

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: CS/HB 375 Patient Safety Culture Surveys

SPONSOR(S): Grant, M. and others

TIED BILLS: **IDEN./SIM. BILLS:** SB 1434

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Health Innovation Subcommittee	11 Y, 4 N	Poche	Poche
2) Health Care Appropriations Subcommittee	10 Y, 4 N, As CS	Clark	Pridgeon
3) Health & Human Services Committee			

SUMMARY ANALYSIS

HB 375 requires the Agency for Health Care Administration (AHCA) to develop patient safety culture surveys to measure aspects of patient safety culture in hospital and ambulatory surgical centers. The surveys shall measure the frequency of adverse events, quality of handoffs and transitions, staff comfort in reporting a potential problem or error, the level of teamwork within hospital units and the facility as a whole, staff compliance with patient safety regulations and guidelines, staff's perception of facility support for patient safety, and staff's opinions on whether or not they would undergo a health care service or procedure at the facility. In designing the survey or surveys, AHCA must review and analyze nationally recognized patient safety culture survey products, including, but not limited to, the surveys developed by the federal Agency for Healthcare Research and Quality and the Safety Attitudes Questionnaire developed by the University of Texas.

The bill requires facilities to annually conduct and submit the results of the AHCA-designed culture survey to the Florida Center for Health Information and Transparency, and authorizes AHCA to adopt rules to govern the survey and submission process. Submission of the culture survey is a condition of licensure. AHCA must include the survey results in the health care quality measures available to the public.

The bill also makes various conforming changes to reflect the provisions of the bill.

The bill provides an appropriation for AHCA to design and process the patient safety culture surveys. The bill provides an appropriation in the sum of \$352,919 in recurring funds from the Health Care Trust Fund and one full-time equivalent (FTE) position with associated salary rate to implement the provisions contained within the bill.

The bill provides an effective date of July 1, 2017.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Background

Health Care Facility Regulation

Hospitals

Hospitals are regulated by the Agency for Health Care Administration (AHCA) under chapter 395, F.S., and the general licensure provisions of part II, of chapter 408, F.S. Hospitals offer a range of health care services with beds for use beyond 24 hours by individuals requiring diagnosis, treatment, or care.¹ Hospitals must make regularly available at least clinical laboratory services, diagnostic X-ray services, and treatment facilities for surgery or obstetrical care, or other definitive medical treatment.²

A specialty hospital, in addition to providing the same services as general hospitals, provides other services, including:

- A range of medical services restricted to a defined age or gender group;
- A restricted range of services appropriate to the diagnosis, care, and treatment of patients with specific categories of medical or psychiatric illnesses or disorders; or
- Intensive residential treatment programs for children and adolescents.³

AHCA must maintain an inventory of hospitals with an emergency department.⁴ The inventory must list all services within the capability of each hospital, and such services must appear on the face of the hospital's license. As of February 13, 2017, 218 of the 307 licensed hospitals in the state have an emergency department.⁵

Hospitals must meet initial licensing requirements by submitting a completed application and required documentation, and the satisfactory completion of a facility survey. The license fee is \$1,565.13 or \$31.46 per bed, whichever is greater.⁶ The survey fee is \$400.00 or \$12.00 per bed, whichever is greater.⁷

Section 395.1055, F.S., authorizes AHCA to adopt rules for hospitals. Separate standards may be provided for general and specialty hospitals.⁸ The rules for general and specialty hospitals must include minimum standards to ensure:

- A sufficient number of qualified types of personnel and occupational disciplines are on duty and available at all times to provide necessary and adequate patient care;
- Infection control, housekeeping, sanitary conditions, and medical record procedures are established and implemented to adequately protect patients;
- A comprehensive emergency management plan is prepared and updated annually;
- Licensed facilities are established, organized, and operated consistent with established standards and rules; and

¹ S.395.002(12), F.S.

² Id.

³ S. 395.002(28), F.S.

⁴ S. 395.1041(2), F.S.

⁵ Agency for Health Care Administration, Facility/Provider Search Results, *Hospitals*, available at <http://www.floridahealthfinder.gov/facilitylocator/ListFacilities.aspx> (reports generated on February 13, 2017).

⁶ Rule 59A-3.006(3), F.A.C.

⁷ S. 395.0161(3)(a), F.S.

⁸ S. 395.1055(2), F.S.

- Licensed facility beds conform to minimum space, equipment, and furnishing standards.⁹

The minimum standards for hospital licensure are contained in Chapter 59A-3, F.A.C.

Ambulatory Surgical Centers (ASCs)

An ASC is a facility, that is not a part of a hospital, the primary purpose of which is to provide elective surgical care, in which the patient is admitted and discharged within the same working day and is not permitted to stay overnight.¹⁰ ASCs are licensed and regulated by the AHCA under the same regulatory framework as hospitals.¹¹ Applicants for ASC licensure must submit certain information to AHCA prior to accepting patients for care or treatment, including:

- An affidavit of compliance with fictitious name;
- Proof of registration of articles of incorporation; and
- A zoning certificate or proof of compliance with zoning requirements.¹²

Upon receipt of an initial application, AHCA is required to conduct a survey to determine compliance with all laws and rules. ASCs are required to provide certain information during the initial inspection, including:

- Governing body bylaws, rules and regulations;
- A roster of registered nurses and licensed practical nurses with current license numbers;
- A fire plan; and
- The comprehensive Emergency Management Plan.¹³

AHCA is authorized to adopt rules for ASCs.¹⁴ Separate standards may be provided for general and specialty hospitals, ASCs, mobile surgical facilities, and statutory rural hospitals,¹⁵ but the rules for all ASCs must include the minimum standards listed above for hospitals.

The minimum standards for ASCs are contained in Chapter 59A-5, F.A.C.

Health Care Price and Quality Transparency

The United States is experiencing significant changes in health care payment and delivery. Record numbers of newly-insured persons are enrolled in both public and private health insurance. Americans bear a greater share of health care costs, and more participate in high deductible health plans. Clear, factual information about the cost and quality of health care is necessary for consumers to select value-driven health care options and for consumers and providers to be involved in and accountable for decisions about health and health care services. To promote consumer involvement, health care pricing and other data should be free, timely, reliable, and reflect individual health care needs and insurance coverage.

⁹ S. 395.1055(1), F.S.

¹⁰ S. 395.002(3), F.S.

¹¹ SS. 395.001-1065, F.S., and Part II, Chapter 408, F.S.

¹² Rule 59A-5.003(4), F.A.C.

¹³ Rule 59A-5.003(5), F.A.C.

¹⁴ S. 395.1055, F.S.

¹⁵ S. 395.1055(2), F.S.

Health Care Quality Transparency

Most Americans believe that the health care they receive is the best available, but the evidence shows otherwise.¹⁶ Although the U.S. spends more than \$3 trillion a year on health care,¹⁷ 17.4 percent of the gross national product,¹⁸ research shows that the quality of health care in America is, at best, imperfect, and, at worst, deeply flawed.¹⁹ Issues with health care quality fall into three categories:

- Underuse. Many patients do not receive medically necessary care.
- Misuse. Each year, more than 100,000 Americans get the wrong care and are injured as a result. More than 1.5 million medication errors are made each year.
- Overuse. Many patients receive care that is not needed or for which there is an equally effective alternative that costs less money or causes fewer side effects.

Research indicates that quality of care in the U.S. is uneven. For example, Americans receive appropriate, evidence-based care when they need it only 55 percent of the time.²⁰ Similarly, more than 400,000 people die each year as a result of preventable hospital errors in the U.S.²¹, and more than 75,000 people died in 2011 from an infection obtained while in the hospital.²²

There are hundreds of health care quality measures developed, maintained, and evaluated for relevancy and accuracy by many different organizations, including the federal Agency for Healthcare Research and Quality, the National Quality Forum, and the National Committee for Quality Assurance. In general, health quality measures can be sorted into four categories:²³

- **Structure measures-** assess the aspects of the health care setting, including facility, personnel, and policies related to the delivery of care.
 - Example- What is the nurse-to-patient ratio in a neonatal intensive care unit?
- **Process measures-** determine if the services provided to patients are consistent with routine clinical care.
 - Example- Does a doctor recommend prostate-specific antigen testing for his male patients at average risk for prostate cancer beginning at age 50?
- **Outcome measures-** evaluate patient health as a result of care received.
 - Example- What is the infection rate of patients undergoing cardiac surgery at a hospital?
- **Patient experience measures-** provide feedback on patients' experiences with the care received.
 - Example- Do patients recommend their doctor to others following a procedure?

Data on health care quality measures come from a number of sources. Some of the most common source include:

- Health insurance claims and other administrative documents;

¹⁶ National Committee for Quality Assurance, *The Essential Guide to Health Quality*, page 6, available at http://www.ncqa.org/Portals/0/Publications/Resource/%20Library/NCQA_Primer_web.pdf (last viewed February 13, 2017).

¹⁷ The Henry J. Kaiser Foundation, Peterson-Kaiser Health System Tracker, *Health Spending Explorer-U.S. Health Expenditures 1960-2014*, available at <http://www.healthsystemtracker.org/interactive/health-spending-explorer/?display=U.S.%2520%2524%2520Billions&service=Hospitals%252CPhysicians%2520%2526%2520Clinics%252CPrescriptions%2520Drug> (last viewed February 13, 2017).

¹⁸ The World Bank, *Data-United States*, available at <http://data.worldbank.org/country/united-states> (last viewed February 13, 2017).

¹⁹ Supra, FN 55.

²⁰ McGlynn, E.A., Asch, S.M., et al., *The quality of health care delivered to adults in the United States*, *New England Journal of Medicine*, 348(26): 2635-45, June 2, 2003.

²¹ James, J., *A New, Evidence-based Estimate of Patient Harms Associated with Hospital Care*, *Journal of Patient Safety*, 9(3): 122-128 (September 2013).

²² Centers for Disease Control, *Healthcare-associated infections (HAI), Data and Statistics-HAI Prevalence Survey*, available at <http://www.cdc.gov/HAI/surveillance/index.html> (last viewed February 13, 2017).

²³ U.S. Government Accountability Office, *Health Care Transparency-Actions Needed to Improve Cost and Quality Information for Consumers*, October 2014, pgs. 6-7 (citing quality measure categories established by the U.S. Department of Health and Human Services, Agency for Healthcare Research and Quality's National Quality Measures Clearinghouse, available at <http://qualitymeasures.ahrq.gov/tutorial/varieties.aspx>).

- Disease registries, such as those maintained by the Agency for Toxic Substances and Disease Registry²⁴ in the Centers for Disease Control and national disease-specific registries, like the National Amyotrophic Lateral Sclerosis (ALS) Registry²⁵ and the Kaiser Permanente Autoimmune Disorder Registry²⁶;
- Medical records; and
- Qualitative data, including information from patient surveys, interviews, and focus groups.²⁷

Standardized healthcare performance measures are used by a range of healthcare stakeholders for a variety of purposes. Measures help clinicians, hospitals, and other providers understand whether the care they provide their patients is optimal and appropriate, and if not, where to focus their efforts to improve. Public and private payers also use measures for feedback and benchmarking purposes, public reporting, and incentive-based payment. Lastly, measures are an essential part of making the cost and quality of healthcare more transparent to all, particularly for those who receive care or help make care decisions for loved ones. The Institute of Medicine's six domains of quality—safe, effective, patient-centered, timely, efficient, and equitable—are one way to organize the information.²⁸ Studies have found patients find effectiveness, safety, and patient-centeredness to be most meaningful in their consideration of health care options.²⁹

As more and more health care consumers shop for their health care, value becomes more important than price alone. Determining value means comparing the cost of care with information on the quality or benefit of the service. Presenting health care price information without accompanying quality information leads consumers to assume that high-priced care is high quality care.³⁰ In fact, there is no evidence of a correlation between cost and quality in health care.³¹

Showing cost and quality information together helps consumers clearly see variation among providers.³² Further, it helps consumers understand that high costs do not necessarily mean high quality—high-quality care is available without paying the highest price.³³ One way to accomplish this would be to present comparative quality and cost information on one, consumer-friendly website, using several specific measures or scores so multiple metrics can be compared at the same time.³⁴

Florida Center for Health Information and Transparency

The Florida Center for Health Information and Transparency (the Florida Center) provides a comprehensive health information system (information system) that includes the collection, compilation, coordination, analysis, indexing, dissemination, and utilization of health-related data. The Florida Center is housed within AHCA and is funded through appropriations in the General Appropriations Act, through grants, gifts, and other payments, and through fees charged for services. Offices within the Florida Center, which serve different functions, are:

²⁴ For more information, visit www.atsdr.cdc.gov/.

²⁵ For more information, visit <https://wwwn.cdc.gov/ALS/Default.aspx>.

²⁶ For more information, visit <https://www.dor.kaiser.org/external/DORExternal/aidr/index.aspx>.

²⁷ Supra, FN 23 at page 11.

²⁸ Institute of Medicine, *Report: Crossing the Quality Chasm: A New Health System for the 21st Century*, March 1, 2001, available at <http://ion.nationalacademies.org/~media/Files/Report%20Files/2001/Crossing-the-Quality-Chasm/Quality%20Chasm%202001%20%20report%20brief.pdf> (last viewed February 13, 2017).

²⁹ Hibbard, JH, Greene, J, Daniel D., *What is Quality Anyway? Performance Reports That Clearly Communicate to Consumers the Meaning of Quality Care*, *Med. Care Res. Rev.*, 67(3): 275-293 (2010).

³⁰ Public Agenda and Robert Wood Johnson Foundation, *How Much Will It Cost? How Americans Use Prices in Health Care*, March 2015, page 5, available at http://www.publicagenda.org/files/HowMuchWillItCost_PublicAgenda_2015.pdf.

³¹ Carman, KL, Maurer M., et al., *Evidence That Consumers Are Skeptical About Evidence-Based Health Care*, *Health Affairs*, 29(7): 1400-1406 (2010).

³² American Institute of Research, The Robert Wood Johnson Foundation, *How to Report Cost Data to Promote High-Quality, Affordable Choices: Findings from Consumer Testing*, February 2014, available at http://www.rwjf.org/content/dam/farm/reports/issue_brief/2014/rwjf410706 (last viewed February 13, 2017).

³³ Id.

³⁴ Id.

- Data Collection and Quality Assurance, which collects patient discharge data from all licensed acute care hospitals (including psychiatric and comprehensive rehabilitation units), comprehensive rehabilitation hospitals, ambulatory surgical centers and emergency departments.
- Risk Management and Patient Safety, which conducts in-depth analyses of reported incidents to determine what happened and how the facility responded to the incident.
- Data Dissemination and Communication, which maintains AHCA's health information website, provides technical assistance to data users, and creates consumer brochures and other publications.
- Health Information Exchange and Policy Analysis, which monitors innovations in health information technology, informatics, and the exchange of health information and provides a clearinghouse of technical resources on health information exchange, electronic prescribing, privacy and security, and other relevant issues.

The Florida Center electronically collects patient data from every Florida licensed inpatient hospital, ambulatory surgery center (ASC), emergency department, and comprehensive rehabilitation hospital on a quarterly basis. The data is validated for accuracy and maintained in three major databases: the hospital inpatient database, the ambulatory surgery database, and the emergency department database.

- The **hospital inpatient database** contains records for each patient stay at Florida acute care facilities, including long-term care hospitals and psychiatric hospitals. These records contain extensive patient information including discharge records, patient demographics, admission information, medical information, and charge data. This database also includes comprehensive inpatient rehabilitation data on patient-level discharge information from Florida's licensed freestanding comprehensive inpatient rehabilitation hospitals and acute care hospital distinct part rehabilitation units.
- The **ambulatory surgery database** contains "same-day surgery" data on reportable patient visits to Florida health care facilities, including freestanding ambulatory surgery centers, short-term acute care hospitals, lithotripsy centers, and cardiac catheterization laboratories. Ambulatory surgery data records include, but are not limited to, patient demographics, medical information, and charge data.
- The **emergency department database** collects reports of all patients who visited an emergency department, but were not admitted for inpatient care. Reports are electronically submitted to the AHCA and include the hour of arrival, the patient's chief complaint, principal diagnosis, race, ethnicity, and external causes of injury.

Florida statute requires the Florida Center to identify available data sets, compile new data when specifically authorized by the Legislature, and promote the use of extant health-related data and statistics. As mentioned previously, the duties and obligations were streamlined by HB 1175 in 2016 to eliminate obsolete language, redundant duties, and unnecessary functions. Now, the Florida Center must maintain any data sets in existence before July 1, 2016, unless such data sets duplicate information that is readily available from other credible sources, and may collect or compile data on:

- Health resources, including licensed health care practitioners, by specialty and type of practice. and including information collected by the Department of Health.
- Health service inventories, including acute care, long-term care, and other institutional care facilities and specific services provided by hospitals, nursing homes, home health agencies, and other licensed health care facilities.
- Service utilization for licensed health care facilities.
- 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.
- The extent of public and private health insurance coverage in this state; and

- Specific quality-of-care initiatives involving various health care providers when extant data is not adequate to achieve the objectives of the initiative.

The Florida Center maintains www.FloridaHealthFinder.gov, which was established to assist consumers in making informed health care decisions and lead to improvements in quality of care in Florida. The website provides a wide array of search and comparative tools to the public which allow easy access to information on hospitals, ambulatory surgery centers, emergency departments, hospice providers, physician volume, health plans, nursing homes, and prices for prescription drugs in Florida. The website also provides tools to researchers and professionals to allow specialized data queries, but requires users to have some knowledge of medical coding and terminology. Some of the features and data available on the website include a multimedia encyclopedia and symptoms navigator, hospital and ambulatory surgery centers performance data, data on mortality, complication, and infection rates for hospitals, and a facility/provider locator. AHCA is frequently improving the functionality of the website by adding more information and search capabilities.

Patient Safety Culture Surveys³⁵

Patient safety culture can be defined as the set of values, beliefs, and norms about what is important, how to behave, and what attitudes are appropriate when it comes to patient safety in a workgroup or organization. In a safe culture, employees are guided by an organization-wide commitment to safety in which each member upholds their own safety norms and those of their co-workers. Safety culture is increasingly recognized as an important strategy to improving deficits in patient safety. The question for health care facilities is how to measure the patient safety climate in the facility.

Agency for Healthcare Research and Quality Hospital and ASC Patient Safety Culture Survey

In 2004, the federal Agency for Healthcare Research and Quality (AHRQ) released the Hospital Survey on Patient Safety Culture, a staff survey designed to help hospitals assess the culture of safety in their institutions by measuring how their staff perceive various aspects of patient safety culture.³⁶ The survey has since been implemented in hundreds of hospitals across the United States, and in other countries. In 2006, AHRQ developed a comparative database on the survey, comprised of data from U.S. hospitals that administered the survey and voluntarily submitted the data.³⁷ The database allows hospitals wishing to compare their patient safety culture survey results to those of other hospitals in support of patient safety culture improvement.³⁸ In 2016, 680 hospitals submitted survey results to the database.³⁹ The database also includes a chapter on trending that presents results showing change over time for 326 hospitals that administered the survey and submitted data at least in 2014 and 2016.⁴⁰ The trends and findings include:

- The average percent positive scores across the 12 patient safety culture composites increased by 1 percentage point.
- For hospitals that increased on Patient Safety Grade, scores for “Excellent” or “Very Good” increased on average by 6 percent.

³⁵ Besides the two patient safety culture surveys highlighted in this section, other measures of safety climate include, but are not limited to, Zohar’s (2000) assessment of unit safety climate; Zohar and Luria’s (2005) measure of unit climate; Hofmann and Stetzer’s (1996, 1998) measure of safety climate including safe practices, safety policies, and/or safety requirements; and Hofmann, Morgeson, and Gerras’ (2003) measure of safety climate.

³⁶ U.S. Department of Health and Human Services, Agency for Healthcare Research and Quality, *Hospital Survey on Patient Safety Culture*, available at <http://www.ahrq.gov/professionals/quality-patient-safety/patientsafetyculture/hospital/index.html> (last viewed February 13, 2017). Besides hospitals, AHRQ developed patient safety culture surveys for hospitals, nursing homes, ambulatory outpatient medical offices, community pharmacies, and ambulatory surgery centers.

³⁷ *Id.*

³⁸ *Id.*

³⁹ U.S. Department of Health and Human Services, Agency for Healthcare Research and Quality, *2016 User Comparative Database Report-Hospital Survey on Patient Safety Culture*, available at https://www.ahrq.gov/sites/default/files/wysiwyg/professionals/quality-patient-safety/patientsafetyculture/hospital/2016/2016_hospitalops_report_pt1.pdf (last viewed February 13, 2017).

⁴⁰ *Id.*

- For hospitals that increased on the number of respondents who reported at least one event in the past 12 months, the average increase was 5 percent.

The survey⁴¹ asks respondents to indicate to what degree they agree or disagree with a statement, how often something occurs, or provide a specific number or grade. Excerpts of the survey follow.

- Teamwork Within Units
 - People support one another in this unit.
 - When a lot of work needs to be done quickly, we work together as a team to get the work done.
 - In this unit, people treat each other with respect.
 - When one area in this unit gets really busy, others help out.
- Supervisor/Manager Expectations & Actions Promoting Patient Safety
 - My supervisor/manager says a good word when he/she sees a job done according to established patient safety procedures.
 - My supervisor/manager seriously considers staff suggestions for improving patient safety.
 - Whenever pressure builds up, my supervisor/manager wants us to work faster, even if it means taking shortcuts.
 - My supervisor/manager overlooks patient safety problems that happen over and over.
- Management Support for Patient Safety
 - Hospital management provides a work climate that promotes patient safety.
 - The actions of hospital management show that patient safety is a top priority.
 - Hospital management seems interested in patient safety only after an adverse event happens.
- Communication Openness
 - Staff will freely speak up if they see something that may negatively affect patient care.
 - Staff feels free to question the decisions or actions of those with more authority.
 - Staff is afraid to ask questions when something does not seem right.
- Handoffs & Transitions
 - Things "fall between the cracks" when transferring patients from one unit to another.
 - Important patient care information is often lost during shift changes.
 - Problems often occur in the exchange of information across hospital units.
 - Shift changes are problematic for patients in this hospital.
- Patient Safety Grade- Excellent, Very Good, Acceptable, Poor, Failing
 - Please give your work area/unit in this hospital an overall grade on patient safety.

AHRQ also developed the Ambulatory Surgery Center Survey on Patient Safety Culture in response to interest from ambulatory surgery centers (ASCs) in assessing patient safety culture in their facilities. This survey is designed specifically for ASC staff and asks for their opinions about the culture of patient safety in their facility.⁴² In 2014, AHRQ conducted a pilot study on the use of the Patient Safety Culture survey in 59 ASCs.⁴³ The pilot study was intended to help ASCs assess the extent to which their culture emphasizes the importance of patient safety by viewing the patient safety culture survey results of the ASCs participating in the study.⁴⁴ The study was also used to prove the reliability and structure of the questions and items contained in the survey. Based on the testing and input from AHRQ and a technical expert panel, the survey was determined to be reliable and it was made available for industry use.

⁴¹ The survey is available at <http://www.ahrq.gov/sites/default/files/wysiwyg/professionals/quality-patient-safety/patientsafetyculture/hospital/resources/hospscanform.pdf>.

⁴² The survey is available at <http://www.ahrq.gov/sites/default/files/wysiwyg/professionals/quality-patient-safety/patientsafetyculture/asc/resources/ascsurvey.pdf>.

⁴³ U.S. Department of Health and Human Services, Agency for Healthcare Research and Quality, *Results From the 2014 AHRQ Ambulatory Surgery Center Survey on Patient Safety Culture Pilot Study*, available at https://www.ahrq.gov/sites/default/files/wysiwyg/professionals/quality-patient-safety/patientsafetyculture/asc/resources/asc_pilotstudy.pdf (last viewed February 13, 2017).

⁴⁴ Id. at pg. 1.

University of Texas Safety Attitudes Questionnaire

Another patient safety culture survey widely used by hospitals and other facilities to measure patient safety culture is the Safety Attitudes Questionnaire (SAQ) developed by researchers at the University of Texas. The SAQ was adapted from two other safety surveys from the aviation industry- the Flight Management Attitudes Questionnaire and its predecessor, the Cockpit Management Attitudes Questionnaire, developed over 30 years ago. The aviation questionnaires were created after researchers found that most airline accidents were due to breakdowns in interpersonal aspects of crew performance such as teamwork, speaking up, leadership, communication, and collaborative decision making. The FMAQ measures crew member attitudes about these topics, and was found to be reliable, sensitive to change, and predictive of flight crew performance. Researchers also found that many of the items contained in the aviation questionnaires were useful in measuring attitudes about the same topics in a medical setting, so the SAQ was developed.

The SAQ was specifically designed to measure safety culture at both the individual and group level. Both the healthcare version (SAQ) and aviation version (FMAQ) of this survey instrument were shown to identify variability within and between hospitals and airlines⁴⁵. The SAQ went through full derivation and validation testing, and was determined to be both a valid and reliable measurement tool for determining patient safety culture.⁴⁶

The SAQ is a one-page, 60 item survey instrument that assesses safety culture across six factors—perceptions of management, job satisfaction, working conditions, stress recognition, teamwork climate and safety climate.⁴⁷ The SAQ defines safety climate as perceptions of a strong and proactive organizational commitment to safety, as one aspect of overall safety culture. Each item is measured on a 5-point Likert scale, from disagree strongly to agree strongly, which is then converted to a 0–100 scale. The scaled scores correspond to the patient safety climate in a facility. The SAQ has been adapted for use in intensive care units, operating rooms, general inpatient settings, and ambulatory clinics.⁴⁸

Research on Patient Safety Culture Surveys

Since 2000, a robust body of research has emerged to measure the effectiveness of patient safety culture surveys in identifying areas of improvement in hospitals, ASCs, and other health care settings. This research has found that facilities with a poor patient safety climate have poor or less desirable patient outcomes following treatment in those facilities. For example, in one study, the SAQ (operating version) was given to 60 hospitals in 16 states to administer to each hospital's operating room caregivers.⁴⁹ When the results of the surveys were compared with a chart showing surgical complication rates for each hospital participating in the study, the charts were nearly identical. The study showed that there was a correlation between patient safety culture in a hospital and patient outcomes.⁵⁰

Another study examined the patient safety culture at 30 intensive care units (ICUs) across the country to determine if there was a correlation between safety culture and patient outcomes, specifically

⁴⁵ Pronovost P, Sexton B. *Assessing safety culture: guidelines and recommendations*. Qual Saf Health Care 2005;14:231–3; see also Sexton JB, Thomas EJ. *Measurement: Assessing Safety Culture*. In: Leonard M, Frankel A, Simmonds T (eds). *Achieving Safe and Reliable Healthcare: Strategies and Solutions*. Chicago, IL: Health Administration Press, 2004, pp. 115–27.

⁴⁶ Sexton JB, Helmreich RL, Neilands TB et al. *The Safety Attitudes Questionnaire: psychometric properties, benchmarking data, and emerging research*. BMC Health Serv Res 2006;6:44.

⁴⁷ Huang, D., Clermont, G. *Intensive care unit safety culture and outcomes: a U.S. multicenter study*. Intl. J. Quality in Health Care 2010;22:151-161.

⁴⁸ For each version of the SAQ, item content is the same, with minor modifications to reflect the clinical area.

⁴⁹ Makary M., Sexton B. *Patient safety in surgery*. Annals of Surgery 2006; 243:628-35.

⁵⁰ Makary, M. *Unaccountable: What Hospitals Won't Tell You and How Transparency Can Revolutionize Health Care* pgs. 90-92 (2012).

hospital mortality and length of stay.⁵¹ Using the SAQ-ICU version, the study found that lower perceptions of management among ICU personnel were significantly associated with higher hospital mortality.⁵² In fact, for every 10 percent decrease in an ICU's percentage of positive scores associated with perceptions of management, the odds of patient death in the ICU increased 1.24 times.⁵³ Also, the study found that lower safety climate, perceptions of management, and job satisfaction were significantly associated with increased lengths of stay in the hospital.⁵⁴ Other studies have also found a correlation between positive teamwork attitudes and patient outcomes in ICUs.⁵⁵

Facilities whose frontline health care workers and managers score higher on patient safety climate surveys have been found to have lower rates of adverse patient safety indicators, such as postoperative sepsis, pressure ulcers, and inpatient falls resulting in a fractured hip.⁵⁶ Another study found a correlation between poor safety climate scores and high burnout rates among NICU nurses.⁵⁷ An additional study found that positive teamwork attitudes measured by patient safety culture survey tools are associated with better patient outcomes in pediatric surgery.⁵⁸

Effect of Proposed Changes

HB 375 requires AHCA to develop hospital and ASC patient safety culture surveys to measure aspects of patient safety culture, including frequency of adverse events, quality of handoffs and transitions, comfort in reporting a potential problem or error, the level of teamwork within hospital units and the facility as a whole, staff compliance with patient safety regulations and guidelines, staff's perception of facility support for patient safety, and staff's opinions on whether or not they would undergo a health care service or procedure at the facility. In designing the survey or surveys, AHCA must review and analyze nationally recognized patient safety culture survey products, including but not limited to the patient safety surveys developed by the federal Agency for Healthcare Research and Quality to develop the patient safety culture survey.

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Finally, the bill also makes various conforming changes to reflect the provisions of the bill.

The bill provides an effective date of July 1, 2017.

B. SECTION DIRECTORY:

Section 1: Amends s. 408.05, F.S., relating to Florida Center for Health Information and Transparency.

⁵¹ Supra, FN 47.

⁵² Id. at pg. 155.

⁵³ Id.

⁵⁴ Id. at pgs. 155-56.

⁵⁵ Baggs J, Schmitt M, Mushlin A, Mitchell P, Eldredge D, Oakes D, Hutson AD: *Association between nurse-physician collaboration and patient outcomes in three intensive care units*. Crit Care Med 1999; 27:1991-8; Shortell S, Zimmerman J, Rousseau D, Gillies R, Wagner D, Draper E, Knaus W, Duffy J: *The performance of intensive care units: Does good management make a difference?* Med Care 1994; 32:508-25; Knaus W, Draper E, Zimmerman J: *An evaluation of outcome from intensive care in major medical centers*. Ann Intern Med 1986; 10:410-8.

⁵⁶ Singer S., Lin S. *Relationship of safety climate and safety performance in hospitals*. Health Serv Res 2009;44:399-421.

⁵⁷ Profit J., Sharek P. *Burnout in the NICU setting and its relation to safety culture*. BMJ Qual Saf 2014;23:806-813.

⁵⁸ de Leval M, Carthey J, Wright D, Farewell V, Reason J: *Human factors and cardiac surgery: A multicenter study*. J Thorac Cardiovasc Surg 2000;119:661-72.

- Section 2:** Amends s. 408.061, F.S., relating to data collection; uniform systems of financial reporting; information relating to physician charges; confidential information; immunity.
- Section 3:** Amends s. 408.810, F.S., relating to minimum licensure requirements.
- Section 4:** Amends s. 400.991, F.S., relating to licensure requirements; background screenings; prohibitions.
- Section 5:** Amends s. 408.8065, F.S., relating to additional licensure requirements for home health agencies, home medical providers, and health care clinics.
- Section 6:** Amends s. 408.820, F.S., relating to exemptions.
- Section 7:** Provides an appropriation.
- Section 8:** Provides an effective date of July 1, 2017.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

AHCA may realize an increase in revenue by imposing fines on hospitals and ASCs that fail to submit patient safety culture survey results. The amount of fines that may be collected under the bill is indeterminate, but will offset costs of investigations and administrative actions.

2. Expenditures:

The cost to implement the patient safety culture survey, including the cost to collect, analyze, and report survey findings is estimated to be \$300,000 in recurring funds from the Health Care Trust Fund. AHCA intends to encourage online survey completion, which would reduce this estimate.⁵⁹ AHCA is examining the cost of developing, distributing, and processing the surveys without a contractor.⁶⁰ Additionally, the cost of one full-time equivalent (FTE) staff to manage the survey process is estimated to be \$52,919 in recurring costs from the Health Care Trust Fund, with associated salary rate of 41,106.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

None.

2. Expenditures:

None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

Health care consumers will have access to patient safety culture survey results from hospitals and ASCs. Consumers may use the information contained in the results, such as whether or not physicians and nurses feel comfortable in receiving treatment in the facilities where they work, to make informed decisions about where they receive health care services. Hospitals and ASCs with poor survey results

⁵⁹ Email correspondence between AHCA staff and Select Committee staff on January 18, 2016 (on file with Health Innovation Subcommittee staff).

⁶⁰ Telephone conference between AHCA staff and Health Innovation Subcommittee staff on February 13, 2017.

may realize a reduction in patient volume, while hospitals and ASCs with positive survey results may realize an increase in patient volume.

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

None. The bill does not appear to affect county or municipal governments.

2. Other:

None.

B. RULE-MAKING AUTHORITY:

Not applicable. AHCA has sufficient existing rule-making authority to implement the provisions of the bill.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

On March 7, 2017, the Health Care Appropriations Subcommittee adopted an amendment that provides an appropriation in the sum of \$352,919 in recurring funds from the Health Care Trust Fund and one full-time equivalent (FTE) position with associated salary rate for the purpose of carrying out this act.

The bill was reported favorably as a committee substitute. The analysis is drafted to the committee substitute as passed by the Health Care Appropriations Subcommittee.