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December 11, 2014

David Seltz, Executive Director
Health Policy Commission
Two Boylston Street, 6th Floor
Boston, Massachusetts 02116

Dear Executive Director Seltz:

On behalf of Steward Health Care System LLC (Steward), I write to offer input on the development of regulations for *Chapter 155 of the Acts of 2014: An Act Relative to Patient Limits in All Hospital Intensive Care Units*.

Steward is the largest, integrated community care model in New England comprised of 11 hospital campuses, over 3,000 physicians, and other provider entities in Eastern Massachusetts. With more than 17,000 employees, Steward is one of the largest employers in Massachusetts, as well as one of the largest taxpayers. Steward is also one of the largest Medicaid providers, and the second largest provider of inpatient behavioral health care services. We are also proud to be one of the largest employers of organized labor, including the Massachusetts Nurses Association and the 1199 SEIU.

I write to you today in response to the statute directing the Health Policy Commission (HPC) to promulgate regulations that facilitate the implementation of the new law, including the formulation of an acuity tool, the creation of a method for public reporting of hospital compliance, and the identification of three to five patient safety indicators to be publicly reported by hospitals.

There are four areas of focus I wish to bring to your attention and that I strongly urge the HPC to address in the regulations:

1. Focus on how hospitals should ***staff patients*** who are placed in an intensive care unit (ICU), not how hospitals should ***staff an Intensive Care Unit (ICU).***
2. Develop and implement a statewide acuity tool that reflects the spectrum of difference among all hospitals with ICUs.

a. Nearly 70% of ICU patients in the Commonwealth are cared for in nine major teaching hospitals (see slide 2 attached to this letter);

b. Teaching hospitals care for a higher number of patients with higher case mix index than community hospitals.

3. Address or exclude patients who "board" in the ICU. This would include patients who are residing in an ICU bed, but not in need of ICU level of medical care.

4. Facilitate - not hinder – innovative, tele-ICU coverage and innovative care strategies currently employed by many community hospitals in Massachusetts.

Focus on how hospitals staff patients, not how hospitals staff units

In concept, I fully agree with the spirit of the legislation. However, as a nurse with over 21 years of experience delivering patient care in various settings, I believe the statute's "one size fits all" mandate, (i.e. *establish a nurse to patient staffing ratio of 1:1 or 1:2 in hospital Intensive Care Units*) is fundamentally flawed and could have unintended consequences. **As a nurse, I strongly believe that what is most essential is how we staff a patient depending on their level of clinical acuity, not how we staff a hospital unit or a bed.** The HPC's regulations must focus hospitals and all stakeholders on how hospitals should best staff a patient who is placed in an intensive care unit, not on how to staff a hospital's intensive care unit.

To be clear, the HPC's regulations - and any sub-regulatory guidance - must acknowledge that the types of patients who present at a community hospital differ greatly from those who present to a teaching hospital or academic medical center. For example, the average patient in the Cardiac Surgery ICU at the Massachusetts General Hospital will have fundamentally different care needs and medical complexities than the patient with an arrhythmia at a small community hospital's ICU like Nashoba Valley Medical Center (see slide 1 attached to this letter).

As such, the HPC's regulations should promote a standardized, statewide acuity assessment tool. A standardized, statewide acuity assessment tool will ensure that all hospitals and nurses are able to work from the same point of reference (i.e. medical acuity) as they assess the appropriate staffing needs of a patient who is placed in a hospital's ICU.

Large teaching hospitals - not community hospitals - account for the majority of all ICU cases

Nearly 70% of all ICU volume statewide is concentrated at nine major Boston-area teaching hospitals (see slide 2). Boston teaching hospitals have significantly higher ICU patient volume and significantly higher case mix in the aggregate. These hospitals often have multiple, specialty ICUs (e.g., cardiac ICU, respiratory ICU, neuro-ICU, etc.) and deliver highly complex medical care that most often cannot or should not be provided in a community setting.

Medical care in teaching hospital ICUs may include complicated hemodynamic support, management of life sustaining cardiac support devices and advanced ventilation interventions. In such ICU units – where a patient's medical care needs are very complex – the nurse to patient staffing may need to be at 1:1 or 1:2. Moreover, the financial structure and resources found at teaching hospitals enables them to sustain high staffing levels, and also to routinely acquire new, sophisticated medical equipment needed to treat patients with such complex medical needs.

In contrast to teaching hospitals that generally have more than one ICU (which affords specialized care by patient condition), community hospitals often have a single ICU that covers medical, surgical and cardiac patients. Community settings traditionally care for less complex patients commensurate with their limited resources for specialty consultation and advanced procedures. In community hospitals, patients may be admitted to the ICU because the level of surveillance or monitoring needed exceeds that which can be provided in the non-ICU medical-surgical units. HPC regulations should therefore acknowledge the difference in the staffing needs of less acute patients in community hospital ICUs, as compared to the complex medical needs of patients undergoing treatments at teaching hospitals, and adopt rules that focus staffing where most ICU patients with higher acuity receive complex medical care.

Community hospital ICU "boarders" should be addressed or excluded

In community hospital settings, patients may be placed in ICUs for many reasons other than the need for critical care. Examples might include a bed shortage during flu season, when all regular beds are full. Another example might be a patient who is the victim of domestic abuse. The ICU may be the only locked unit available for patient protection. The HPC regulations should offer community hospitals the flexibility to exclude or make adjustments for non-critical patients who "board" in an ICU. Rigid staffing requirements that do not allow for distinction will force community hospitals to place only the most critically ill patients in the ICU and deny access to this "location" within the ICU, which benefits community hospital patients today.

The regulations should not hinder innovative, Tele-ICU coverage

Many community hospitals, including Steward hospitals, have invested significant dollars in the tele-ICU as a means of amplifying nursing and physician support around the clock. The literature supports the fact that tele-ICU is associated with lower mortality and shorter lengths of stay. Further, tele-ICU programs facilitate standardized care in ventilator management, transfusion utilization, blood clot prevention, glucose control, etc. These best practices are measured and benchmarked, driving further improvements. At Steward we have observed significant improvement after implementation of the tele-ICU. We urge the HPC to address the staffing increment that innovative, tele-ICU care strategies have introduced across many community hospitals.

Additional Observations

To require the same rigid staffing requirements at teaching hospitals and community hospitals alike, challenges the flexibility, efficiency and productivity of smaller community hospitals, and ignores the vast difference of their respective patient statuses, or a community hospital's function in the full spectrum of care delivery. By not taking into account the differences between and among the patients that depend on accessing care in the communities where they live versus teaching hospitals, the regulations will place undue financial burden on community hospitals already strained by inadequate reimbursements and lower margins – this is the antithesis of the HPC's mission and arguably not in the best interest of patients (see slide 3).

We look forward to working with the HPC on the development of these important regulations. The final regulations should help all hospitals to prioritize the medical care needs of patients – not the staffing vicissitudes of a hospital unit. The right way to achieve this is by understanding the clinical acuity specific to each and every patient that seeks hospital care.

Thank you for your attention to these comments.

Sincerely,

Donna Leger

Donna Leger, MSN, RN, CCRN, NE-C
Senior Director of Critical Care Nursing and Tele Health Services
Steward Health Care System LLC

Enclosure

Cc: Dr. Stuart Altman, HPC Board Chair
Dr. Wendy Everett, HPC Board Vice Chair
Dr. David Cutler, HPC Board Commissioner