats for the reporting to the patient safety network of databases maintained under subsection (a) of nonidentifiable patient safety data, including necessary data elements, common and consistent definitions, and a standardized computer interface for the processing of such data. To the extent practicable, such standards shall be consistent with the administrative simplification provisions of part C of title XI of the Social Security Act.

"SEC. 924. PATIENT SAFETY ORGANIZATION CERTIFICATION AND LISTING.

''(a) CERTIFICATION.—

''(1) INITIAL CERTIFICATION.—Except as provided in paragraph (2), an entity that seeks to be a patient safety organization shall submit an initial certification to the Secretary that the entity intends to perform the activities described in subparagraphs (A) through (F) of section 921(3).

''(2) DELAYED CERTIFICATION OF COLLECTION FROM MORE THAN ONE PROVIDER.—An entity that seeks to be a patient safety organization may—

''(A) submit an initial certification that it intends to perform the activities described in subparagraph (A) through (F) of section 921(3) other than the activities described in subparagraph (B) of such section; and

''(B) within 2 years of submitting the initial certification under subparagraph (A), submit a supplemental certification that it performs the activities described in section 921(3)(B).

''(3) EXPIRATION AND RENEWAL.—

''(A) EXPIRATION.—An initial certification under paragraph (1) or (2)(A) shall expire on the date that is 3 years after it is submitted.

''(B) RENEWAL.—

''(i) IN GENERAL.—An entity that seeks to remain a patient safety organization after the expiration of an initial certification under paragraph (1) or (2)(A) shall, within the 3-year period described in subparagraph (A), submit a renewal certification to the Secretary that the entity satisfies the criteria described in subparagraph (A) through (F) of section 921(3).

''(ii) TERM OF RENEWAL.—A renewal certification under clause (i) shall expire on the date that is 3 years after that date on which it is submitted, and may be renewed in the same manner as an initial certification.

''(b) ACCEPTANCE OF CERTIFICATION.—Upon the submission by an organization of an initial certification pursuant to subsection (a)(1) or (a)(2)(A), a supplemental certification pursuant to subsection (a)(2)(B), or a renewal certification pursuant to subsection (a)(3)(B), the Secretary shall review such certification and—

''(1) if such certification meets the requirements of subsection (a)(1) or (a)(2)(A), (a)(2)(B), or (a)(3)(B), as applicable, the Secretary shall notify the organization that such certification is accepted; or

''(2) if such certification does not meet such requirements, as applicable, the Secretary shall notify the organization that such certification is not accepted and the reasons therefore.

''(c) LISTING.—

''(1) IN GENERAL.—Except as otherwise provided in this subsection, the Secretary shall compile and maintain a current listing of patient safety organizations with respect to which the Secretary has accepted a certification pursuant to subsection (b).

''(2) REMOVAL FROM LISTING.—The Secretary shall remove from the listing under paragraph (1)—

''(A) an entity with respect to which the Secretary has accepted an initial certification pursuant to subsection (a)(2)(A) and which does not submit a supplemental certification pursuant to subsection (a)(2)(B) that is accepted by the Secretary;

''(B) an entity whose certification expires and which does not submit a renewal application that is accepted by the Secretary; and

''(C) an entity with respect to which the Secretary revokes the Secretary's acceptance of the entity's certification, pursuant to subsection (d).

''(d) REVOCATION OF ACCEPTANCE.—

''(1) IN GENERAL.—Except as provided in paragraph (2), if the Secretary determines that a patient safety organization does not perform any activity described in subparagraph (A) through (F) of section 921(3), the Secretary may, after notice and an opportunity for a hearing, revoke the Secretary's acceptance of the certification of such organization.

''(2) DELAYED CERTIFICATION OF COLLECTION FROM MORE THAN ONE PROVIDER.—A revocation under paragraph (1) may not be based on a determination that the organization does not perform the activity described in section 921(3)(B) if—

''(A) the listing of the organization is based on its submittal of an initial certification under subsection (a)(2)(A);

''(B) the organization has not submitted a supplemental certification under subsection (a)(2)(B); and

''(C) the 2-year period described in subsection (a)(2)(B) has not expired.

''(e) NOTIFICATION OF REVOCATION OR REMOVAL FROM LISTING.—

''(1) SUPPLYING CONFIRMATION OF NOTIFICATION TO PROVIDERS.—Within 15 days of a revocation under subsection (d)(1), a patient safety organization shall submit to the Secretary a confirmation that the organization has taken all reasonable actions to notify each provider whose patient safety data is collected or analyzed by the organization of such revocation.

''(2) PUBLICATION.—Upon the revocation of an acceptance of an organization's certification under subsection (d)(1), or upon the removal of an organization from the listing under subsection (c)(2), the Secretary shall publish notice of the revocation or removal in the Federal Register.

''(f) STATUS OF DATA AFTER REMOVAL FROM LISTING.—

''(1) NEW DATA.—With respect to the privilege and confidentiality protections described in section 922, data submitted to an organization within 30 days after the organization is removed from the listing under subsection (c)(2) shall have the same status as data submitted while the organization was still listed.

''(2) PROTECTION TO CONTINUE TO APPLY.—If the privilege and confidentiality protections described in section 922 applied to data while an organization was listed, or during the 30-day period described in paragraph (1), such protections shall continue to apply to such data after the organization is removed from the listing under subsection (c)(2).

''(g) DISPOSITION OF DATA.—If the Secretary revokes the acceptance of an organization's certification under subsection (d)(1) and removes the organization from the listing as provided for in subsection (c)(2), with respect to the patient safety data that the organization received from providers, the organization shall—

''(1) with the approval of the provider and another patient safety organization, transfer such data to such other organization;

''(2) return such data to the provider of that patient safety data; or

''(3) if returning such data to the provider is not practicable, destroy such data.

''SEC. 925. TECHNICAL ASSISTANCE.

''The Secretary, acting through the Director, may provide technical assistance to patient safety organizations, including annual meetings for patient safety organizations to discuss methodology, communication, data collection, or privacy concerns.

''SEC. 926. PROMOTING THE INTEROPERABILITY OF HEALTH CARE INFORMATION TECHNOLOGY SYSTEMS.

''(a) DEVELOPMENT.—Not later than 36 months after the date of enactment of the Patient Safety and Quality Improvement Act of 2003, the Secretary shall develop or adopt voluntary national standards that promote the electronic exchange of health care information.

''(b) UPDATES.—The Secretary shall provide for the ongoing review and periodic updating of the standards developed under subsection (a).

''(c) DISSEMINATION.—The Secretary shall provide for the dissemination of the standards developed and updated under this section.

''SEC. 927. AUTHORIZATION OF APPROPRIATIONS.

''There is authorized to be appropriated such sums as may be necessary to carry out this part.''.

SEC. 4. STUDIES AND REPORTS.

(a) IN GENERAL.—The Secretary of Health and Human Services shall enter into a contract (based upon a competitive contracting process) with an appropriate research organization for the conduct of a study to assess the impact of medical technologies and therapies on patient safety, patient benefit, health care quality, and the costs of care as well as productivity growth. Such study shall examine—

(1) the extent to which factors, such as the use of labor and technological advances, have contributed to increases in the share of the gross domestic product that is devoted to health care and the impact of medical technologies and therapies on such increases;

(2) the extent to which early and appropriate introduction and integration of innovative medical technologies and therapies may affect the overall productivity and quality of the health care delivery systems of the United States; and

(3) the relationship of such medical technologies and therapies to patient safety, patient benefit, health care quality, and cost of care.

(b) REPORT.—Not later than 18 months after the date of enactment of this Act, the Secretary of Health and Human Services shall prepare and submit to the appropriate committees of Congress a report containing the results of the study conducted under subsection (a).

Mr. KENNEDY. Mr. President, I commend Senator GREGG, Senator JEFFORDS, Senator DODD, SENATOR FRIST, Senator SESSIONS, and all of the other Democratic and Republican members of our Health committee who have devoted extraordinary energy and skill to finding bipartisan consensus on the complex issue of medical errors and improving patient safety.

For even one American to die from an avoidable medical error is a tragedy. That thousands die every year is a national disgrace—and an urgent call to action.

More than 4 years ago, the Institute of Medicine reported that medical errors cause 98,000 deaths every year. The IOM recommended that health care professionals should be encouraged to report medical errors, without fearing that their reports will be used against them. Our legislation implements this sensible recommendation by establishing patient safety organizations to analyze medical errors and recommend ways to avoid them in future. The legislation also creates a legal privilege for material reported to these safety organizations, while seeing that original records, such as a patient's chart, remain accessible to patients.

Drawing the boundaries of this privilege requires a careful balance. The legislation is designed to create a culture in which medical professionals feel secure in reporting errors without fear of punishment, and it is right to do so. But we must be careful that in doing so, we do not actually shield those who have negligently or intentionally caused harm to patients. We must also make sure not to interfere with existing State laws on reporting.

The proposal that the Senate considers today has made substantial and welcome progress on these and other important issues, and I look forward to making further progress in conference with our colleagues in the House. I will do all I can to see that we continue the bipartisan cooperation that has allowed today's important action. I look forward to working with our colleagues in the House to produce a conference report that includes the best features of the Senate and House proposals. I believe that several features of the bipartisan House legislation are worth close consideration by the conference, including the strong protections against conflict of interest.

I hope that this legislation is the beginning of our action on patient safety—not the conclusion. Other steps are also necessary. The Federal Government should play a leading role in the quest for improving quality and safety for patients. Indeed, the very title of one of IOM's most important reports, ''Leadership by Example,'' highlights the central role that the Federal Government must play in transforming the quality of health care.

I thank all my colleagues from both sides of the aisle, who came together and put their differences aside to bring this legislation to the floor. This legislation sends a promising message that every patient in America will receive effective, high quality health care.

Mr. JEFFORDS. Mr. President, I am very pleased that today the Senate will pass a measure that many have worked on for many years. The Patient Safety and Quality Improvement Act, and similar companion legislation, have been the focus of considerable efforts by many of our colleagues since 1999. I must thank Senator GREGG, Senator KENNEDY and our other colleagues for all their hard work in bringing S. 720 before the Senate today.

In 1999, Americans were shocked by the findings of the landmark Institute of Medicine study on medical errors. As we all know, that study reported that the number of deaths associated with medical errors could be as high 98,000 each year.

Most importantly, the report noted that more than half of these deaths resulted from preventable errors—needless deaths that could have been prevented if we only had a system in place that would help providers learn from each other's mistakes.

The bill starts with a simple premise. Let's set up a system that helps our health

care providers learn from each other. Let's set up a system that promotes the reporting and analysis of medical errors. Let's set up a system that engenders the trust of providers and the patients they serve.

Of course, we also live in a complex society, one in which medical errors that may have harmed a patient might also be the basis for litigation. It is a right under our laws to seek a remedy when harmed, and we need to preserve access to certain information for this redress of grievances.

However, an unfortunate consequence of living in a litigious society is that hospitals and providers often feel that it's not in their best interests to share information openly and honestly. We know, in fact, that their attorneys and risk managers often advise them not to do so. So, in order for our system to work, it needs to balance these sometimes competing demands.

The bill we are considering strikes this balance. It calls for the creation of new entities we call Patient Safety Organizations that would collect voluntarily reported patient safety data. This bill provides the protections of confidentiality and privilege to that patient safety data, but the bill also sets definite limitations on what can be considered confidential and privileged.

This legislation does nothing to reduce or affect other Federal, State or local legal requirements pertaining to health related information. Nor does this bill alter any existing rights or remedies available to injured patients. The bottom line is that this legislation neither strengthens nor weakens the existing system of tort and liability law.

Instead, the legislation before us creates a new, parallel system of information collection and analysis, designed to educate our doctors and protect patients' safety everywhere. This bill reflects difficult negotiations and many compromises over almost 5 years of consideration. Through the contributions of Members on both sides of the aisle, this legislation has been greatly strengthened since I first introduced it back in the 106th Congress. I have appended these remarks with an article I wrote that provides a more detailed description of the efforts that have been made to reduce medical errors and I ask unanimous consent that it will be printed in the RECORD.

There being no objection, the material was ordered to be printed in the RECORD, as follows:

FIRST, DO NO HARM

With the publication of the Institute of Medicine IOM study, To Err is Human 1999, we were all reminded that Hippocrates' maxim to ''first, do no harm'' is as relevant to the practice of medicine today as it was in 400 B.C. The IOM report was among the first to galvanize national attention on the issue of patient safety when it reported that medical errors contribute to approximately 100,000 patient deaths a year. This startling and troubling statistic has been verified in subsequent studies and cited in peer reviewed articles in the leading journals of biomedical research, including the Journal of the American Medical Association, the Lancet, and the New England Journal of Medicine.

When I was Chairman of the Senate Committee on Health, Education, Labor, and Pensions in 1999, I undertook several hearings—five in all—to examine this issue and discuss the recommendations of the To Err is Human report. The testimony overwhelmingly agreed with several of the original Institute of Medicine recommendations.

Perhaps the most important of these recommendations stress that improving patient safety requires a learning environment rather than a punitive environment; voluntary data gathering systems as opposed to mandatory systems; and appropriate legal protections—including confidentiality and privilege from discovery—that allow for the review and analysis of medical error information.

In response to this focused attention, a myriad of public and private patient safety initiatives have begun. The Department of Health and Human Services has initiated several patient safety projects, including project grants funded by the Agency for Healthcare Research and Quality AHRQ. The work of the Veteran's Administration in developing and implementing innovative patient safety systems—especially in the area of medication management—has drawn attention from throughout the country. In addition, the Quality Interagency Coordination Taskforce has recommended steps to improve patient safety that can be taken by each Federal agency involved in health care, and agency activities to implement these steps are ongoing.

In addition, several non-governmental organizations and professional societies have ''stepped up to the plate'' of patient safety. The Joint Commission on Accreditation of Healthcare Organizations, the U.S. Pharmacopoeia, the American Medical Association, and other health care providers including the American Federation of Hospitals and American Hospital Association have launched innovative efforts dedicated to improving patient safety. However, many of the organizations currently collecting patient safety data have expressed the need for legal protections that will allow them to review protected information so that they may collaborate in the development and implementation of patient safety improvement strategies.

The work of Lucien Leape, a member of the IOM panel and adjunct professor of health policy at Harvard University, has supported this view. Dr. Leape has argued persuasively that we as a society will continue to have difficulty in reducing medical errors and improving patient safety because our institutions are ''still locked into a blame and punish approach to errors and a focus on individual culpability,'' and that ''the fear of malpractice litigation thus becomes a major barrier to openly discussing and reporting errors.''

I have introduced legislation with my colleagues, Senators Bill Frist, John Breaux, and Judd Gregg, which seeks to address these concerns. The legislation raises expectations for higher standards for continuous patient safety improvement and it encourages a new and needed culture of patient safety among health care providers and American hospitals. The bill accomplishes these goals by establishing appropriate legal protections for patient safety information voluntarily shared among patient safety organizations and providers. Our legislation reflects the belief that a culture of patient safety can flourish only in an environment where information, data, process, and recommendations enjoy legal protection and privilege.

Because it appropriately addresses an obvious need and concern, the Jeffords Patient Safety and Quality Improvement Act has enjoyed widespread endorsement by hospital, patient, doctor, and consumer advocacy organizations. This degree of support underscores the broad appeal and essential nature of this proposed legislation.

In the time since the release of To Err is Human, the Congress has been unable to enact sensible legislation to reduce medical errors and increase patient safety. However I believe we can accomplish that goal this year. The House of Representatives has already passed its version of patient safety legislation and we are working to pass the Patient Safety and Quality Improvement Act in the Senate. I am hopeful that we can reconcile disagreements that have previously stopped this legislation from moving forward and I am committed to seeing that happen.

It has been three years since the release of the IOM report. That means, based on the IOM's statistics, that an additional 300,000 deaths and an untold number of injuries have occurred from medical errors. We need to apply Hippocrates' admonition to ''first, do no harm'' beyond the medical community to the legislative community. We need to pass legislation now that will help the health care community stop the needless injury caused by unintentional medical errors.

Mr. JEFFORDS. I offer my appreciation to the many contributions from Chairman GREGG, Ranking Member KENNEDY, and Senators FRIST, BREAUX, ENZI, SESSIONS, DODD, and BINGAMAN.

We legislate many essential issues in the Congress, but rarely can we say that what we do is a matter of life and death. This, however, is one of those issues. The time to act is long overdue. This is an area where delay will lead to deaths that can be prevented. I urge all of my colleagues to vote in support of this bill.

Mr. FRIST. I ask unanimous consent that the amendment at the desk be agreed to, the committee amendment as amended be agreed to, the bill as amended be read a third time, and the HELP Committee be discharged from further consideration of H.R. 663, and the Senate proceed to its consideration; provided that all after the enacting clause be stricken and the text of S. 720, as amended, be inserted in lieu thereof; provided further that the bill, as amended, be read a third time and passed, the Senate insist upon its amendment and request a conference with the House of Representatives on the disagreeing votes of the two Houses, and the Chair be authorized to appoint conferees with a ratio of 4 to 3.

Finally, I ask unanimous consent that S. 720 be returned to the Calendar.

The PRESIDING OFFICER. Is there objection?

Mr. REID. Mr. President, reserving the right to object, I was on the Senate floor a few weeks ago with the distinguished chairman of the HELP Committee. At that time there was an attempt to move the bill.

I said at that time this bill could be done. There were ways we could accomplish it. This is an extremely important piece of legislation. Through the Chair to the distinguished majority leader, he knows better than I. He is a

physician. But from what I know of patient safety, this is an extremely important piece of legislation, and we have been able to do it. We are going to be able to go to conference. There has been agreement between the Chair and the ranking member. I think this is an important step forward.

I would say, through the Chair to my friend who is not here, the distinguished chairman of the HELP Committee, I am glad he brought this to the Senate's attention. I am glad we did not agree to what his unanimous consent request was at that time. But we were able to get it done, and I am very happy for that.

I have no objection. This is an important piece of legislation. I now wish the conferees well.

The PRESIDING OFFICER. Without objection, it is so ordered.

The amendment (No. 3568) was agreed to.

(The amendment is printed in today's RECORD under ''Text of Amendments.'')

The committee amendment in the nature of a substitute, as amended, was agreed to.

The bill (H.R. 663), as amended, was read the third time and passed.

(The bill will be printed in a future edition of the RECORD.)

The Presiding Officer (Mr. ENZI) appointed Mr. GREGG, Mr. FRIST, Mr. ENZI, Mr. ALEXANDER, Mr. KENNEDY, Mr. DODD, and Mr. JEFFORDS conferees on the part of the Senate.

Mr. FRIST. Mr. President, I do want to congratulate Senator GREGG, chairman of the HELP Committee, and ranking member, Senator KENNEDY. This is a piece of legislation that people can trace. Several years ago, the Institute of Medicine did an outstanding report. We rely on the Institute of Medicine again and again to objectively, in a nonpartisan way, look at a whole range of issues, from the financing of health care, health care delivery, preventive health care, acute treatment, chronic treatment. They really respond very much to outside bodies like the Senate and do studies.

One great study they did—people have argued their numbers aren't exactly right, too high, too low—but it was that about 100,000 people die every year from systems' lapses, medical errors. Those are, for the most part, preventable deaths, if you improve the systems. This bill goes right at the heart of improving the systems and does so in a way that relies on individuals who may observe something that didn't work out, sharing that data with their peers in a way that they do not have to fear lawsuits.

Obviously, if there is wrongdoing, lawsuits would be appropriate. But, if it is an error, minor error, or even a more serious error, it can be addressed upfront in a way that you do not have to be afraid somebody is going to come in and crush you from the outside.

I say that because it is a bipartisan bill. It went through the Health, Education, Labor and Pension Committee. I think the fundamental structure of the bill went through the committee unanimously. It shows tremendous leadership.

There were disagreements on a few items that have been worked out, with Senator GREGG's leadership, working with Senator KENNEDY. With that, we have a very good bill, a strong bill that will change systems of health care in a positive way, and clinics and hospitals and physicians offices such that we can eliminate or greatly reduce the number of unnecessary medical errors that occur in large part through systems approaches.

Just an example would be if somebody is on 10 different medicines and somebody prescribes a new medicine. You don't know the interaction of those medicines. You need a system to identify that. That sort of organized, commonsense approach to improve systems is made possible by this bill.

Mr. ENZI. Mr. President, the Senate this evening has taken a major step toward better and safer health care for all Americans.

Tonight, we approved the Patient Safety and Quality Improvement Act. The goal of this legislation is to allow health care providers some freedom from legal fear so they can do what we all strive to do every day—learn from our mistakes.

This bill would create a framework through which hospitals, doctors, and other health care providers can work to improve health care quality in a protected legal environment. It would accomplish this by granting privilege and confidentiality protections to health care providers to allow them to report health care errors and ''near misses'' to patient safety organizations.

This bill would not permit anyone to hide information about a medical mistake. Lawyers would still have access to medical records and other information that would normally be discoverable in a legal proceeding. However, the bill would ensure that the analysis of that information by patient safety organizations would take place on a separate track in a protected legal environment.

Under the bill, patient safety organizations would have the freedom to collect and analyze data on health care errors in confidence, and then report their findings to the health care community. These findings would help health care providers understand how mistakes happen in our health care system, and how to prevent them.

If we can reach an agreement in conference in the House and send this bill to the President, health care providers will be much more likely to share information about honest mistakes, because they will have some assurance that the analysis of their information won't result in a tidy package of information that a personal injury lawyer could use against them in court.

I express my appreciation for the hard work that the members of the Committee on Health, Education, Labor, and Pensions put into this bill, particularly Chairman GREGG, Majority Leader FRIST, the lead sponsor Senator JEFFORDS, and Senators SESSIONS and KENNEDY.

I also thank the staff who worked so diligently over the course of this Congress to craft this legislation, particularly Vince Ventimiglia, Peggy Carlson, David Fisher, Dean Rosen, Jim Hippe, Sean Donohue, Megan Clarke, David Nexon, David Bowen, and of course Stephen Northrup with my office.

Mr. President, I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The legislative clerk proceeded to call the roll.

Mr. FRIST. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER. Without objection, it is so ordered.

UNITED STATES-MOROCCO FREE-TRADE AGREEMENT IMPLEMENTATION ACT

The PRESIDING OFFICER. Under the previous order, the Senate having received H.R. 4842, the companion measure to S. 2677, an act to implement the United States-Morocco Free-Trade Agreement, the House bill is read a third time and passed; the passage of S. 2677 is vitiated, and the bill is returned to the Calendar.

The bill (H.R. 4842) was read the third time and passed.

The PRESIDING OFFICER. The majority leader.

THE DEPARTMENT OF DEFENSE APPROPRIATIONS BILL

Mr. FRIST. Mr. President, a few minutes ago we passed the Department of Defense appropriations bill, with a vote of 96 to 0. I want to take this opportunity to congratulate the chairman of the Appropriations Committee, who is also chairman of the Defense Subcommittee, Senator STEVENS, and his ranking member, Senator INOUYE, on bringing this first appropriations conference report for next year to completion.

This is a critically important bill. It provides nearly $418 billion in resources to our dedicated men and women in the global war on terrorism. The legislation will immediately make available $26.8 billion to the Department of Defense as emergency appropriations to cover the costs associated with operations in Iraq and Afghanistan, upon signature by the President.

As GAO reported this week, these funds are needed, and they are needed quickly, for the operation and maintenance and military personnel through the end of the current fiscal year. Further, critical funding is provided immediately to the Department of State for our diplomatic programs, for our consular programs, and embassy security in Iraq.