

HOUSE OF REPRESENTATIVES STAFF FINAL BILL ANALYSIS

BILL #: CS/CS/HB 763 Patient Safety Culture Surveys

SPONSOR(S): Health & Human Services Committee and Health Market Reform Subcommittee, Grant, M. and others

TIED BILLS: **IDEN./SIM. BILLS:** CS/CS/SB 1370

FINAL HOUSE FLOOR ACTION: 119 Y's 0 N's **GOVERNOR'S ACTION:** Approved

SUMMARY ANALYSIS

CS/CS/HB 763 passed the House on March 4, 2020, and subsequently passed the Senate on March 11, 2020.

Patient safety culture is the extent to which the beliefs, values, and norms shared by the staff of a health care organization support and promote patient safety. Patient safety culture surveys are used to measure patient safety culture by determining what is rewarded, supported, expected, and accepted in a health care organization as it relates to patient safety. They provide health care organizations with an understanding of the safety related perceptions and attitudes of its managers and staff and are used as diagnostic tools to identify areas for improvement. These can also be used to measure organizational conditions that can lead to adverse incidents and patient harm.

The bill requires hospitals and ASCs to use the Hospital or ASC Survey on Patient Safety Culture (SOPS), as applicable, to conduct patient safety culture surveys of facility staff. The facilities must conduct the survey biennially, and submit the data to AHCA in a format specified by rule. The bill requires the facility to conduct the survey anonymously to encourage staff employed by or working in the facility to complete the survey. The bill authorizes a hospital or ASC to contract to administer the survey, and to develop an internal action plan to identify survey measures to improve upon between surveys, which may be submitted to AHCA.

The bill requires AHCA to collect, compile, and publish patient safety culture survey data submitted by hospitals and ASCs. The bill requires AHCA to publish the survey results for each hospital and ASC, in the aggregate, and by composite measure. For hospitals, AHCA must also publish the survey results by unit work areas. AHCA must designate the use of updated versions of the surveys as they occur.

The bill requires AHCA to customize the surveys to include questions that will generate certain data, including, data on the likelihood of a respondent to seek care for the respondent, and for the respondent's family, at the surveying facility, both in general and, for hospitals, within the respondent's specific unit or department.

The bill also requires AHCA to customize the hospital survey to allow a respondent to identify themselves as working in certain areas of a hospital that are not currently identifiable in the survey, including a pediatric cardiology patient care unit and a pediatric cardiology surgical services unit.

The bill authorizes one full-time equivalent position, with associated salary rate of 45,560, and \$74,173 in recurring funds and \$87,474 in nonrecurring funds from the Health Care Trust Fund to the Agency for Health Care Administration. The bill has no fiscal impact on local government.

The bill was approved by the Governor on June 29, 2020, ch. 2020-134, L.O.F., the effective date is July 1, 2020.

I. SUBSTANTIVE INFORMATION

A. EFFECT OF CHANGES:

Current Situation

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

Ambulatory Surgical Centers (ASCs)

An ASC is a facility, which 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 24 hours.³ ASCs are licensed and regulated by the AHCA under the same regulatory framework as hospitals.⁴

Health Care Quality

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.

Most Americans believe that the health care they receive is the best available, but the evidence shows otherwise.⁵ Although the U.S. spends more than \$3 trillion a year on health care,⁶ 18 percent of the gross national product,⁷ research shows that the quality of health care in America is, at best, imperfect, and, at worst, deeply flawed.⁸ 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.

¹ S. 395.002(12), F.S.

² Id.

³ S. 395.002(3), F.S.

⁴ SS. 395.001-1065, F.S., and Part II, Chapter 408, F.S.

⁵ National Committee for Quality Assurance, *The Essential Guide to Health Quality*, page 6, available at http://www.kdheks.gov/hcf/news/download/04172007_NCQA_Health_Quality.pdf (last visited March 16, 2020).

⁶ The Henry J. Kaiser Foundation, Peterson-Kaiser Health System Tracker, *Health Spending Explorer-U.S. Health Expenditures 1960-2017*, available at <https://www.healthsystemtracker.org/interactive/?display=U.S.%2520%2524%2520Billions&service=&rangeType=range&years=1960%252C2017> (last visited March 16, 2020).

⁷ The World Bank, *Data-United States*, available at <http://data.worldbank.org/country/united-states> (last visited March 16, 2020).

⁸ Supra, FN 5.

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.⁹ Similarly, more than 250,000 people die each year as a result of preventable hospital errors in the U.S.¹⁰, and more than 72,000 people died in 2015 from an infection obtained while in the hospital.¹¹

Quality Measures

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:¹²

- **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?

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.¹³ Studies have found patients find effectiveness, safety, and patient-centeredness to be most meaningful in their consideration of health care options.¹⁴

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

⁹ 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.

¹⁰ John Hopkins Medicine, *Medical Error-The Third Leading Cause of Death in the U.S.*, available at <https://www.bmj.com/content/353/bmj.i2139.full> (last visited March 16, 2020).

¹¹ 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 visited March 16, 2020).

¹² 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> (last visited March 16, 2020).

¹³ Institute of Medicine, *Report: Crossing the Quality Chasm: A New Health System for the 21st Century*, March 1, 2001, available at <http://www.nationalacademies.org/hmd/-/media/Files/Report%20Files/2001/Crossing-the-Quality-Chasm/Quality%20Chasm%202001%20%20report%20brief.pdf> (last visited March 16, 2020).

¹⁴ 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).

information leads consumers to assume that high-priced care is high quality care.¹⁵ In fact, there is no evidence of a correlation between cost and quality in health care.¹⁶

Showing cost and quality information together helps consumers clearly see variation among providers.¹⁷ Further, it helps consumers understand that high costs do not necessarily mean high quality—high-quality care is available without paying the highest price.¹⁸ 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.¹⁹

Florida Center for Health Information and Transparency

The Florida Center for Health Information and Transparency (the Florida Center), within AHCA, provides a comprehensive health information system (information system) that includes the collection, compilation, coordination, analysis, indexing, dissemination, and utilization of health-related data.

Current law requires every Florida licensed inpatient hospital, ambulatory surgery center (ASC), emergency department, and comprehensive rehabilitation hospital to report data to AHCA quarterly.²⁰ The Florida Center electronically collects this data validates it and maintains it in three major databases:

- 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.

The Florida Center applies this data to standardized quality measures and price levels including total hospitalizations, high and low charges, infection rates, readmission rates and patient satisfaction among many other quality measures. 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 that allows 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

¹⁵ 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 (last visited March 16, 2020)

¹⁶ Carman, KL, Maurer M., et al., *Evidence That Consumers Are Skeptical About Evidence-Based Health Care*, Health Affairs, 29(7): 1400-1406 (2010).

¹⁷ 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 <https://www.rwjf.org/en/library/research/2014/02/how-to-report-cost-data-to-promote-high-quality--affordable-choi.html> (last visited March 16, 2020).

¹⁸ Id.

¹⁹ Id.

²⁰ S. 408.061, F.S.

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.

Patient Safety Culture Surveys²¹

Organizational culture refers to the beliefs, values, and norms shared by staff throughout the organization that influence their actions and behaviors. Patient safety culture is the extent to which these beliefs, values, and norms support and promote patient safety.²² Patient safety culture can be measured by determining what is rewarded, supported, expected, and accepted in an organization as it relates to patient safety.²³ 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.²⁴ 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 (SOPS 1.0), 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.²⁵ The survey occurs once every two years and has since been implemented in hundreds of hospitals across the United States, and in other countries.

In 2018, AHRQ began developing a new version of the survey, with the goal of shortening the survey.²⁶ A pilot test was conducted with 25 hospitals, the data of which was used to examine the survey's reliability. In 2019, AHRQ released a new version of the survey, the SOPS 2.0.²⁷

Patient safety data collected from the survey results is not only provided in the aggregate, it can also be broken down to a more granular level. The first question on the survey allows the respondent to identify their position, title or area of expertise. The second question asks the respondent to identify the unit or department in which they work in the hospital. This allows survey data to be collected and categorized by staff position and by units or departments. As a result, a hospital can identify the specific positions and departments that may need improvement. The survey 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
 - In this unit, we work together as an effective team.
 - During busy times, staff in this unit help each other.

²¹ 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.

²² U.S. Department of Health and Human Services, Agency for Healthcare Research and Quality, *2018 User Database Report-Hospital Survey on Patient Safety Culture*, at pg. 3, available at http://www.ahrq.gov/sites/default/files/wysiwyg/sops/quality-patient-safety/patientsafetyculture/2018hospitalopsreport_0.pdf (last visited March 16, 2020).

²³ Id.

²⁴ Pronovost P, Sexton B. *Assessing safety culture: guidelines and recommendations*. *Qual Saf Health Care* 2005;14:231-3;

²⁵ 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 visited March 16, 2020). Besides hospitals, AHRQ developed patient safety culture surveys for nursing homes, ambulatory outpatient medical offices, community pharmacies, and ambulatory surgery centers.

²⁶ U.S. Department of Health and Human Services, Agency for Healthcare Research and Quality, *Pilot Test Results from the 2019 AHRQ Surveys on Patient Safety Culture (SOPS) Hospital Survey Version 2.0*, pg. 2, available at <http://www.ahrq.gov/sites/default/files/wysiwyg/sops/surveys/hospital/hsops2-pilot-results-parti.pdf> (last visited March 16, 2020).

²⁷ The survey is available at <http://www.ahrq.gov/sops/surveys/hospital/index.html> (last visited March 16, 2020).

- There is a problem with disrespectful behavior by those working in this unit.
- When one area in this unit gets really busy, others help out.
- Supervisor/Manager, or Clinical Leader Support for Patient Safety
 - My supervisor/manager, or clinical leader seriously considers staff suggestions for improving patient safety.
 - My supervisor/manager, or clinical leader wants us to work faster during busy times, even if it means taking shortcuts.
 - My supervisor/manager, or clinical leader takes action to address patient safety concerns that are brought to their attention.
- Hospital Management Support for Patient Safety
 - Hospital management provides adequate resources to improve 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
 - In this unit, staff speak up if they see something that may negatively affect patient care.
 - When staff in this unit see someone with more authority doing something unsafe for patients, they speak up.
 - In this unit, staff are afraid to ask questions when something does not seem right.
- Handoffs and Information Exchange
 - When transferring patients from one unit to another, important information is often left out.
 - During shift changes, important patient care information is often left out.
 - During shift changes, there is adequate time to exchange all key patient care information.
- Patient Safety Grade- Poor, Fair, Good, Very Good, Excellent
 - How would you rate your unit/work area on patient safety?²⁸

AHRQ developed a tool kit and a user guide to provide instruction to hospitals on administering the Hospital SOPS survey.²⁹ The user guide includes instructions for modification and customization of the survey. The staff positions and departments on the survey can be modified to better match the names and titles used within a hospital. The survey may also be customized by adding questions.

The rate at which hospital staff have participated in the survey has never been high and has declined slightly in recent years, going from 55 percent in 2016³⁰ to 54 percent in 2018³¹. This may be the result of the prior survey being perceived as long or tedious.

AHRQ developed a comparative database on the survey, comprised of data from U.S. hospitals that administered the survey and voluntarily submitted the data.³² The database allows hospitals to compare their patient safety culture survey results to those of other hospitals in support of patient safety culture improvement.³³ AHRQ utilizes the database to publish a biennial report presenting non-identifiable statistics on the patient safety culture of all participating hospitals. In 2018, 630 hospitals

²⁸ Id.

²⁹ U.S. Department of Health and Human Services, Agency for Healthcare Research and Quality, *Hospital Survey on Patient Safety Culture Version 2.0 User's Guide*, available at <https://www.ahrq.gov/sites/default/files/wysiwyg/sops/surveys/hospital/hospitalsurvey2-users-guide.pdf> (last visited March 16, 2020).

³⁰ U.S. Department of Health and Human Services, Agency for Healthcare Research and Quality, *2016 User Database Report-Hospital Survey on Patient Safety Culture*, at pg. 8, available at http://www.ahrq.gov/sites/default/files/wysiwyg/professionals/quality-patient-safety/patientsafetyculture/hospital/2016/2016_hospitalops_report_pt1.pdf (last visited March 16, 2020).

³¹ U.S. Department of Health and Human Services, Agency for Healthcare Research and Quality, *2018 User Database Report-Hospital Survey on Patient Safety Culture*, at pg. 5, available at http://www.ahrq.gov/sites/default/files/wysiwyg/sops/quality-patient-safety/patientsafetyculture/2018hospitalopsreport_0.pdf (last visited March 16, 2020).

³² The database is available at <http://www.ahrq.gov/sops/databases/hospital/index.html> (last visited March 16, 2020).

³³ U.S. Department of Health and Human Services, Agency for Healthcare Research and Quality, *2018 User Database Report-Hospital Survey on Patient Safety Culture*, at pg. 1, available at <https://www.ahrq.gov/sites/default/files/wysiwyg/sops/quality-patient-safety/patientsafetyculture/2018hospitalopsreport.pdf> (last visited March 16, 2020).

submitted survey results to the database. However, only 306 of those hospitals submitted surveys in 2016. As a result, to identify trends, comparisons can only be drawn from the data submitted by those 306 hospitals.³⁴

The 2018 biennial report includes a chapter on trending that presents results showing change over time for the 306 hospitals that administered the survey and submitted data in 2016 and 2018.³⁵ The trends and findings include:

- The average 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.
- 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.

This seems to suggest that these hospitals improved their patient safety cultures after publication of the 2016 survey results.

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.³⁶ Like it did for the hospital survey, AHRQ developed a tool kit and a user guide to provide instruction to ASCs on administering the survey.³⁷ The ASC survey may be customized by adding questions, and the user guide includes instructions for customization of the survey.

In 2014, AHRQ conducted a pilot study on the use of the Patient Safety Culture survey in 59 ASCs.³⁸ 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.³⁹ 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.

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

³⁴ Id. at pg. 29.

³⁵ Id.

³⁶ The survey is available at <https://www.ahrq.gov/sops/surveys/asc/index.html>.

³⁷ U.S. Department of Health and Human Services, Agency for Healthcare Research and Quality, *Ambulatory Surgery Center Survey on Patient Safety Culture User's Guide*, available at <https://www.ahrq.gov/sites/default/files/wysiwyg/professionals/quality-patient-safety/patientsafetyculture/asc/userguide/ascusersguide.pdf> (last visited March 16, 2020).

³⁸ 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/userguide/ascusersguide.pdf> https://www.ahrq.gov/sites/default/files/wysiwyg/professionals/quality-patient-safety/patientsafetyculture/asc/resources/asc_pilotstudy.pdf (last visited March 16, 2020).

³⁹ Id. at pg. 1.

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 airlines⁴⁰. 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.⁴¹

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.⁴² 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.⁴³

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.⁴⁴ 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.⁴⁵

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 hospital mortality and length of stay.⁴⁶ Using the SAQ-ICU version, the study found that lower perceptions of management among ICU personnel were significantly associated with higher hospital mortality.⁴⁷ 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.⁴⁸ 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.⁴⁹ Other studies have also found a correlation between positive teamwork attitudes and patient outcomes in ICUs.⁵⁰

⁴⁰ 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.

⁴¹ 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.

⁴² 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.

⁴³ For each version of the SAQ, item content is the same, with minor modifications to reflect the clinical area.

⁴⁴ Makary M., Sexton B. *Patient safety in surgery*. Annals of Surgery 2006; 243:628-35.

⁴⁵ Makary, M. *Unaccountable: What Hospitals Won't Tell You and How Transparency Can Revolutionize Health Care* pgs. 90-92 (2012).

⁴⁶ Supra, FN 41.

⁴⁷ Id.

⁴⁸ Id.

⁴⁹ Id.

⁵⁰ 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,

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.⁵¹ Another study found a correlation between poor safety climate scores and high burnout rates among NICU nurses.⁵² An additional study found that positive teamwork attitudes measured by patient safety culture survey tools are associated with better patient outcomes in pediatric surgery.⁵³

Effect of the Bill

The bill requires hospitals and ASCs to use the applicable SOPS survey to conduct patient safety culture surveys of facility staff. The facilities must conduct the survey biennially, and submit the data to AHCA in a format specified by rule. The bill requires the facility to conduct the survey anonymously to encourage staff employed by or working in the facility to complete the survey. This will not only ensure a staff member's privacy is protected, but will lead to more reliable data by increasing the sample size of the survey. The bill authorizes a hospital or ASC to contract to administer the survey, and to develop an internal action plan to identify survey measures to improve upon between surveys, which may be submitted to AHCA.

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The bill requires AHCA to customize the surveys to include questions that will generate certain data, including, data on the likelihood of a respondent to seek care for the respondent, and for the respondent's family, at the surveying facility, both in general and, for hospitals, within the respondent's specific unit or department.

The bill also requires AHCA to customize the hospital survey to allow a respondent to identify themselves as working in certain areas of a hospital that are not currently identifiable in the survey, including, a pediatric cardiology patient care unit and a pediatric cardiology surgical services unit.

The bill provides an effective date of July 1, 2020.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

None.

2. Expenditures:

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.

⁵¹ Singer S., Lin S. *Relationship of safety climate and safety performance in hospitals.* Health Serv Res 2009;44:399-421.

⁵² Profit J., Sharek P. *Burnout in the NICU setting and its relation to safety culture.* BMJ Qual Saf 2014;23:806-813.

⁵³ 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.

The AHCA has projected a need for one full-time equivalent position to oversee the project and \$85,000 in contracted services to build the survey system to include associated programming and web-design costs. The bill authorizes one full-time equivalent position, with associated salary rate of 45,560, and \$74,173 in recurring funds and \$87,474 in nonrecurring funds from the Health Care Trust Fund to the Agency for Health Care Administration.

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 to make informed decisions about where they receive health care services. Hospitals and ASCs with poor survey results 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.