HB 2697 Testimony in Opposition

Thank you, Chair Nosse, Vice Chairs Goodwin and Nelson and the Committee members, for allowing me to express my strong opposition to HB2697.

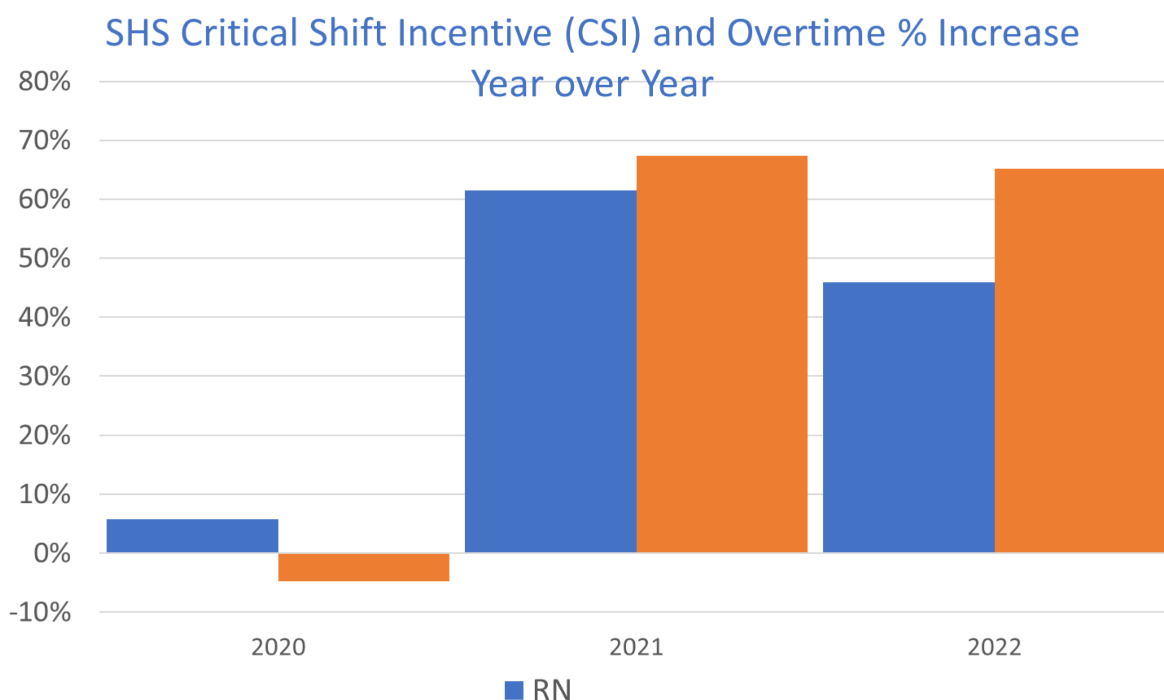
My name is Tim Eixenberger, here on behalf of the nurse leadership within Samaritan Health Services (SHS). I have worked 46 years in health care in a variety of positions and states. I have a bachelor's degrees in nursing and respiratory therapy, master's in business administration and my Doctorate in Nursing Practice. I am a strong proponent of providing high quality and safe care along with exceptional patient experience and highly engaged nursing staff.

This bill intends to enforce strict ratios to improve patient safety and staff engagement. Unfortunately, passing this bill as proposed will result in the opposite. I will make my points as to why this is a going to have a very serious negative impact on the health and the care provided throughout Oregon.

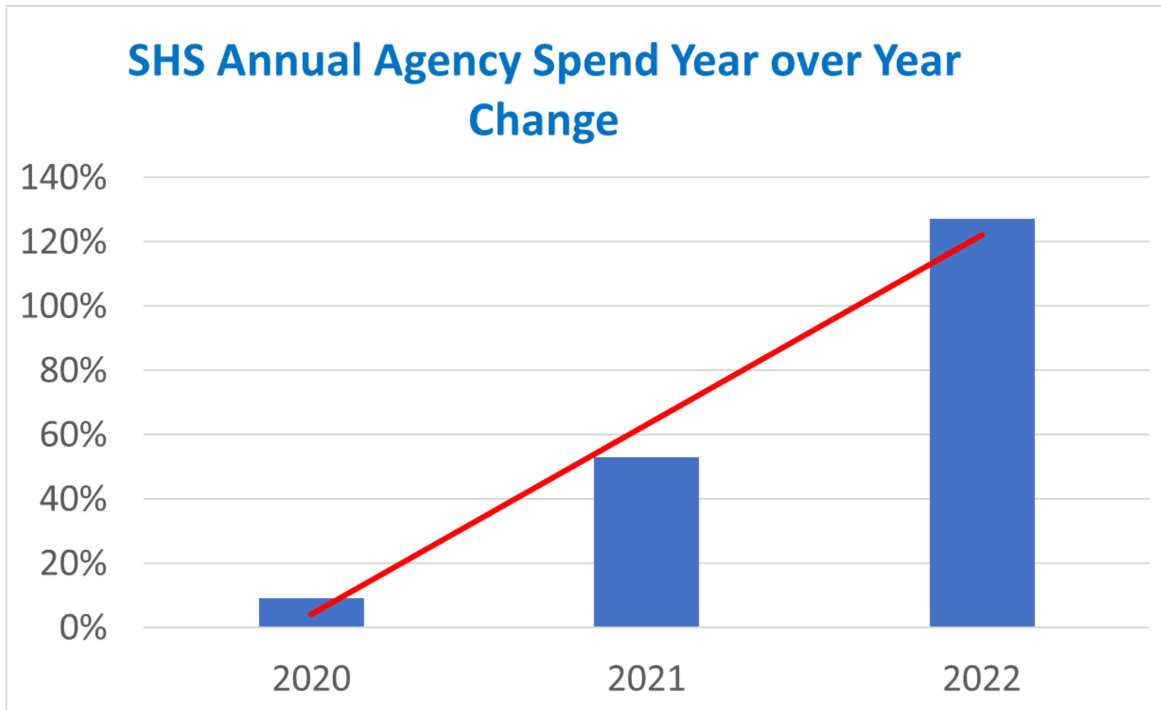
Staffing and Demand

This Bill does not address the severe shortage of nurses, CNAs, and other allied health professions in Oregon. If there is any doubt of this shortage, you only need to look at the high dependence of bringing in Traveler RNs and other health professions from other states. At Good Samaritan Regional Medical Center (GSRMC) we routinely operate and fill 160 patient beds. We are utilizing 65 full-time nurse travelers at this time, and we are financially incentivizing nurses to pick up shifts beyond their regularly scheduled shifts with significant financial costs to the organization. You will see this information in graphic form below. We are not alone in the effort to hire and retain staff. We are in critical shortage of RNs, CNAs, and other professions.

In 2022 Samaritan labor costs for Critical Shift Incentive pay and in Overtime pay was 155% greater than in 2019. This is done to provide the staff needed at the bedside and as close to agreed upon staffing plans.

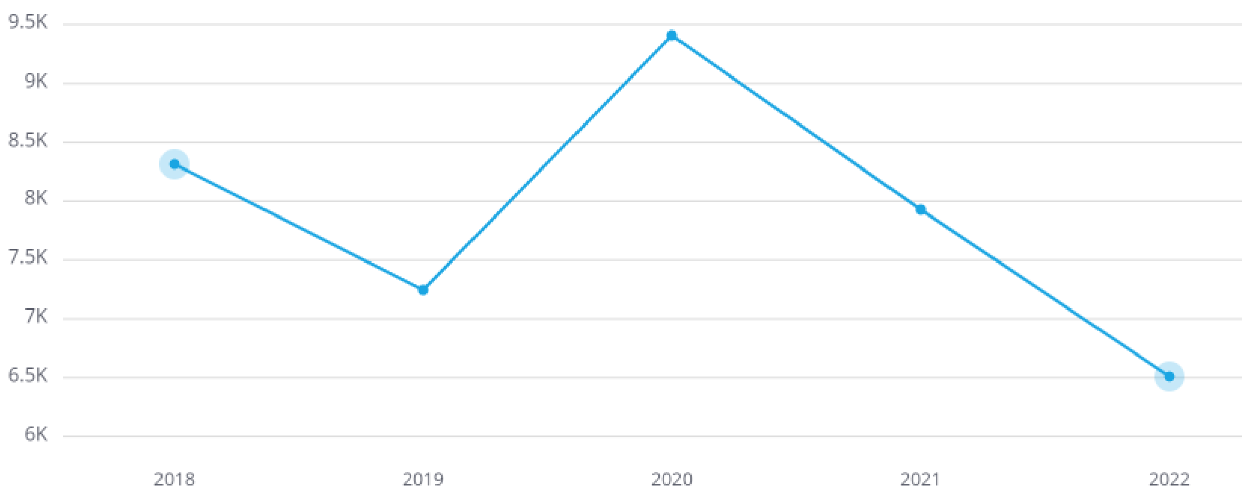


Agency dependence is a significant cost to healthcare. We do this because there is a severe shortage of RNs and all health care professionals.

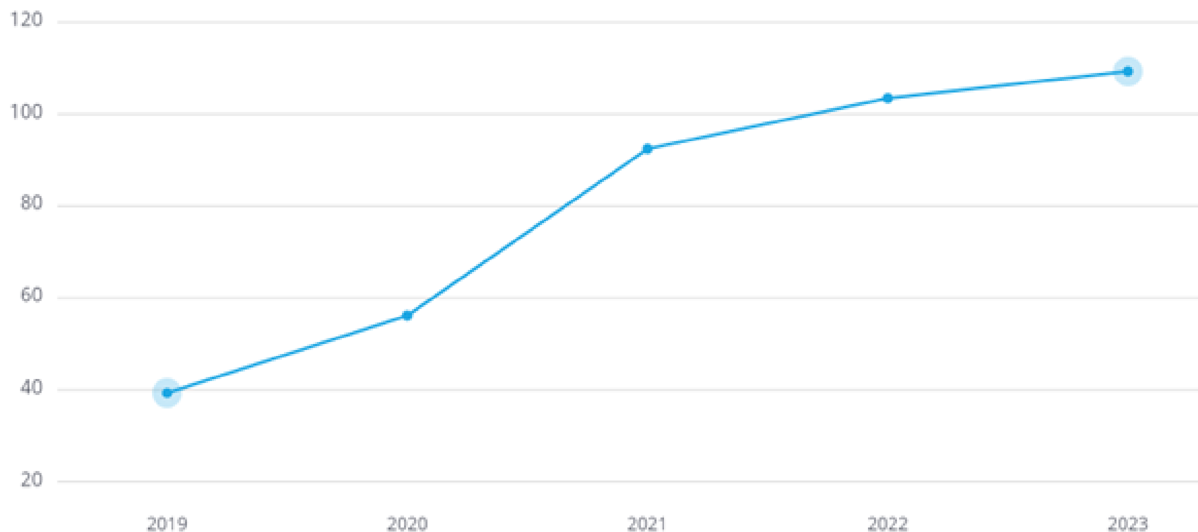


This Bill does not provide any additional staff. It does significantly increase demand especially with the "at all times" with no exceptions. It is our estimate that this bill as written will increase the demand on RNs by 120 FTEs for Samaritan Health Services and 65 FTEs at Good Samaritan Regional Medical Center (GSRMC) alone. And there will l be significant increases with other health professionals as well.

5-year trend employment applications



5-year trend of open RN position vacancies



Passing a Bill that mandates tight staffing ratios at all times is designed to significantly increase the demand for more health care workers when there is not enough staff currently available within the state.

Four of our Five hospitals rely on GSRMC, the regional referral center, to accept patients that require dialysis, cardiac cath, vascular surgery, trauma, high risk OB and NICU along with higher complexity care in ICU, to name a few. Below are a few of the cases experienced over the last couple of months. This is due to current staff shortages despite the high number of traveler RNs and high financial incentives for staff to pick up additional shifts.

Example one: An elderly man was brought in by EMS due to abdominal pain and required a hernia reduction that evening. After several hours the patient's respiratory status declined, and the patient was found to have several broken ribs from a fall that had occurred several days prior to this visit with a large hematoma pleural effusion. In consult with the Pulmonologist at the acute care center, it was determined that he required surgical intervention to remove. Multiple acute care facilities were contacted for transfer and all of them were full, many of which were full due to staffing. On day three, the patient was finally placed with assistance from the Oregon Medical Coordination Center to a higher level of care. This man resided in the ED, untreated for 3 days because the facility had no ability to treat him as well as no ability to move him to an appropriate level of care. This increased his risk for mortality, skin breakdown, further complications, and poor outcome.

Example two: A 54 yr. old man come in with chest pain, he was diagnosed with a non-STEMI heart attack. Because it was not a STEMI, we were not able to get him to a Cath lab emergently and had to go through the normal channels. The ED provider called the Cardiologist asking for consult, was told patient needed to go to Cath lab ASAP but was unable to find a bed. Patient sat in ED for 3 days on Heparin while the heart had ongoing damage indicated by increasing Troponin levels until a facility had a

bed, appropriately staffed open. As a result of living in Oregon on the Coast and an inability of hospitals to accept patients while beds remain open, and nurses set with 4-5 patients this patient has lifelong cardiac disease that will shorten his life span.

We have staffing shortages that are threatening patient care. Implementing ratios, as HB 2697 does, prolongs a patient's ability to get the care when they need it.

Patients who can't be transferred wait in settings that do not improve their conditions. Sometimes we are able to admit them and families decide to make them DNR due to condition. This has taken a toll on our staff, they must stand by knowing that one procedure, one surgery, one treatment would save the patient, but because we do not have the staff, we cannot make those services available to them. So our caregivers watch patients that require dialysis deteriorate because we cannot find a facility to treat them. We have patients that have complex surgical needs that we are unable to safely care for, yet we must provide the best possible care for them we can. We have physicians being asked to function as intensivists and being pushed to provide care they feel they are incapable of safely providing.

Just recently we had a patient brought to us by EMS, a woman in her late 70s requiring extensive abdominal surgery, one that is typically done in larger facilities with specialists on staff and available. To save her life our surgeon took her to surgery and completed a resection with a colostomy. The patient returned to an ICU bed where the hospitalist and surgeon worked together to try to keep her alive. Family was called and told that their mother, grandmother, sister, friend would probably not leave the hospital. After a few days she went into kidney failure and required dialysis. The family was told that if we could not find a hospital to transfer her to that she would not make it. Providers worked to find a hospital willing to take her and after about 24 hours they found one facility that had an open ICU bed. Once she arrived the intensivist stabilized her, they were able to provide dialysis, and after several weeks she was ready for skilled care. Had we not found her a place with advanced services instead of celebrating birthdays and holidays this year with her family, they would have planned and held a funeral and had only memories of their mother, grandmother, sister, friend.

From one of our intensivists: "I was on-call for the unit and received a request to accept a transfer from "one of our sister hospitals". This was a patient with acute respiratory distress syndrome whom they were having difficulty finding an accepting facility to accept due to staffed beds in the state and region. The patient was being treated in a coma like state with high sedation of 5 Ketamine and 50 fentanyl for several days. The hospital could not accept the patient even though we had a bed. We did not have the staff to care for the patient. Under a one-size-fits all law, this scenario will occur more often. Hospitals may have the bed, but because of HB 2697 they will not have the staff to care for our community.

The staff are not worried about the ratios, they are worried about their ability to do their job safely. When laws are put in place that prevent patients from being cared for appropriately i.e. unable to transfer to specialty care due to staffing, and nurses have to stand by helpless watching patients decline and die knowing that one procedure could save their life, they become overwhelmed and frustrated. They become burnt out and experienced compassion fatigue, so while you want to focus on the numbers you need to stop and focus on the core problem. There are not enough staff to provide the care of patients." This bill will significantly compound this problem.

Ratios are not the solution, it will only close more beds and make it more difficult for patients to receive treatment. Imagine having your appendix rupture, you show up to the ED and the front doors have a sign that says “at capacity, closed” you get into the car, and you drive to the next hospital which may be 40 miles away only to find the same thing. At this point you are hurting, you are running a fever and you can no longer drive, so you return home and call 911, you are told that all ambulances are tied up with patients and they are not sure when they will get to you, but just wait. Many hours later you see EMS, they start the treatment for sepsis, they know of a facility that has just opened so off you go. When you arrive, the surgeon is called in and he takes you the OR, your belly is full of puss, and you are septic. Over the next few days, you get worse and at one point your partner is told that they are not sure you will make it. That if only you would have been treated sooner. This is the care you are proposing for our patients. You are asking healthcare workers to stand by and watch this happen, not one person signed up to do this. While I want safe care and I want workers to be supported it is not through mandatory ratios that close hospital beds due to ratios at all times. The impact will likely force more hospital and service closures

Staffing Committees

We currently have staffing committees that help to set safe staffing based on the American Nurses Association standards of using clinical decisions based on patient acuity and intensity along with the nurses’ skills, knowledge, and capabilities to provide safe quality care. This bill does not address that. It is always strict very limited ratios at all times. Not all patients have the same needs, yet this bill treats all patients the same i.e. ratios at all times.

Oversight within the state of Oregon for RN and CNA staffing already exists. Each hospital has a staffing committee that requires consensus on each nursing unit’s staffing plan. Adding more bureaucracy will make this more complicated and impede the care provided to the communities we serve. This Bill supersedes the clinical knowledge and the variation in patient complexity with a rigid model, at all times.

At All Times

Health care is a dynamic, not static service. Significant swings in patient census occur hourly. Hospitals cannot control the demand. This is due to fluctuations in the ED, OB, Cardiac patients, trauma, strokes, surgical emergencies, and other factors. This is routine for health care professions. There is not an expectation that we can prevent the variation in demand. This bill is going to increase demand even beyond our current staffing needs. For SHS it is estimated to be 120 more RNs to always maintain these proposed ratios. Please refer to the significant cost of agency and critical incentives to maintain approved staffing plans. It is common knowledge that adjustments are made to provide safe quality care by adjusting assignments that address patients preparing to leave the hospital while accepting additional patients that require more attention of the nursing staff. This Bill does not allow for that flexibility. The only option hospitals have is to mitigate the demand through closure of EDs, restrict surgical cases, close doors to EMS and transfers, only provide essential services, all due to staffing. We already know there is not ample staffing to accommodate these fluctuations in staffing and demand.

Providing care for our communities is dynamic and responsive. The way HB 2697 is drafted makes staffing static without exceptions or a hospitals ability to be responsive to mee the demands or needs of our community.

Models of Care

There are many models of care that cannot be utilized based on how this bill is written. The cost of care in the USA is one of the highest in the world and ranks around the 25th percentile in health care. This is not where anyone wants to be. Unfortunately, this Bill is designed around team health approach (Nurses, Techs, professional and service staff). Ironically the ratios being presented in the Bill are based on a primary care model. This restricts hospitals from trialing and or utilizing other ways to care for patients. We know that changes in the model for health care delivery are very likely if not required when you consider the lack of available health care workers, extreme cost of healthcare delivery, inefficient and ineffective care. Technology is very likely to have an impact on the way we provide care. This Bill has no provision for accommodating improvement. You are required to keep this model regardless. There must be innovation, not stifling of the care model.

Impact of this Bill Beyond Hospitals

EMS

Forcing strict ratios on Nurse-to-patient care will force the ED to restrict access. When that happens the wait times for EMS will go beyond what is reasonable. EMS has the legal right to drop off patients and leave. If that happens and back up staff cannot come in, there will be continuous violations of the Bill and no manageable way to address the demand. If EMS remains in the ED with the patients until there is a ratio met to accept, they won't be available for their community's 911 calls. Even worse is if hospital EDs go on divert or at critical capacity, EMS will have to bypass their local hospital and drive long distances to find any available ED that can accept patients. Again, this impacts EMS's ability to care for their local community.

Surgeons and Proceduralists

To meet ratios at all times, will require surgeons and proceduralists to restrict their practice. Elective, and even urgent cases will have to be scheduled only when there is enough staff to meet the post operative ratio model. As occurred this past year, GSRMC was down 1,000 surgical cases due to lack of staff to meet our agreed upon staffing. If there are emergency surgeries and procedures, they will bump medical patients which will back up other patients to the ED, impacting other hospitals. Eventually this will drive surgeons and other proceduralists out of the state, if they cannot provide consistent services to their patients.

ED volume

The ED is a very dynamic patient flow area. It is very common to see even now, when one regional ED is busy so are the rest of the EDs within that region, often the whole state gets impacted at the same time. When all EDs are busy either in a community or within the state, and we continue to have strict ratios to

meet at all times, where will patients be forced to go. This is occurring now, without the strict ratios at all times. Staff do flex up and down to meet these demands. That flexibility is taken away in this Bill. With such loose associations to safety and quality of care, this is a capricious effort based on weak evidence of staffing impact on safety and quality (see references).

Specialized Services

There are hospitals that specialize in providing high risk care:

- Heart attack STEMI
- Trauma
- OB high risk deliveries
- Strokes
- Dialysis
- Critical Care (adult and pediatric)

When this specialized care is needed and staffing ratios are not met, hospitals will have to say Sorry, we are at our max nurse-to-patient ratio. Keep driving until you find a hospital that can accept you. This is not why nurses and healthcare professionals went into their career.

Who is going to pay for this unnecessary bill?

The increase in costs of this bill on nursing alone is staggering. At SHS (5 hospitals), there is an estimated need for over 120 more RNs. For SHS the cost increase to maintain our current staffing patterns is a 520% increase from prior years. This does not include the additional 120 RNs. Why is it so costly? There is not enough staff in Oregon to manage the volume of patients being seen. We must utilize travelers and additional premium pay to incentivize staff to work extra shifts. This bill increases the demand and does not help solve a fundamental issue of lack of staff.

What does the literature actually state on staffing ratios?

Butler et al 2019 Hospital nurse-staffing models and patient and staff related outcomes (lit review)

There is Low Certainty of evidence that suggest there is no relationship between Nurse Staffing and patient mortality, nurse turnover, and costs is unclear due to the very low certainty of evidence. This was the conclusion after independent pairs extracted data from each potentially relevant study to assess risk of bias and certainty of evidence.

Cook et al 2012 Effects of hospital nurse staffing mandate on patient health outcomes, Evidence from CA minimum staffing regulations. They reviewed Aiken et al study and found significant issues with the study including omitted variable bias, endogenous sorting issues. *In sum, we find no evidence of a causal impact of the patient -nurse ration on failure to rescue, a commonly measured patient outcome.*

Chiara Dall'Ora et al 2022 Nurse staffing levels and patient outcomes: a systematic review of longitudinal studies. "*There is some evidence of harm linked to high levels of assistant staffing and temporary staffing".*

Law et. al. 2018 Patient outcomes after the introduction of statewide intensive care unit nurse staffing regulations. *We did not identify improvement in patient outcomes associated with the Massachusetts nursing regulations. Results were robust to multiple sensitivity and subgroup analysis.*

Twigg et all 2020 The impact of nurse staffing methodologies on nurse and *patient* outcome*. Evidence on the impact of specific nurse staffing methodologies and patient and nurse outcomes remain highly limited. Findings related to patient outcomes were inconclusive.*

CA Issues Brief 2009 Assessing the Impact of Ca Nursing staffing ratios on Hospitals and patient care.

There was a significant increase in labor cost and reduction in operating margin. The main desired outcome of minimum nurse staffing legislation was the improvement of patient outcomes.: however, most of the quality measures analyzed for this study do not appear to have been directly affected by the increase in RN staffing. These measures include Average LOS, pressure injuries, failure to rescue, DVT, pneumonia mortality, and post op sepsis.