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February 25, 2015

David Seltz
Executive Director
Health Policy Commission
50 Milk Street, 8th Floor
Boston, MA 02109

Via Electronic Mail to HPC-regulations@state.ma.us

Dear Executive Director Seltz:

Thank you for the opportunity to provide comments to the Health Policy Commission (HPC) concerning proposed regulations to establish a registered nurse-to-patient ratio in acute care hospital intensive care units ("ICUs") as required by M.G.L. c. 111, § 231.

Steward Health Care System LLC ("Steward") is New England's largest integrated community-care, provider network encompassing ten hospital campuses, nearly 3,000 physicians, specialists, nurses as well as home health, behavioral health, and outpatient services. Steward is also the third largest private employer in the Commonwealth, with over 17,000 employees. We are proud to be one of the largest employers of organized labor, including members from the Massachusetts Nurses Association and the 1199 SEIU. These partnerships are a key component to Steward's mission to provide world-class health care in the communities where our patients live.

We appreciate the HPC's engagement and thoughtfulness on this issue to date. But we are concerned that as currently drafted, the proposed regulations add new, burdensome regulatory requirements to community hospitals at a time when reimbursements continue to decline and when the regulatory environment requires hospitals to provide more care with less resources. This regulation could result in unintended consequences, such as patient care redirected away from needed services (behavioral health as an example) to simply meet the requirements of such a rule that does not improve overall health.

We strongly urge the HPC to approach the allocation of health care resources from the perspective of fixed assets being distributed for the overall betterment of patients, and not from the perspective of unlimited capital and resources being allocated in distinct silos. Resources – especially at community hospitals – are not unlimited.

Through this letter we respectfully submit a table with suggested changes to the regulation that we believe will help to strengthen the final rule and bring it in line with the desired outcome. We also echo the concerns we expressed in writing to you on December 11, 2014, where we urged the HPC to develop final regulations that:

1. Recognize the significant differences between community hospital ICUs and teaching hospital ICUs and provide flexibility to community hospitals, especially those who are disproportionate share (DSH);
2. Focus the regulations' directives on *patient acuity*, not on how hospitals staff an ICU; and
3. Encourage providers to continue to adopt and utilize innovative technologies that improve care and lower costs, such as tele-ICU.

Consistent with these recommendations and concerns, community hospitals will require greater lead-time to implement the new regulatory requirements and administrative burdens within this rule. Specifically, we recommend allowing disproportionate share hospitals an additional year to come into compliance with the final rule.

Finally, we hereby also include suggested revisions to the proposed regulation in an attached table that we believe improve the proposed regulation. We welcome an opportunity to provide clarification or additional feedback as needed.

Thank you for your consideration.

Sincerely,

A handwritten signature in black ink, appearing to read 'David Morales', with a long horizontal flourish extending to the right.

David Morales
Chief Strategy Officer

Enclosures (2):

1. Table of suggested revisions to the proposed regulation
2. Letter submitted by Steward to HPC on December 11, 2014 regarding the proposed regulation

Attachment #1

Steward's Recommendations for Revising the Proposed Regulations

Specific language recommended for 958 CMR 8.00

Section	Comment	Steward's Rationale
8.02 Definition of ICU Patient	Narrow definition to focus on critically ill inpatients, not any patient physically located within the ICU	Consistency with description of a patient in ICU Unit definition – “critically ill” and “requires immediate and concentrated continuous care”. <i>Unintended Consequence: If left unaddressed, Community Hospitals may be forced to move all lower acuity patients (example: patients waiting for transfers to medical beds) from the physical geography of the ICU. This could ultimately disrupt patient care.</i>
8.02 Definition of Nurse Manager	Insert “that includes” the ICU.	Clarifies that a nurse managing the ICU may have management responsibilities inclusive of, but not limited to, the ICU. <i>Unintended Consequence: If left unaddressed, this language suggests that all hospitals must have a dedicated nurse to oversee the ICU. At small community hospitals with low daily ICU census, nurse managers are shared among more than one unit. It is not practical to hire additional management at a time when hospitals are focused on delivering high-quality patient care, while keeping healthcare costs low.</i>
8.02 Definition of Patient Assignment	Add “at any given time”	Consistency with language in 8.04
8.02 Definition of Staff Nurse	Add “to an ICU patient”	Clarifies the focus of this regulation on the patient.
8.04(3)	Clarified that this rule cannot require staffing greater than 1:1	This change makes the regulation consistent with the statute.

8.04	Add statement related to Staff Nurse breaks	Clarifies that hospitals can facilitate breaks of 30 minutes or less for a Staff Nurse assigned to an ICU Patient and remain in compliance with this regulation. <i>Unintended Consequence: Implementation would be burdensome and costly. It is also unrealistic to expect community hospitals to have unassigned staff on hand at all times to simply cover short breaks.</i>
8.05(1)	Add language re: initial assessment	Makes it clear that more than one assessment may be carried out during a Shift
8.05(2)	Delete reference to other environmental factors	Nurse manager still has the final decision, but nurse manager can seek input.
8.05(3)(b)	Allow for assessments more frequently than one per Shift	This recommendation is in the best interest of patient care.
8.06(1)(a)	Clarified that this rule cannot require staffing greater than 1:1	This change makes the regulation consistent with the statute.
8.06(1)(b) and 8.07(2)	Remove word “unique” and reference to “physical environment”	Acuity tool is patient centric, not facility centric.
8.06(2)(a)	Replace “shall” with “may”	Allows flexibility for hospitals to form advisory committee reflective of the composition of the patient care team.
8.06(2)(b)(4)	Delete subsection	These speak to the suitability of the ICU and are not related to the Acuity Tool or its use. In general, these are DPH issues.
8.06(2)(c)	Include physician review of Acuity tool	Allows for broader input into testing and validation of Acuity Tool.
8.06(2)(d)	Replace “address and respond” with “review”	The advisory committee is advisory only, not a forum for negotiation.
8.06(3)	Delete union language	Collective bargaining issues are outside the scope of the HPC’s authority.

8.06(3)	Include system language	Hospital systems should be able to create or select a standard Acuity Tool and convene a system-wide Advisory Committee, accordingly.
8.07(1)	Clarify that tools can be on paper or electronic or both	Provide clarification and flexibility for hospital implementation.
8.07(4)(b)	Delete	Non-clinical factors that may be considered but are not required.
8.07(5)	Revise language regarding purpose of the Acuity Tool	Consistency with 8.04
8.08(1)	Shorten record retention period regarding records of process	Once Acuity Tool is approved these records become irrelevant.
8.08(1)(b)	Delete reference to “other indicators of Staff Nurse workload”	Focus of the Acuity Tool should be on the patient.
8.08(2)	Shorten record retention period of results of assessments	No need to keep records this long, especially if they are not used for medical treatment or medical history.
8.10	Remove reference to “hospital’s website”	Not needed, costly, and duplicative for hospitals that participate in other initiatives that publish this information.
8.10(1) and (2)	Report annually	Quarterly reporting puts an unnecessary administrative and costly burden on hospitals.
8.11(3)	Replace “public” with “Commission”	Hospitals are responsible for reporting to the Commission; the Commission is responsible for reporting to the public.
8.12	Remove ICU staffing plan	Redundant, as regulation sets staffing plan for ICUs.
8.12	Require annual report of cost of this regulation	Tracks cost impact of this initiative.

8.13	Allow DSH hospitals additional time to comply with regulation	<p>Consistent with our recommendation related to significant differences between teaching hospitals and community hospitals.</p> <p><i>Unintended Consequence: Forcing community hospitals to implement without proper planning periods will cause undue financial and operational stress on community hospitals, especially those with DSH status.</i></p>
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