

Good Morning. My name is Tania Mangahas, and for my Master's Nursing Program, I recently completed an in-depth review of acuity tools and possible solutions in the context of this legislation. I currently work as a nursing informatics specialist at Lahey Hospital and Medical Center, and have extensive experience in Critical Care and Emergency Medicine as both a bedside nurse and educator. This background combined with my knowledge of healthcare information systems selection, implementation, and maintenance provides me with a broad knowledge of how an acuity tool can impact patient care and hospital operations.

To meet the bill requirements that have been proposed by this committee, an acuity tool must be able to quantify the patient care workload via a score or level that the charge and staff nurses can translate into nurse assignments for current and future shifts. Thus at its most basic level the tool must be able to identify available staff, identify patient census, and score or level the patients. Further, and most importantly, it must be patient centered, objective, valid and reliable. While this may seem an easy task, nothing is simple in today's healthcare environment with patient and nursing practice complexity increasing and ever decreasing resources both in human and financial capital.

In order for an organization to meet the requirements and intent of this bill, they must create or select an acuity tool that can assist in differentiating between a single or double assignment status. Completion and utilization of the tool must be efficient and seamless to nursing practice to not be burdensome to the nurse. By requiring or prescribing measurement of specific clinical indicators as detailed in 8.07 (4) (a) and (b), the calculation of acuity for an organization that opts for a manual system will be extremely time consuming. I suggest that that 8.07 (4) (a) and (b) be removed, and that the statement contained in 8.07 (4) be amended to state "The Acuity Tool shall include indicators that incorporate patients' physiological and psychosocial complexity related to care, scheduled procedures, medication, and therapeutic supports appropriate to the ICU population and its environment."

This general statement will allow organizations and staff the latitude to develop a valid and reliable tool that reflects their environment and patient population by supporting their unique types of critical care units and staff competency levels. They should have a holistic methodology that account for the physiological, psychosocial, education, and care coordination needs of the patients. In essence, it must include the nurse's assessment of the patient that would impact the calculation of acuity and nurse workload. If this is done, then the acuity calculation and resulting assignment recommendations will be a valid and reliable reflection of the staff nurse's assessment of the patient.

Regardless of the system that is chosen, either electronic or manual, these are complex tools to implement. Either will require a team to complete a market scan to identify tools that fit their environment and needs, and complete the RFP process to narrow the choices and select an option. They must then submit and get approval for budget allocation for purchase, development, testing, validation, training, implementation, and maintenance costs. Further if an electronic acuity tool is selected, this will require system integration and interoperability via interfaces and mapping for ADT, staffing, HR, and EHR solutions. All of this needs to occur in the context of other competing organizational projects that require funding and resources. Therefore I urge the committee to maintain the wording found in 8.06 (2) a. that tasks the "advisory committee to make recommendations to the

Acute Hospital on the development or selection and implementation of the Acuity tool.” This decision must be made in the context of understanding an organization’s IT infrastructure, financial resources, available and required expertise. Without this broad understanding, I fear that the resulting tool will not be successful in meeting the bill or staff needs.

In section 8.13 the deadline for certification and implementation by all Massachusetts hospitals is October 1, 2015. This deadline is unrealistic. Given that this date is a mere 25 weeks away and the DPH certification requirements have yet to be defined, hospitals do not know what to implement. Even if these were defined, 25 weeks is too brief a time to properly assess, purchase and implement a tool. Therefore I would strongly urge this committee to refrain from setting an implementation deadline until certification requirements have been clearly defined. Once these requirements have been determined, the committee should consider the vast array of complexities I have outlined and establish a more realistic time frame by which Massachusetts hospitals must implement their acuity tool. My suggestion is to allow for one calendar year in order for hospitals to properly and effectively implement a tool.

The implementation and utilization of an acuity tool in the context of this legislation is going to directly impact how we care for critically ill patients and indirectly impacts all patient care in an acute care organization. An acuity tool must be valid, reliable and grounded in the nurses’ assessment. In order for this to be successful, organizations must have both a clear understanding of the bill requirements, acuity tool functionality, and limitations in the context of their systems. I request that this committee develop regulations that provide guidance to nurses and their leaders, but that are not so prescriptive as to add more burdens to an already complex healthcare environment.

Thank you,

Tania Mangahas RN BSN
Nursing Informatics Specialist
Lahey Hospital and Medical Center