COMMONWEALTH OF MASSACHUSETTS

HEALTH POLICY COMMISSION

Quality Improvement and Patient Protection Committee

May 20, 2015

Agenda

- Approval of Minutes from the March 4, 2015 Meeting
- Discussion of Proposed Updates to Office of Patient Protection (OPP) Regulations
- Discussion of Final Regulation and Quality Measures for Nurse Staffing Ratios in ICUs
- Schedule of Next Committee Meeting (July 8, 2015)

Agenda

- **Approval of Minutes from the March 4, 2015 Meeting**
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Vote: Approving Minutes

Motion: That the Quality Improvement and Patient Protection Committee hereby approves the minutes of the Committee meeting held on March 4, 2015, as presented.

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Office of Patient Protection Regulation Updates

Medical Necessity Criteria

958 CMR 3.101

- Changes to state law providing access to medical necessity criteria took effect on July 1, 2014, pursuant to FY 2015 budget*
- Updates are required to conform regulation to applicable Massachusetts law
- Updates will clarify expanded access to proprietary and non-proprietary medical necessity criteria

Open Enrollment Waivers

958 CMR 4.000

- Updates are required to conform regulation to Affordable Care Act and related Massachusetts law
- Definition of “eligible individual” changed
- Updates would not significantly change waiver process

* Ch. 165 of the Acts of 2014, sections 18, 172 & 173 amending M.G.L. c. 6D, §16(a); c. 176O, §§12(a) & 16(b)

Medical Necessity Criteria Regulation, 958 CMR 3.101

OPP Regulation	Proposed Update
958 CMR 3.101(3)(b)	Replace current language. Criteria will be disclosed to OPP, proprietary criteria not subject to Mass. public records laws, M.G.L. c. 4, §7, clause Twenty-sixth and M.G.L. c. 66, §10.
958 CMR 3.101(3)(c)	Non-proprietary criteria: access to the general public.
958 CMR 3.101(3)(d)	Proprietary criteria: access to insureds, prospective insureds and health care providers. Requester must identify particular treatments or services for which applicable criteria or protocols are requested.
958 CMR 3.101(4)	Non-proprietary criteria: publication on publicly available website, must be up to date.
958 CMR 3.101(5)	Insurance carrier must provide requested criteria as soon as possible and within 30 days.

Open Enrollment Waiver Regulations, 958 CMR 4.000

OPP Regulation	Proposed Update
958 CMR 4.020	Change definition of “creditable coverage” to add ACA-compliant plans, remove YAP plans which are no longer offered
958 CMR 4.020	Change definition of “eligible individual” to comply with changes to statute; resident of Massachusetts
958 CMR 4.020	Minor clarifications to definitions of “health plan,” “intentionally forgo enrollment” and “nongroup health plan”
958 CMR 4.030	Add reference to ACA, remove outdated waiver eligibility requirements
958 CMR 4.050	Updates to include reference to ACA; include reference to Health Connector as additional source of guidance
958 CMR 4.060	Minor clarification to wording
958 CMR 4.070	Change reporting date from July 1 to April 1 to consolidate and simplify report to OPP

Proposed Timeframe To Update OPP Regulations

- May 20, 2015 – QIPP Committee review of proposed regulations
- June 10, 2015 – HPC review of proposed regulations
- July 8, 2015 – Public hearing on proposed regulations at QIPP committee meeting
- August 2015 – Deadline to submit public comments on proposed regulations (date TBD)
- Fall 2015 – QIPP Committee review of final regulations
- Fall 2015 – HPC review of final regulations
- Fall/Winter 2015 – Publication of final regulations in Mass. Register

Vote: Approving and advancing proposed regulations

Motion: *That the Quality Improvement and Patient Protection Committee hereby approves the advancement of the PROPOSED updates to Office of Patient Protection regulations, 958 CMR 3.00, Health Insurance Consumer Protection, and 958 CMR 4.00, Health Insurance Open Enrollment Waivers, and recommends that the Commission vote to issue the PROPOSED updates to the regulations for public comment at its meeting on June 10, 2015.*

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Nurse Staffing Law – Chapter 155 of the Acts of 2014

An act relative to patient limits in all hospital intensive care units.

Section 231. For the purposes of this section, the term "intensive care units" shall have the same meaning as defined in 105 CMR 130.020 and shall include intensive care units within a hospital operated by the commonwealth.

Notwithstanding any general or special law to the contrary, in all intensive care units 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 acuity tool and by the staff nurses in the unit, including the nurse manager or the nurse manager's designee when needed to resolve a disagreement.

The acuity tool shall be developed or chosen by each hospital in consultation with the staff nurses and other appropriate medical staff and shall be certified by the department. The health policy commission shall promulgate regulations governing the implementation and operation of this section including: the formulation of an acuity tool; the method of reporting to the public on staffing compliance in hospital intensive care units; and the identification of 3 to 5 related patient safety quality indicators, which shall be measured and reported by hospitals to the public.

Codified at MGL c. 111, § 231

Regulatory Development: Stakeholder Engagement/Feedback

Public Listening Sessions

- CHIA Daley Room October 29, 2014
- State House Gardner Auditorium November 19, 2014

HPC Staff ICU Visits

- Boston Children's Hospital
- Brigham and Women's Hospital
- Steward Morton Hospital & eICU campus

Feedback on Quality Measures

- HPC solicited feedback on quality measures on December 10, 2014
- Received 3 submissions

QIPP Committee Meetings

- August 13, 2014
- October 29, 2014
- December 10, 2014
- January 6, 2015
- March 4, 2015 (release of 4 proposed quality measures)

HPC Staff Meetings with Stakeholders

- Massachusetts Hospital Association
- Massachusetts Nurses Association
- American Nurses Association-MA Chapter
- Department of Public Health (DPH)
- Organization of Nurse Leaders
- Quadramed (acuity tool vendor)
- Massachusetts Council of Community Hospitals
- Steward Health Care System
- Navigant Consulting Inc.
- Accenture
- DPH Shattuck Hospital

Release of Proposed Regulation 958 CMR 8.00

- Voted on by QIPP Committee January 6, 2015
- Voted on by HPC Board January 20, 2015

Public Hearings on Proposed Regulation

- Boston March 25, 2015
- Worcester April 2, 2015

Official Public Comment Period

- January 20, 2015 – April 13, 2015

958 CMR 8.00 – Public Comment Process By the Numbers

45

Parties who testified at the public hearings

225+

Total people in attendance at public hearings

4+ **Hours of oral testimony**

48 **Written comments submitted***

**The original deadline for submission of public comment was extended by one week to April 13, 2015.*

Key Considerations in Development of Regulation 958 CMR 8.00

Recognition of Hospital/ICU Differences

- Recommended final regulation strikes the appropriate balance consistent with the statutory goals of promoting patient-centered staffing while recognizing unique circumstances of each hospital ICU
- Emphasis on the process for development or selection of acuity tool

Role of ICU Staff Nurses

- Meaningful opportunity for participation and input by ICU Staff Nurses in the selection, development and implementation of Acuity Tool

Consideration of Administrative Burden

- Recommended final regulation's reporting requirements balance need to ensure staffing compliance with reasonable administrative requirements.

Role of DPH

- The Department of Public Health (DPH) will develop and implement certification and compliance procedures

Recommended Final Regulation 958 CMR 8.00

958 CMR: HEALTH POLICY COMMISSION

958 CMR 8.00: PATIENT ASSIGNMENT LIMITS FOR REGISTERED NURSES IN INTENSIVE CARE UNITS IN ACUTE HOSPITALS

Section

Recommendations in response to public comments

Default Ratio of 1:1

Overview of Issue	▪ Statute specifies that "the patient assignment for the registered nurse shall be 1:1 or 1:2 depending on the stability of the patient…" ▪ Proposed regulation reflects this statutory language and does not require Acute Hospitals to implement a "default" Patient Assignment of 1 nurse to 1 patient in ICUs
Summary of Comments	▪ Some commenters argued that the plain language of the statute requires a default ratio of one nurse to one patient ▪ Those commenters also suggested that the legislative intent was to include a 1:1 default
Recommendation	▪ The statute is clear on its face that the ratio "shall be 1:1 or 1:2 depending on the stability of the patient…" ▪ Assessment of ICU Patient stability by the Staff Nurse and the Acuity Tool should result in a 1:1 nurse-to-patient ratio where necessary ▪ No change recommended to the Patient Assignment limits

Recommendations in response to public comments

Application of Limits to the Unit (Definition of ICU Patient – 958 CMR 8.02)

Overview of Issue	▪ Statute requires compliance with nurse staffing requirements in all intensive care units ▪ Proposed regulation reflects the statutory language and specifies that the staffing requirements apply to intensive care units in Acute Hospitals and hospitals operated by the Commonwealth ▪ Proposed regulation requires compliance for all patients in an ICU
Summary of Comments	▪ Some comments suggested that the staffing requirements should apply only to critically-ill patients in the ICU, as opposed to all patients in the ICU, because not all patients in an ICU are critically ill ▪ These commenters recommended amending the definition of ICU Patient (which is defined in the proposed regulation as a patient occupying a bed in an ICU) accordingly
Recommendation	▪ HPC recognizes that some Acute Hospitals, particularly community hospitals, may have patients with lower acuity in an ICU for a variety of reasons (e.g., lower acuity patients for whom transfer or discharge is not recommended, boarders, location of specialized technology or equipment, patients with unique care needs) ▪ However, the statute requires unit-wide applicability of the staffing limit requirements and the HPC does not have flexibility on this issue

Recommendations in response to public comments

Application of Limit "at all times" – 958 CMR 8.04

Overview of Issue	▪ Proposed regulation says the Patient Assignment for each Staff Nurse shall be one or two ICU Patients "at all times during a shift" (8.04(1)) and the maximum Patient Assignment for each Staff Nurse may not exceed two ICU Patients "at any time during a Shift" (8.04(2)) ▪ Language intended to make clear that the limits must be complied with and are not elective, and hospitals staff accordingly ▪ HPC understands the requirements must be practical and circumstances such as meal and restroom breaks and unanticipated emergency situations must be addressed in some manner
Summary of Comments	▪ Some commenters asserted that "at all times" goes beyond the scope of the statute, creating significant operational and financial issues, and would require hospitals to maintain a costly "float pool" of nurses to relieve assigned nurses on daily/routine basis ▪ Other commenters strongly support inclusion of the language for clarity, citing the law's mandatory nature ▪ Other commenters suggested revisions to address emergency situations
Recommendation	▪ Based on public comments, including that the specific language is not required by statute, recommend removal of "at all times during a shift" and "at any time during a shift" from 958 CMR 8.04(1) and (2), respectively ▪ Removal of the "at all times" language does not change the compulsory nature of the Patient Assignment limit in ICUs ▪ DPH may also consider issuing guidance on this issue

Recommendations in response to public comments

Definition of Intensive Care Unit – 958 CMR 8.02

Overview of Issue	▪ Statute applies to "all intensive care units," including those "within a hospital operated by the Commonwealth"; "the term 'intensive care units' shall have the same meaning as defined in 105 CMR 130.020…" ▪ DPH licensure regulation defines "intensive care unit' as well as Coronary Care Unit (CCU), Burn Unit, Pediatric Intensive Care Unit (PICU), and Neonatal Intensive Care Unit (NICU) ▪ Proposed regulation applied to all such units licensed by DPH
Summary of Comments	▪ Hospital commenters objected to the application of the Patient Assignment limits to ICUs other than adult ICUs on legal and policy grounds. They stated that NICUs, PICUs, CCUs and burn units are separately defined in 130.020 and raised a number of policy and operational concerns with a broad definition, especially for NICUs which have unpredictable admissions and require flexibility to care for infants with a range of acuity. ▪ Other commenters disputed a narrow interpretation of applicability of the statute, supporting the application to all ICU types because the statute contains no explicit exceptions or indications that the law was intended to apply to adult ICUs only.
Recommendation	▪ The definition of ICU in the proposed regulation was based on a reasonable interpretation of the statute and the DPH licensure regulation. ▪ However, given extensive commentary asserting alternative legal interpretations and policy considerations, staff recommends the Committee advance the proposed regulation's definition of ICU in 958 CMR 8.00 for further discussion at the full Commission meeting on June 10

Recommendations in response to public comments

Assessment of Patient Stability – 958 CMR 8.05(1)

Overview of Issue	▪ Language in proposed regulation 958 CMR 8.05(1): *(1) For purposes of determining a Patient Assignment, the Staff Nurse assigned to care for the ICU Patient shall assess the stability of the ICU Patient utilizing:* *(a) The Acuity Tool developed or selected by the Acute Hospital and certified by the Department, pursuant to 958 CMR 8.00; and* *(b) The exercise of sound nursing assessment and judgment within the parameters of the Staff Nurse's continuing education and experience.*
Summary of Comments	▪ Some commenters suggested reversing the order of (a) and (b), listing the Staff Nurse's exercise of sound nursing assessment and judgment before the use of the Acuity Tool, and also suggested that ICU Patient stability must be assessed by all of the Staff Nurses collectively as a group, citing the reference to Staff Nurses (plural) in the statute ▪ Other commenters raised questions about the process for Patient Assignment (i.e., who decides which patient(s) a staff nurse will care for)

Recommendation	▪ Recommend the following amendments:
	  ▪ Reverse 8.05(1)(a) and (b)
	  ▪ Replace "*For purposes of determining a Patient Assignment…*" with "*For purposes of implementing 958 CMR 8.04"…* for clarity
	  ▪ Replace "*assigned to care for*" with "*assessing*"
	▪ No change recommended on the issue of collective Staff Nurse assessment, based on the law and supporting testimony and comments
	▪ In response to comments from nurses, recommend including language to clarify that nothing in 8.05 limits the application of relevant state or federal law to registered nurses, including the state licensure requirements for nurses

Recommendations in response to public comments

Assessment of Patient Stability – 958 CMR 8.05(2)

Overview of Issue	▪ Language in Proposed Regulation 958 CMR 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 within the parameters of the Staff Nurse's continuing education and experience 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 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*
Summary of Comments	▪ Some commenters asserted that the role of the Nurse Manager is to resolve a disagreement among all of the Staff Nurses concerning their collective assessment of patient stability, or a disagreement between the Staff Nurses' assessment and the Acuity Tool's assessment
Recommendation	▪ Per the statute, in the event of a disagreement between the judgment of the Staff Nurse assessing the patient and the Acuity Tool, the regulation allows the Nurse Manager to consult with Staff Nurses on the unit, in addition to other factors, to determine the appropriate Patient Assignment ▪ In addition to other technical clarifications, recommend that "*assigned to care for*" be replaced with "*assessing*" as in 8.05(1)

Recommendations in response to public comments

Frequency of Patient Assessment – 958 CMR 8.05(3)

Overview of Issue	▪ Language in Proposed Regulation 958 CMR 8.05(3): *(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) At other intervals or circumstances as specified in the Acute Hospital's policies and procedures established pursuant to 958 CMR 8.07(6)*
Summary of Comments	▪ Commenters suggested alternative intervals for assessment using the Acuity Tool (e.g., some commenters recommended assessments every 4 hours and "when a substantial event or change in a patient's condition or treatment occurs;" others said that assessment should be continuous, citing unintended consequences of limiting assessments)
Recommendation	▪ Consistent with the proposed regulation, 8.05(3) establishes the appropriate minimum assessment using the Acuity Tool ▪ More frequent assessments using the acuity tool may be required by hospitals as part of their policies and procedures under 8.06(3)(a), in addition to ongoing assessment by Staff Nurses ▪ As in 8.08(1) and (2), recommend that "*assigned to care for*" be replaced with "*assessing*"

Recommendations in response to public comments

Development or Selection and Implementation of the Acuity Tool – 958 CMR 8.06

Overview of Issue	▪ Language in Proposed Regulation 958 CMR 8.06(2): *(2) Each Acute Hospital shall develop, implement and document the process for development or selection and implementation of the Acuity Tool to be deployed in each ICU, which shall include but not be limited to the following required elements:* *(a) Formation of an 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 Registered Nurses who are not Nurse Managers, a majority of whom are 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;*
Summary of Comments	▪ There was consensus around the notion that Registered Nurses on the advisory committee should be ICU nurses, including some comments that advocated for at least 50% direct care ICU nurses ▪ Some comments stated that the committee should ultimately select the tool, not merely advise the hospital ▪ Others suggested that where members of the committee are represented by collective bargaining agent, the agent should be responsible for selection of the members ▪ Commenters stated that the language referencing bargaining obligations (proposed regulation 8.06(3)) is not required by the statute and could cause confusion
Recommendation	▪ Recommend amending the composition of the advisory committee to include at least 50% direct care Staff Nurses in the ICU in which the Acuity Tool will be deployed ▪ The statute requires that “the acuity tool shall be developed or chosen by each hospital in consultation with the staff nurses and other appropriate medical staff…”; no change recommended to advisory nature of committee ▪ Based on public comment, recommended language has been added (8.06(4)) to address potential administrative efficiency in Acute Hospitals with multiple ICUs ▪ Based on public comment and the fact that it was a restatement of applicable obligations, recommend the language in the previous 8.06(3) referencing bargaining obligations be removed

Recommendations in response to public comments

Required Elements of the Acuity Tool – 958 CMR 8.07

Overview of Issue	▪ The list of Clinical Indicators of Patient Stability in 958 CMR 8.07(4)(a) in the proposed regulation is exemplary, reflected by the language “such as” ▪ The same is true for the other Indicators of Staff Nurse Workload in 8.07(4)(b)
Summary of Comments	▪ Some commenters requested the inclusion of additional Clinical Indicators of Patient Stability (e.g., vascular, integument, psychosocial, behavioral health, substance abuse issues, and infectious status) ▪ Other comments objected to “requiring or prescribing measurement of specific clinical indicators” in 8.07(4) ▪ Other commenters requested the removal of the specific clinical indicators, because the indicators listed are not required
Recommendation	▪ Recommend creating a defined term for Clinical Indicators of Patient Stability with language from previous 8.07(4) ▪ Recommend creating a defined term for Indicators of Staff Nurse Workload with language from previous 8.07(4) ▪ The Acuity Tool shall include a method for scoring a defined set of indicators, which includes Clinical Indicators of Patient Stability and Indicators of Staff Nurse Workload; the specific indicators will be determined during the Acuity Tool development or selection processes

Recommendations in response to public comments

Records of Compliance for Certification Purposes – 958 CMR 8.08(1)

Overview	▪ Language in Proposed Regulation 958 CMR 8.08(1): *(1) Development or Selection of Acuity Tool(s). Each Acute Hospital shall document, retain for a minimum period of ten (10) years and provide to the Department and the Commission upon request, the process it followed for development or selection of the Acuity Tool required by 958 CMR 8.06(2), including but not limited to:* *(a) Membership of the advisory committee including name and title;* *(b) The rationale for selection or development of an Acuity Tool including how the Acute Hospital addressed recommendations of the advisory committee and the decision 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;* *(c) Written policies and procedures regarding the implementation of the Acuity Tool required in 958 CMR 8.07(5); and* *(d) The process for validating and periodically evaluating the use of the Acuity Tool in each ICU in the Acute Hospital.*
Comments	▪ Some commenters requested the deletion of portions the language in 8.08(1)(a) and (b) ▪ Some commenters asserted that the provisions are overly broad and burdensome and raised questions as to the types of documents that may be required for retention as a result of the language ▪ There were also requests to shorten the retention period
Recommendation	▪ Recommend further specification of the types of records required to be retained, which is now a defined set of records ▪ In consultation with DPH, no change recommended to the 10 year retention requirement

Recommendations in response to public comments

Records of Staffing Compliance – 958 CMR 8.08(2)

Overview	▪ Language in Proposed Regulation 958 CMR 8.08(2): *(2) Records of Staffing Compliance. Each Acute Hospital shall document and retain for a minimum period of ten (10) years records indicating the results of the assessment of ICU Patient stability and determination of Patient Assignment for each ICU Patient.*
Comments	▪ Some commenters requested that the results of the Acuity Tool assessment be documented in the patient's medical record and retained for 10 years ▪ Others reiterated their comments on 8.08(1), citing administrative burden and cost and inquiring as to the statutory authority to require these records, and recommended deletion of 8.08(2) ▪ Others requested a shorter retention period
Recommendation	▪ As in 8.08(1), no change recommended to the 10 year retention requirement ▪ Recommended final regulation allows Acute Hospitals to determine the appropriate mechanism for documentation and retention, consistent with state and federal law applicable to records that include individually-identifiable health information, used by hospitals to make decisions about the care and treatment of patients

Recommendations in response to public comments

Acuity Tool Certification and Compliance (958 CMR 8.09)

Overview	▪ Language in Proposed Regulation 958 CMR 8.09: *<u>8.09: Acuity Tool Certification, Enforcement by the Department of Public Health</u>* *(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;* *(2) The Department shall determine whether the Acuity Tool(s) was developed or selected by the Acute Hospital in accordance with the procedures and requirements of 958 CMR 8.00; and* *(3) Acute Hospitals shall comply with the procedures for certification and enforcement as established by the Department.*
Comments	▪ Commenters requested a public process, including a public hearing, for DPH's development of certification and compliance procedures; additionally, requested the removal of 8.09(2) in its entirety
Recommendation	▪ In order to provide flexibility to DPH in its development of certification and compliance procedures, recommend removal of 8.09(1) and (2) in their entirety

Recommendations in response to public comments

Public Reporting on Nurse Staffing Compliance – 958 CMR 8.10

Overview	▪ Language in Proposed Regulation 958 CMR 8.10: *8.10: Public Reporting on Nurse Staffing Compliance* *(1) Each Acute Hospital shall report to the Department, at least quarterly and in the form and manner specified by the Department:* *(a) Reports of Staff Nurse-to-patient ratios by ICU; and* *(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.* *(2) Each Acute Hospital shall issue reports quarterly to the public on Staff Nurse-to-patient ratios by ICU on the Acute Hospital's website, and as may be specified in guidance of the Commission.*
Comments	▪ Some hospital commenters urged removal of the requirement for hospitals to post on their websites because it is "duplicative" and suggested annual reporting via DPH's Health Care Facility Reporting System (HCFRS) ▪ Other comments urged more detailed required reporting ▪ Some comments specifically requested the removal of 8.10(1)(b) ▪ Other comments urged the HPC to require hospitals to post the staffing law in ICUs or family waiting areas
Recommendation	▪ Recommend simplification of the method for reporting in 8.10(2) to require that Acute Hospitals post the reports provided to DPH on the hospital's website ▪ Further, recommend clarifying DPH's role in determining the appropriate form and manner for reporting on staffing compliance to DPH ▪ Based on public comments, recommend removal of 8.10(1)(b) in its entirety ▪ No change recommended on the question of posting or requiring notice of the law

Recommendations in response to public comments

Collection and Reporting of Quality Measures – 958 CMR 8.11

Overview	▪ Language in Proposed Regulation 958 CMR 8.11: *8.11: Collection and Reporting of Quality Measures* *Each Acute Hospital shall:* *(1) Report ICU-related quality measures to the Department, as specified in guidance of the Commission;* *(2) Report the specified quality measures to the Department, at least annually, and in the form and manner specified by the Department; and* *(3) Issue reports to the public on the specified quality measures for each ICU, at least annually, on the Acute Hospital's website, and as may be specified in guidance of the Commission.*
Comments	▪ One commenter said that the quality measures should be issued by the HPC through sub-regulatory guidance and that the measures should track DPH's Adverse Event reporting requirements to avoid unnecessary duplication ▪ Another comment urged the state to adopt the process and measures from Patient CareLink into the DPH HCFRS ▪ Some commenters cited administrative burden in relation to the requirement that hospitals post the quality measure information on their websites
Recommendation	▪ Recommend simplification of the method for reporting in 8.11(3) to require that Acute Hospitals post the reports provided to DPH on their website ▪ Further, recommend clarifying DPH's role in determining the appropriate form and manner for reporting quality measures

Recommendations in response to public comments

Identification of Quality Measures (pursuant to 958 CMR 8.11)

Overview	▪ The statute requires the HPC to identify 3-5 related patient safety quality indicators, which shall be measured and reported by hospitals to the public ▪ At the March 4 QIPP committee meeting, the HPC released the following four proposed quality measures for public comment: (1) Central Line-Associated Blood Stream Infection (CLABSI); (2) Cather-Associated Urinary Tract Infection (CAUTI); (3) Pressure Ulcers (hospital acquired); and (4) Patient Fall Rate (all falls, with or without injury)

Comments	▪ Comments received on all of the quality measures proposed by the HPC
	▪ One comment indicated that hospitals and state agencies can "easily adopt three out of the four proposed measures in the ICU setting with minimal costs and time, but with maximum benefits"
	▪ There was consensus to change the all fall rate to "Patient Falls with Injury"
	▪ Some commenters suggested the inclusion of other measures, such as:
	  ▪ Adult inpatient self-report of pain control
	  ▪ Death among surgical inpatients (i.e., failure to rescue)
	  ▪ Registered nurse hours per patient day

Recommendation	▪ The HPC recommends the following four quality measures:
	  ▪ (1) CLABSI – NQF #0139
	  ▪ (2) CAUTI – NQF #0138
	  ▪ (3) Pressure Ulcers – NQF #0201; and
	  ▪ (4) Patient Falls with Injury – NQF #0202
	▪ Following promulgation of the regulation, the HPC will issue a bulletin specifying the measures, which will be distributed widely and posted on the HPC's website

Recommendations in response to public comments

Certification Timeline (958 CMR 8.12, as renumbered)

Overview	▪ Language in Proposed Regulation 958 CMR 8.13: *<u>8.13: Implementation Timeline</u>* *Each Acute Hospital shall submit an Acuity Tool for each ICU to the Department for certification no later than October 1, 2015.*
Comments	▪ Commenters asserted that given the complexity of acuity tools, procedural requirements of the proposed regulation, and uncertainty over DPH's certification process, it is not possible for hospitals to apply to DPH for certification by October 1, 2015 ▪ Some comments specifically requested extension of timeline for community hospitals and disproportionate share hospitals

Recommendation	▪ Incorporating feedback on the timeline, recommend amendments to 8.12, as renumbered, as follows:
	  ▪ Academic medical centers must comply with DPH's requirements for certification of Acuity Tools by March 31, 2016, or as otherwise specified in DPH's requirements for certification
	  ▪ All other Acute Hospitals must comply with DPH's requirements for certification of Acuity Tools by September 30, 2016, or as otherwise specified in DPH's requirements for certification

Next Steps

May 20: QIPP Meeting

Vote to advance recommended final regulation to HPC Board

June 10: HPC Board Meeting

Discussion of and vote to approve and promulgate 958 CMR 8.00

Post-Promulgation of 958 CMR 8.00:

- HPC issues guidance identifying the four patient safety quality measures for public reporting
- DPH develops certification and compliance requirements
- Considerations for evaluation of the law

Vote: Approving and advancing final regulation

Motion: *That the Quality Improvement and Patient Protection Committee hereby approves the advancement of the recommended FINAL regulation on patient assignment limits for registered nurses in intensive care units in acute hospitals, developed pursuant to section 231 of Chapter 111 of the General Laws, provided however, that the Committee recommends further discussion by the Commission of the definition of "intensive care unit," and recommends that the Commission vote to approve and promulgate 958 CMR 8.00 at its meeting on June 10, 2015.*

Agenda

- Approval of Minutes from the March 4, 2015 Meeting
- Discussion of Proposed Updates to Office of Patient Protection (OPP) Regulations
- Discussion of Final Regulation and Quality Measures for Nurse Staffing Ratios in ICUs
- **Schedule of Next Committee Meeting (July 8, 2015)**

Contact Information

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