"You don't need peoples' opinions on a fact. You don't need a poll asking: Which number is bigger? 15 or 5? Or: Do Owls exist? " -- John Olver, host of Last Week Tonight

"The very definition of intensive care, demanded by the patient's condition, should be delivered on a one to one basis." -- Representative Denise Garlick

"We are through this legislation establishing the appropriate staff ratio is one nurse, one patient." -- Senator Stan Rosenberg

"It is clear the legislature intended to have a one patient to one nurse assignment with the ability to move to a two patient to one nurse assignment based upon the stability of the patients as assessed by the direct care nurses … the acuity tool was intended only to supplement the clinical judgment of the staff nurses, not replace it." -- Senator Marc Pacheco

"Any regulations derived from this legislation should not deviate from the clear legislative intent of the law." -- Representatives Nick Collins, Edward Coppinger, Diana DiZoglio, and David Linsky

"Dr. Allen noted that it is important to keep patient safety and quality of care in mind as the ultimate goal of the regulation." -- Minutes of QIPP Committee, December 10, 2014

Good morning. My name is Harley Keisch. I work as a nurse in the critical care unit at Berkshire Medical Center. Thank you for this opportunity to speak.

(In the interests of time I will summarize my written testimony.)

First, In the presence of facts, opinions should hold no sway. It is a fact that the people of Massachusetts through their democratically elected representatives have chosen safer, higher quality care for all ICU patients, regardless of cost.

And, It has now been thoroughly documented that the clear and unambiguous intent of the legislature, in passing this new law, is to set the **default** safe standard of care for all Massachusetts ICUs as one nurse to one patient. It is also intended that direct care staff nurses **shall** use their professional judgment, aided by an acuity tool, to decide if a patient is stable enough for them *to accept* the care of a second stable patient. It is also intended that hospital management **shall** support the decisions of the staff nurses with sufficient resources. It is intended that no exceptions to the new standard of care be allowed in time or space.

If anyone has any doubt whatsoever about the legislative intent, I would refer you to Representative Garlick's testimony before this committee at the first listening session and at the first public hearing on the proposed regulations; and to Senator Rosenberg's description of the bill's intent on the floor of the senate just minutes before its unanimous passage. I have provided transcripts and links to the videos of each below in "Reference".

Even more proof of the intent may be found in the testimony provided to this Committee by Senator Marc Pacheco's staff last week and in the letters submitted by Representatives Diana DiZoglio, David Linsky, Edward Coppinger, and Nick Collins.

All of this evidence is totally consistent with what the senior leadership of the MNA (who were present at the negotiations of this law) have been testifying to before this body with regards to the intent of the legislation.

In fact this tidal wave of documentation should wash away any of the mere opinion and spin being posited by the hospitals and nursing executives. Most of their testimony on the legislative intent is simply not credible. To the contrary, it is transparently self-serving and supports only maintaining the status quo and preserving the chronic understaffing that prompted this legislation in the first place.

I trust that this body is working diligently to support, clarify, and strengthen the intent of the legislature and I pray you will not waver nor succumb to pressure from the hospital lobbyists endeavoring to dilute, obfuscate, subvert, delay and weaken it.

Therefore, with the intent of the legislature in mind, and from my perspective as front-line critical care nurse, I have some suggestions for changes to the proposed regulations.

In my remaining time I'll highlight a few of them.

First, in at least three places, the proposed regulations incompletely re-state the text of the statute -- creating the impression that 1:1 or 1:2 are equally acceptable ratios -- when that was never the intent. If it is necessary to restate any portion of the law, simply restate that portion fully and without change.

Second, 8.05 (2) improperly substitutes the Manager's determination of a patient assignment for that of the direct care nurse which would frustrate the legislative intent that managers may only be involved in a dispute resolution role with the determination ultimately left to the individual nurse responsible for that patient's care.

Third, 8.05 (3) (c) – Should be amended to allow the nurse to assess or re-assess a patient's condition *whenever* a change in the patient's condition warrants it, not at only some predetermined frequency

Fourth, 8.06 -- Should be amended to give the Acuity Tool Development Committee the final say over the creation and adoption of acuity tools for that hospital's ICUs, not merely an advisory role. As Representative Garlick strongly cautioned, care must be taken to not create a" straw man". Also critically important: The staff nurses should be allowed to choose their own representation to the committee (whether or not they are represented by a bargaining unit)

Fifth, 8.10 -- Please require hospitals to post an explanation of the law in the family waiting area for each ICU and to give a written copy to the patient or family upon admission. Patients and families have a right to know they are now entitled to a higher standard of care.

Sixth, 8.12 --The currently proposed deadline of October 1st, 2015 will mark a year's time that the law has been in effect – a year and a quarter since it was signed by the governor. That will have been plenty of time for hospitals come into compliance with the new standard of care. Please do not give more time for foot dragging. And as far the suggestion to delay compliance at Disproportionate Share Hospitals for another entire year -- I guess you won't be surprised that I object to deliberately subjecting our neediest, least wealthy communities to a lower standard of care for an additional year.

Finally, there is only one employer for critical care nurses in Berkshire County. While I have accepted the risk of being active and vocal, almost all of the nurses I work with are afraid to speak up on this issue for fear of retaliation – I believe it is a legitimate fear. Please insert another section to provide protection for nurses and other employees who are advocating one to one care for critically ill patients by prohibiting any retaliation or disciplinary action against them.

Thank you.

Harley Keisch, R.N.

I would be glad to answer any questions you may have.

Section	Suggested Revisions Additions are **bold** Deletions are ~~struck~~	Comment/Rationale
8.01 Scope and Purpose:	*958 CMR 8.00 governs the implementation of M.G.L. c. 111, §231, which establishes a Registered Nurse-to-patient ratio of one-to-one or one-to-two in Intensive Care Units***, depending on the stability of the patient as assessed by the acuity tool and by the staff nurses in the unit,** *in Acute Hospitals licensed by the Massachusetts Department of Public Health and in hospitals operated by the Commonwealth of Massachusetts.*	If the regulations are going to restate the law or portions of the law, simply restate it fully, or restate the portion of it being referenced *in full and without change*. No abridgement is needed or helpful as deviations from the original language will inevitably inject ambiguity and uncertainty.
8.02 Definition Acuity Tool.	Acuity Tool. A decision support tool using a method for assessing patient stability for the ICU Patient according to a defined set of indicators, and used **by a Staff Nurse to aid them** in the determination of a Patient Assignment.	When possible, the regulations should clarify and support the now well documented legislative intent that the Staff Nurse's professional judgment of stability is to be afforded primacy.
8.02 Definition Patient Assignment.	***Patient Assignment*** - The assignment of a Staff Nurse to care for one or two specified ICU Patient(s) ~~for a shift~~ ***based upon the stability of the patient as assessed by the acuity tool and the staff nurses in the unit*****,** consistent with the education, experience and demonstrated competence of the Staff Nurse, the needs of the ICU Patient, and the requirements of 958 CMR 8.00.	If the regulations are going to restate the law or portions of the law, simply restate it fully, or restate the portion of it being referenced *in full and without change*. No abridgement is needed or helpful as deviations from the original language will inevitably inject ambiguity and uncertainty. I recommend that "for a shift" should be deleted as it implies that the only time period of patient assignments is in "whole" or "entire" shifts. This does not account for temporary assignments during procedures, breaks, transports etc. nor for changes in patient condition nor

		for changes in critical environmental factors that might necessitate changes in patient assignments during portions of the "shift".
8.04 <u>Staff Nurse Patient Assignment in Intensive Care Units</u> (1)	*(1) In all ICUs,* ***and at all times,*** *the Patient Assignment for each Staff Nurse shall be one or two ICU Patients,* ***based upon the stability of the patient as assessed by the acuity tool and the staff nurses in the unit*** ~~*at all times during a shift*~~*.* ***(2) A Staff Nurse shall never accept or keep an assignment that exceeds their assessment of stability.*** ***(3) Each hospital shall at all times provide adequate numbers of Staff Nurses to allow for compliance with 8.04 (1) and (2).*** *(4)* ~~*(2)*~~ *The maximum Patient Assignment for each Staff Nurse may not exceed two ICU Patients at any time during a Shift.* *(5)* ~~*(3)*~~ *Nothing in 958 CMR 8.00 prohibits a Patient Assignment of more than one Staff Nurse for an ICU Patient.*	If the regulations are going to restate the law or portions of the law, simply restate it fully, or restate the portion of it being referenced *in full and without change*. No abridgement is needed or helpful as deviations from the original language will inevitably inject ambiguity and uncertainty. When possible, the regulations should clarify and support the now extremely well documented legislative intent. To this end, and to emphasize the responsibilities the new law places on the staff nurses and the hospital management, I would strongly recommend adding (2) and (3) as shown.
8.05 (2)	(2) If the Staff Nurse assigned to care for the ICU Patient determines within the exercise and scope of sound nursing assessment and judgment that the ICU Patient's stability requires a different Registered Nurse-to-patient ratio than that indicated by the Acuity Tool, the Nurse Manager or the Nurse Manager's designee shall support the Staff Nurse's	I suggest rewriting paragraph (2) and inserting (3) and (4) as shown: Paragraph (2) improperly substitutes the Managers determination of a patient assignment for that of the direct care nurse; which would frustrate the intent of the statute. Managers may ONLY be involved in a dispute resolution

	decision ~~the Nurse Manager or the Nurse Manager's designee shall resolve the disagreement between the Acuity Tool and the Staff Nurse's assessment, in consultation as appropriate with the other Staff Nurses on the unit and taking into account critical environmental factors such as nursing skill mix and patient census on the unit, and shall determine the appropriate Patient Assignment~~. **(3) Only if there is a disagreement between the Staff Nurses as to the assessment of the patient's stability may the Nurse Manager or the Nurse Manager's designee help resolve the disagreement.** **(4) At no time may the Manager simply substitute their judgment of patient stability for that of the Staff Nurses.**	role and it remains with the individual nurse to make the final determination "…including the nurse manager or the nurse manager's designee when needed to resolve a disagreement." Senators Rosenberg and Pacheco, and Representative Garlick have each given clear descriptions of the legislative intent -- managers are not to substitute their judgment for that of the staff nurses nor are they to override that judgment. Whenever possible, the regulations should clarify and support the legislative intent.
8.05 (3)	The Staff Nurse assigned to care for the ICU Patient shall assess the stability of the ICU Patient using the Acuity Tool at a minimum: (a) Upon the ICU Patient's admission or transfer to the ICU; (b) Once during a Shift~~; and~~ **(c) Each time an ICU Patient's condition changes to the extent that the Staff Nurse judges a new assessment of stability is prudent** **(d) Whenever critical environmental factors in the ICU degrade or improve to the extent that the Staff Nurses**	8.05 (3) (c) – Should be amended to allow the nurse to assess or reassess a patient's condition whenever a change in the patient's condition warrants it, not at only some predetermined frequency.

	judge new assessments are warranted; and **(e)** At other intervals or circumstances as specified in the Acute Hospital's policies and procedures established pursuant to 958 CMR 8.07(6).	
8.06 (2) (a)	(a) Formation of an Acuity Tool Development committee to **develop (or select) an Acuity Tool and plan for its implementation** ~~advisory committee to make recommendations to the Acute Hospital on the development or selection and implementation of the Acuity Tool~~, which committee shall be composed of at least 50 percent **direct care Staff Nurses,** ~~Registered Nurses~~ who are not Nurse Managers, ~~a majority of whom are Staff Nurses~~ **selected by the Staff Nurses**, and other members selected by the hospital including but not limited to representatives of nursing management, and other appropriate ancillary and medical staff;	Should be amended to give the Acuity Tool Development Committee the final say over the creation and adoption of acuity tools for that hospital's ICUs. The nurses, and definitely not the managers, should be allowed to choose their own representation to the committee (whether or not they are represented by a bargaining unit) – otherwise it is all too easy to imagine that the management would be more than happy to stack the committee with their sycophants.
8.06 (2) (b)	(b) A process for the **Acuity Tool Development Committee to choose and develop** ~~advisory committee to address and make recommendations on the elements of~~ the Acuity Tool and other considerations for its implementation including but not limited to the following:	Should be amended to give the Acuity Tool Development Committee the final say over the creation and adoption of acuity tools for that hospital's ICUs.
8.06 (2)(b)(4)	4. Critical environmental factors relevant to the particular ICU and that may affect the ability of Staff Nurses to care for one or two ICU Patients that	To reinforce the legislative intent.

	shall ~~should~~ be addressed in the selection or development of the Acuity Tool, such as:	
8.07 (4) (a)	12. Immune; ~~and~~ **13. Vascular;** **14. Psychosocial (including substance abuse); and**	Add vascular and psychosocial to be comprehensive.
8.08 (1) (a)	(a) Membership of the **Acuity Tool Development** ~~advisory~~ committee including name and title;	Support the legislative intent that staff nurses be involved in both the development and approval of the tool, not just as advisors.
8.08 (1) (b)	(b) The rationale for selection or development of an Acuity Tool ~~including how the Acute Hospital addressed recommendations of the~~ **by the Acuity Tool Development Committee** ~~advisory committee~~ and the **basis of their** decision**s** to include or exclude certain clinical indicators of ICU Patient stability and other related indicators of Staff Nurse workload, and how critical environmental factors in 958 CMR 8.06 (2)(b)4 were taken into account in the selection and the method for scoring of the indicators;	Support the legislative intent that staff nurses be involved in both the development and approval of the tool, not just as advisors.
8.10 (1) (b) and **(c)**	(b) Any instance and the reason in which the minimum Staff Nurse-to-patient ratio of one to two was not maintained by the Acute Hospital; and **(c) Any instance and the reason in which the staff nurses assessment that a patient assessed as requiring a one nurse to one patient ratio was not maintained as one to one by the Acute Hospital.**	I agree with the MNA that the regulations should compel hospitals to document and report to DPH and the public those instances where there is a disagreement over the assignment of patients and each instance where the required nurse-to-patient ratio was not maintained.
8.10 (2)	(2) Each Acute Hospital shall issue reports quarterly to the	I agree with the MNA that the regulations should compel

	public on Staff Nurse-to-patient ratios by ICU on the Acute Hospital's website**, including details of each instance described in 8.10 (b) and (c),** and as may be specified in guidance of the Commission.	hospitals to document and report to DPH and the public those instances where there is a disagreement over the assignment of patients and each instance where the required nurse-to-patient ratio was not maintained.
8.10 **(3)**	**(3) Each acute hospital shall post a copy of M.G.L. c. 111, §231 along with a brief description of the legislative intent that the new default standard of care is one nurse to one patient, conspicuously in the patient waiting area or lounge of each ICU and also provide a copy to each patient or their family upon admission to the ICU.**	The regulations should call for posting of the law on all units and the family waiting area for each ICU, with instructions on how the family member can question the determination of acuity and patient assignment. The law is fundamentally about the patient's right to a safe standard of care.
8.13 Protection for patient advocates.	**Hospitals shall not take any retaliatory action against any employee (including staff nurses) because the employee advocated 1:1 patient care for a patient or patients, advocated for the adoption of measures to comply with M.G.L. c. 111, §231 or with 958 CMR 8.00, or reported violations (or suspected violations) of M.G.L. c. 111, §231 or of 958 CMR 8.00 to the Health Policy Commission or to the Department of Public Health.** **"Retaliatory action" for the purposes of 8.13 includes but is not limited to the negative evaluation, discharge, suspension or demotion of an employee, or other adverse employment action taken against an employee in the terms and conditions of employment.**	Empower staff nurses and other employees to advocate for compliance with the law and for the safety of their patients without the fear of reprisal.

Reference:

Representative Denise Garlick, lead sponsor of the ICU safe staffing law in the House, October 29, 2014, Daley Room on the fifth floor of Two Boylston Street testifying at the first listening session.

> *"**These regulations need to guarantee that the most critically ill patients in our states hospitals are receiving safe and appropriate care as determined by their condition. The very definition of intensive care, demanded by the patient's condition, should be delivered on a one to one basis.** Some unique situations may allow for a two to one patient to nurse assignment."*
>
> *"Each word of the legislation was negotiated, is directed and is deliberate. The words convey the legislative intent. Overall it is a very clear legislative intent. **On this bill, that received a unanimous roll call in the House of Representatives, the clear intent is that direct care staff nurses will be involved in the decisions governing the development and adoption of the hospital's acuity tool.**"*
>
> *"I strongly caution the Health Policy Commission to avoid any ambiguity in this [acuity] tool. However, to guard against this, **it is also a deliberate goal of the legislature that the language ensures that staff nurses, the direct care nurse, make an assessment of the patient at the time of any questionable assignment. And that the direct care staff nurse should determine if that intensive care unit patient needs the sole focus of a nurse, or if that nurse can or should allow his or her attention and care of the patient be divided.**"*
>
> *https://www.youtube.com/watch?v=3okB6L6qEDs*

Senate President (then Senate Majority Leader) Stan Rosenberg -- the lead negotiator of the bill -- describing the intent of the legislation just minutes before its unanimous passage on June 26th, 2014:

> *"I want to provide explanation on this bill pending before us, and ask for support so we can move it to the governor's desk. **The matter is the question of limiting the number of patients a nurse would be responsible for in intensive care units. A patient is entitled to have one nurse assigned to them for their care, that nurse has exclusive responsibility for that patient at that time, and no other patient. People in intensive care are the sickest. So, we are through this legislation establishing the appropriate staff ratio is one nurse, one patient.***

There will be circumstances, upon a patient becoming stable needing less attention. There may be patients that require additional assistance. A stable patient could be considered as not needing as much attention. The nurse, in agreement with her colleagues, could take on another patient.

The further provision in the bill is if there is a question about whether a second patient can be added to the workload of the nurse, and it can't be resolved among the nurses on the floor, then and only then would a nurse manager be involved."

http://youtu.be/GWU7DMmzmaU

Representative Denise Garlick testifying at the first public hearing on the proposed regulations, March 25th, 2015:

"My name is Denise Garlick. I am the state representative for the 13th Norfolk; I am both a nurse and a legislator.

I want to share with you as a nurse that I have worked in ICUs over the course of a career that began in 1975. I was an ICU nurse in both medical and surgical ICUs in the VA system. I worked in a non-union community hospital's special care unit. I worked in a non-union ICU in a rural hospital. And I spent many, many years in an ICU in an acute care hospital in Boston.

In addition to that, as a legislator, ***I just wanted to share with you, when you look at the actual legislation that was passed on this ICU regulation, in the space for the Speaker of the House, I was given the privilege to sign this bill. It's the senate president's name, the governor's name, and my name. When I tell you that I know what's in this bill, I know what's in this bill. And I stake my own name and career on it.***

HPC is being asked to deal with the biggest issue of all -- the quality of care. This is the issue that this ICU regulation is about, that you're being asked to deal with. The fourth stakeholder in this is, of course, the patient. And I want to tell you that, without drama, I am telling you that an ICU nurse is the difference between life and death for a patient. An ICU patient is so vulnerable, is so fragile, circumstances can change so quickly, that the presence of the nurse is what makes the difference. It is in fact the reason the patient is in the the intensive care unit -- those very words -- intensive care.

******

This law was about one to one nursing care for a patient in the intensive care unit. Any reasonable person knows that there might be some instance when it could be one to two. The patient is ready to move out of the intensive care unit. You know, for that brief period of time where they are waiting the bed on the floor, that patient may be more stable.

I think the HPC in its desire to be clear became somewhat ambiguous, because the repetition of "1 to 1" and "1 to 2" in your proposed regulations makes it sound like these are equal events.

It was NEVER intended to be an equal event. The law was written for 1 to 1 nursing care with respect to the fact in rare, RARE instances, it might be 1 to 2.

****

I want you to know, this proposed regulation, your hard work, and I know we tossed you the hardest ball of all, I know we did so in the legislature but it was a very hard choice

It was a very tough choice for the nurses and for the hospitals who were agreed to this legislation. ***It was clear in that language what we were agreeing to. We were agreeing to 1:1 nursing care in the intensive care unit. And that legislation was passed unanimously in the House of Representatives. Any deviation from that intent of the law would be a travesty.*** *And I ask you not to do that. Although I know how careful and reasoned you are trying to be, I ask you to return to that language, return to that intent that is so clear..."*

https://youtu.be/uDtcuVSwOHU

Please accept this addendum to my prior testimony:

> ***RE: Focus Questions on Proposed ICU Nurse Staffing Regulation***
>
> ***What additional information should the Commission consider regarding:***
>
> ***7. The implementation timeline for submission of the Acuity Tool(s) to the Department of Public Health for certification?***

Separate deadlines for selection vs. implementation?

The hospital lobby asserts that twenty-five weeks are insufficient to "assess purchase and implement a tool" and several recommend that an additional year (or two) will be required **for implementation** especially if it is an electronic tool that is selected.

I believe a year-long extension is not warranted for the development/selection phase and that the deadline for submitting a developed tool or selected tool for approval by DPH should be separated from a deadline for implementation. After all, as the proposed regulations currently state (emphasis mine):

> *8.09: (1) Each Acute Hospital shall submit the Acuity Tool for each ICU to the Department for certification* ***prior to implementation*** *and periodically as determined by the Department;*

It is simply not necessary or prudent to wait for an IT team to work through the issues of *software* development and integration with existing information systems. The details of the tool can and should be submitted for certification well ahead of the final implementation of an electronic version.

It simply makes no sense to work on implementation before the tool is certified. In fact, the sooner the tool is submitted, the sooner the IT team can begin software development and integration of an electronic version.

For those purchasing a tool, it would be wise to make sure the DPH will certify it before purchase. Again, the sooner the selection is presented to the DPH the better.

Thomas Jefferson took 17 days to write the Declaration of Independence, and the Second Continental Congress spent just two days making some changes before it was signed.

I believe it is feasible to develop and/or select an acuity tool in twenty-five weeks. It only requires the will to do so.

Please consider what the HPC itself has accomplished in a similar time frame. Only 26 weeks will have elapsed from the QIPP's first listening session held on October 29th, 2014, until the likely release of the final regulations on May 5th, 2015. As you are keenly aware, the process of drafting and approving the regulations included two public listening sessions, multiple committee hearings, advisory committee meetings, fact finding visits, and two public hearings on draft regulations. I am sure there were many other staff meetings and work sessions behind the scenes. Yet we will soon have a set of regulations. Should we believe the development of an acuity tool will really be any more complex and time consuming?

Care delayed is care denied.

Patient safety and the right of patients to receive the new safer standard of care under MGL c. 111, § 231 should not be delayed or denied by hospitals because an IT team is struggling with implementation and integration -- or because it is not prioritized by hospital management.

Please consider that you have received testimony from several front-line caregivers that many hospitals are thus far deliberately ignoring the law. Sadly, this is the situation where I work. I fear that if the deadline for the submission of an acuity tool is extended, the hospitals will seize on this as their next convenient excuse for inaction.

Regardless of the time frame the HPC ultimately chooses to allow, I recommend it be made explicit in the regulations that the mere absence of an approved acuity tool does not obviate the necessity for hospitals and nurses to comply with the law or any of the other provisions of the regulations. In the absence of the tool to aid nurses in our judgments of acuity, the regulations should specify that we shall simply rely upon our professional judgment. The regulations should also explicitly reinforce the legal duty of the hospitals to provide sufficient staffing, and to do so *now* -- without waiting for final implementations, certifications, sub-regulatory guidance, etc.

There may be other situations when a valid, certified acuity tool may not be available for the staff nurses to aid them in their legally mandated obligation to assess patient acuity and stability.

For example, consider the scenario in which the tool submitted is not approved by the DPH and sent back for revision. How long would this delay safer care? Would the hospitals be afforded another several months, or even a second additional year, to submit the revisions?

What if the tool is approved and the IT department takes a year or two to implement it?

What if the regulations governing the acuity tool change and invalidate the current acuity tool, requiring it to be revised or a new tool to be developed and certified?

What if a hospital simply runs out of the paper-based acuity tool forms because someone forgot to place an order at the printers?

Or what if the computer system is down and an electronic acuity tool is unavailable?

Shall we delay again if the hospital decides that the acuity tool software should be modified for use on with a different device such as iPad? Or for use on an Android based tablet?

How about using a good, old-fashioned paper version in the interim?

In all of these situations, or whenever a certified acuity tool is unavailable, the direct care staff nurse's professional judgment of patient acuity and stability must be sufficient and paramount. This supports the now extremely well documented legislative intent that the nurses' professional judgment is supreme, with the acuity "tool" merely a "tool" to aid nurses in being comprehensive and consistent in their assessments.

A separate timeline for the collection and reporting of data

Neither should any delay in the development, submission, approval, revision, or implementation of an acuity tool be factored into the collection and reporting of compliance and quality data. Hence, the timelines for data collection and reporting should also be decoupled from the acuity tool submission deadline. In fact, it may be quite valuable to later analysis efforts to require the collection and reporting of data to begin immediately so as to obtain some pre-compliance baseline information.

Please find below my suggested changes to Section 8.13

Respectfully,

Harley Keisch, R.N.

Section	Suggested Revisions Additions are **bold** Deletions are ~~struck~~	Comment/Rationale
8.13: Implementation Timeline**S**	**(1)** Each Acute Hospital shall submit an Acuity Tool for each ICU to the Department for certification no later than October 1, 2015. **(2) The DPH certified acuity tool shall be implemented no later than January 1, 2016.** **(3) Acute Hospitals shall commence collection of compliance and quality data, as specified in 8.10 and 8.11, on June 1st, 2015 with the first report of this data, to the public and to the DPH due no later than October 1, 2015.** **(4) In the absence of a certified acuity tool, due to any circumstance, the patient assignment for the registered nurse shall be 1:1 or 1:2 depending on the stability of the patient as assessed by the staff nurses in the unit.** **(5) Nothing in the timelines specified in this section should delay the compliance with any other aspect or provision of these regulations nor delay compliance with obligations under MGL c. 111, § 231 which became effective September 28.**	There should be separate deadlines for Acuity Tool submission, Acuity Tool implementation, and the start of collection and reporting of Compliance and Quality data. The deadline for submissions should not be extended due to Information Technology implementation and integration concerns. A paper form can easily be provided while the IT team completes its integration tasks. A tool is a tool. The legislative intent has been abundantly and clearly documented that the tool is just an aid for the direct care staff nurses to use as they make their assessments. The regulations should support the legislative intent in every way possible. Whatever the circumstances that are causing the lack of an approved acuity tool, it is still the duty of the direct care staff nurses under MGL c. 111, § 231 to use their professional judgment to assess the patients and determine the safety of an assignment. Adding **(4)** would make this explicit and provide

	2014.	support for those advocating for compliance with the law. For clarity, the requirement to be in compliance with all other aspects and provisions of the law and regulations should be explicitly stated.

REFERENCES:

At least one major software vendor views the suggested October 1st, 2015 deadline as **eminently feasible**:

"The AcuityPlus tool is already valid and reliable; is in use, and ready to be submitted per DPH schedule."

Heather Wood Product Manager, AcuityPlus QuadraMed Corporation

http://www.mass.gov/anf/budget-taxes-and-procurement/oversight-agencies/health-policy-commission/nurse-staffing/20150402-public-testimony-heather-wood.pdf

Lahey Health thinks **"implementation"** will take longer…

"An implementation timeframe of October 2015 for certification with DPH is insufficient given that the final regulation is anticipated to be approved in April 2015. There will likely be a 6 month backlog, at a minimum, for those hospitals that purchase an acuity tool from market vendors."

Scott V. Hartman Vice President, Government Relations, Lahey Health

http://www.mass.gov/anf/budget-taxes-and-procurement/oversight-agencies/health-policy-commission/nurse-staffing/20150402-public-testimony-lahey-health-system.pdf

Steward Health care **wants to create an "underclass"** of hospitals with a lower standard of care for less wealthy communities. Again the extended timeline advocated here is for "**implementation**".

"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 this rule"

"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."

David Morales, Chief Strategy Officer, Steward Health Care System, LLC

http://www.mass.gov/anf/budget-taxes-and-procurement/oversight-agencies/health-policy-commission/nurse-staffing/20150219-steward.pdf

The American Nurses Association Massachusetts also implies a **separate deadline for implementation vs. selection.**

The **selection** of an Acuity Tool requires a thoughtful process that is inclusive of the multiple stakeholders within an Acute Hospital. The October 1, 2015 deadline for Acute Hospitals to submit a tool to the Department does not provide sufficient time. The deadline for **implementation** should be extended to January 31, 2016.

Tara M. Tehan, President ANA Massacusetts

http://www.mass.gov/anf/budget-taxes-and-procurement/oversight-agencies/health-policy-commission/nurse-staffing/20150325-ana-tara-tehan.pdf

The ONL wants more time **if** it is an **electronic system** due to, once again, **implementation** issues AND poorly planned FY2015 budgets:

Technical Requirements: If the hospital selects or develops **an electronic tool**, the following are needed to assure functionality of an acuity tool…

***

These hospitals estimated that it could take 1-2 years to select/develop **and implement** a new acuity tool. **Implementation** of such a tool would also depend on the hospital allocating capital funds for its purchase and installation, as well as the ability of the vendor to meet the demand for the systems. Estimated implementation costs of acuity tools can vary widely depending on the size of the hospital, but in all cases the costs of such a tool are significant. The cost, timeline, and training required are important to keep in mind when drafting regulations governing the new ICU staffing law...

***

The acuity system selected must also effectively interface with the hospitals information technology operating system. **Time to fully implement** could range from 1 to 2 years.

***

ETC.

Joan Vitello, President of the ONL Massachusetts & Rhode Island , Associate Chief Nurse, Brigham and Women's Hospital

http://www.mass.gov/anf/budget-taxes-and-procurement/oversight-agencies/health-policy-commission/nurse-staffing/onl-testmony-hpc-nurse-staffing-final-v2-11-14-14.docx